Black Maternal Health, Poverty, and the Fight for Reproductive Justice

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Legal Problems of the Poor

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Abstract

This paper explores how U.S. legal and policy systems—including Medicaid, maternal care guidelines, and mental health service regulations—fall short in addressing the needs of low-income Black women during pregnancy and postpartum. Drawing from my own pregnancy and postpartum experience navigating Medicaid coverage and mental health care, I argue that even when safety nets exist, structural limitations, racial bias, and financial inaccessibility restrict the bodily autonomy of Black women, especially those who wish to pursue midwifery, doula care, or home birth options. Using a reproductive justice framework, I analyze key precedents including *Harris v. McRae*, *Dobbs v. Jackson Women's Health Organization*, and *Rosie D. v. Romney*, demonstrating how the law has been weaponized to coerce motherhood while denying essential care. A brief comparison with maternal care models in Ghana and Haiti illustrates how culturally grounded and community-based care—even in resource-limited settings—offers alternatives that U.S. systems fail to provide. The paper concludes with concrete policy recommendations aimed at restoring autonomy and dignity to Black mothers—ranging from Medicaid reforms to expanded perinatal mental health support. Achieving reproductive justice ultimately requires systemic change that centers the voices and needs of Black women.

Introduction: Medical Gatekeeping and Reproductive Justice

In the U.S., the government is increasingly forcing pregnant women to carry pregnancies to term—as seen in the overturn of *Roe v. Wade*. At the same time, it withholds meaningful health care support for those pregnancies. The traditional reproductive rights movement has largely centered around abortion access and reproductive autonomy through a legal lens. But for many Black women, especially those living in poverty, this narrow framing was never enough. In response, Black women activists developed the reproductive justice framework in 1994. As

defined by SisterSong, a Black women-led collective, reproductive justice is the "human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[1]

This framework matters because it acknowledges that legal rights do not guarantee access. Even if abortion is technically legal in a state, low-income Black women may still face barriers to transportation, childcare, housing, or accessing clinics. Similarly, birth choices like using midwives or doulas—though not legally prohibited—are still inaccessible when Medicaid fails to cover them. Reproductive justice brings these interlocking barriers into focus and pushes us to demand more meaningful support. It also emphasizes community-based solutions, cultural competency, and political inclusion, making it the most relevant framework for analyzing maternal health outcomes under structural racism and economic marginalization.

Historical Roots of Exclusion

To illustrate how the barriers faced by Black women manifest in real life, I share my personal experience navigating pregnancy and postpartum under Medicaid.

My dream has always been to have a water birth, preferably at home but was open to a birthing center. I was certain that I did not want a hospital birth, especially given the well-documented disparities Black women face in institutional settings. To understand why this dream was so important—and so difficult to achieve— we must look at the historical exclusion of Black women from institutional maternal care in the U.S. Historically, hospitals either excluded Black patients or severely limited their access.[2] "In addition to 'separate-but-equal' hospitals, significant

[1] SisterSong, *About Us*, https://www.sistersong.net/about-x2

[2] Daryll C. Dykes, *Health Injustice and Justice in Health: The Role of Law and Public Policy in Generating, Perpetuating, and Responding to Racial and Ethnic Health Disparities Before and After the Affordable Care Act*, 41 Wm. Mitchell L. Rev. 1129 (2015).

federal funds went to hospitals that segregated patients on the basis of race."[3] These incentives perpetuated the racial disparities Black individuals—particularly women—faced when navigating the health care system. The Hill-Burton Act of 1946, which provided construction grants to hospitals, often supported institutions that refused to accept Black patients or subjected them to substandard conditions.[4] This program provided over $30 million[5] in federal grants for hospital construction and remodeling—disproportionately supporting white-serving facilities by providing only $4 million to Black facilities, despite the greater need for resources.

Although the Civil Rights Act of 1964 formally prohibited racial discrimination by federally funded institutions, structural racism persists in health care.[6] Black women are still more likely to have their pain dismissed, receive inadequate diagnoses, and suffer worse outcomes, including death. According to the World Health Organization (WHO), maternal mortality is "the death of a woman while pregnant or within 42 days of termination of pregnancy . . . from any cause related to or aggravated by the pregnancy or its management."[7] In 2023, the Centers for Disease Control and Prevention (CDC) reported that the maternal mortality rate for Black women was 50.3 deaths per 100,000 live births—more than three times that of white women (14.5).[8]

These disparities, with structural racism embedded in health care, have led many Black women to seek alternative birthing options that feel safer, more supportive, and more culturally affirming. Structural racism has long-term psychological effects that place Black women at higher

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[3] *Id*.
[4] *Id*. at 1161.
[5] Today, $30 million in 1946 is roughly equivalent to $520 million.
[6] *Id*. at 1162-3.
[7] World Health Organization, *Maternal Mortality*, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622
[8] Nat'l Ctr. for Health Stat., Ctrs. for Disease Control & Prevention, *Maternal Mortality Rates in the United States, 2023,* https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/maternal-mortality-rates- 2023.htm

risk for serious health problems that are harmful to both them and their babies.[9] These risks include complications like preeclampsia and embolisms, as well as mental health challenges. Other life-threatening conditions like diabetes, high blood pressure and heart disease are also more common. Their increased risk for complications during pregnancy, including preterm labor, can lead to lost wages and job insecurity due to inadequate workplace protections. Statistics have shown that "compared to non-Hispanic white women, Black women are more likely to quit, be fired, or return to work before they are healthy after giving birth due to inadequate leave policies." (Black Mamas Matter Alliance, *Black Maternal Health: Statistical Brief* (Apr. 2022). Between 2011 and 2015, nearly three in ten pregnancy discrimination charges were filed by Black women.[10] The stress of navigating racism, poverty, and poor maternal care can elevate cortisol levels, which negatively affects both maternal and infant health. These factors all contribute to the compounding cycle of disadvantage for low-income Black women.

Personal Narrative: Support with Strings Attached

The legacy of exclusion directly shaped my own experiences navigating pregnancy under Medicaid.

I was approved for Medicaid during my pregnancy in 2022. This provided relief with expenses I could not afford otherwise, like prenatal visits and the birth itself. However, this financial safety net came at the cost of autonomy. Medicaid only covered hospital births at certain facilities. If I wanted a water birth at home or in a birthing center, I would have to pay thousands of dollars out of pocket—an option that was financially out of reach. These exclusions reflected deeper institutional decisions about which births deserve to be supported. Even after qualifying for

[9] Black Mamas Matter Alliance, *Black Maternal Health: Statistical Brief* (Apr. 2022), https://blackmamasmatter.org/wp-content/uploads/2022/04/0322_BMHStatisticalBrief_Final.pdf
[10] *Id*.

Medicaid, I encountered delays in receiving care. At over four months pregnant, I was repeatedly denied appointments because some facilities did not accept Medicaid or prioritized only current patients. This systemic rigidity—where care is often denied or delayed—reflects a health care system more concerned with profit than health equity. Eventually, I found a provider but felt like I was pushed through the 10-minute appointment loop that barely scratched the surface of my needs. As a lower-income Black woman, I was already in a vulnerable category. The rushed nature of care reinforced the sense that my well-being was not a priority.

Thereafter, I switched to UNC Family Medicine's midwife program—though it was largely meant to be symbolic, since there was only one midwife on staff and the medical protocols generally remained the same. Still, I felt safer under the care of a Black woman provider. Through her, I learned about the LEADoula program, which pairs trained Black doulas with Black mothers at no cost. Their goal is to improve Black women's maternal and birth outcomes and increase access to social and educational support.[11] The doula I was matched with added value to my pregnancy and postpartum experience. But this is not the norm for Black mothers. Many Medicaid programs in the U.S. do not cover or reimburse doula services; or if they do, they often pay low rates or create excessive bureaucratic hurdles that discourage access.[12] True reproductive justice would ensure that every pregnant mother has access to the culturally affirming support they need, not just those lucky enough to find loopholes.

Medical Bias and Cost: The C-Section Crisis

Beyond the birth experience itself, systemic racial disparities extend into the type of care received—particularly in the rising rates of cesarian (C-section) births among Black women.

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[11] LEADoula, https://www.leadoula.org/theprogram

[12] Rory Peters & Alexis Robles-Fradet, *2024 Update: Medicaid Coverage for Doula Care Requires Sustainable and Equitable Reimbursement to be Successful*, National Health Law Program (Jan. 2025), https://healthlaw.org/2024-update-medicaid-coverage-for-doula-care-requires-sustainable-and-equitable-reimbursement-to-be-successful/.

Black women are disproportionately subjected to C-section deliveries. In 2022, as provided by the CDC, nearly 37% of Black mothers were delivered by C-sections, compared to just over 31% of white mothers.[13] These disparities raise concerns about implicit bias, over-medicalization of Black women, and the quality of care received. Hospital births involving surgical interventions like C-sections are substantially more expensive than community-based options such as home births or births attended by midwives or doulas. Despite this, many insurance plans, including Medicaid, offer limited coverage or reimbursement for these lower-cost, lower-intervention alternatives.

The way Medicaid and private insurance reimburses care often favors hospital-based, intervention-heavy births. The health care system often incentivizes high-intervention birth (like C-sections) because they are more profitable. C-sections, while lifesaving when medically necessary, carry higher risks of infection, hemorrhage, longer recovery times and complications in future pregnancies.[14] For Black women, who already face higher risks during pregnancy and childbirth and chronic levels of poverty, unnecessary surgical interventions can further worsen outcomes. According to recent estimates, the total average hospital bill for a vaginal birth is around $15,000, while for a C-section it rises to about $26,000, with ensured patients typically paying about $3,400 out-of-pocket.[15] Yet, data from the National Association of Certified Professional Midwives (NACPM) shows that a home birth costs about $4,650, and a birth center delivery averages $8,309—thousands of dollars less than hospital births. Despite these safer, more autonomous, and more affordable alternatives, many people—particularly those on Medicaid—

[13] Nat'l Vital Stat. Rep., Vol. 73, No. 2 (2024), https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-02-tables.pdf

[14] Am. Pregnancy Ass'n, *C-Section Complications*, https://americanpregnancy.org/healthy-pregnancy/labor-and-birth/c-section-complications/

[15] Rachel Morgan Cautero, *How Much Does It Cost to Have a Baby in America?* (Nov. 2023), https://www.investopedia.com/how-much-does-it-cost-to-have-a-baby-in-america-6745508

are left with hospital-based options due to insurance restrictions and lack of access to midwifery care. This forces Black mothers into higher-cost, high-intervention settings, even when they might prefer and benefit from community-based care.

Legal Battles over Reproductive Autonomy

While these systemic barriers are evident in health care practices, they are reinforced—and sometimes created—by legal precedent.

The story begins with *Roe v. Wade* (1973), which declared abortion a constitutional right under the Due Process Clause of the 14th Amendment.[16] However, the scope of that right was narrowed seven years later in *Harris v. McRae* (1980), when the Supreme Court upheld the Hyde Amendment, restricting the use of Medicaid funds for abortion services.[17] This has effectively denied abortion access to many low-income women for decades, proving that legality does not equal accessibility. These cases reveal how legal decisions have historically restricted reproductive autonomy—particularly for low-income Black women—while coercing childbirth.

Later, *Planned Parenthood v. Casey* (1992), introduced the "undue burden" standard, allowing states to impose restrictions on abortion as long as they did not place a "substantial obstacle" in the way.[18] These restrictions, like waiting periods or parental notification laws, disproportionately affected low-income Black women who may not have the resources to comply. Finally, in *Dobbs v. Jackson Women's Health Organization* (2022), the Court overturned *Roe* entirely, eliminating the constitutional right to abortion. For women already navigating a hostile system, the *Dobbs* decision represented a legal stripping of agency. This trajectory illustrates how the law has never fully protected reproductive freedom for marginalized women. Instead, courts

[16] *Roe v. Wade*, 410 U.S. 113 (1973).
[17] *Harris v. McRae*, 448 U.S. 297 (1980).
[18] *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

and policymakers have often used the law to control, constrain and criminalize reproductive choices.

The U.S. is not alone in facing resource constraints, but how those constraints are addressed varies greatly. Comparing global models offer insight into alternative, culturally rooted maternal care systems.

Global Comparisons: Lessons from Ghana and Haiti

On a recent trip to Ghana, I witnessed maternal care embedded in community support. Midwives appear to be integrated into local structures. Though the health system faces financial limits, care is culturally grounded and collaborative. While traditional birth methods remain common, there is less shame and stigma around needing help. Similarly, in Haiti, maternal care is embedded in community trust and spiritual practice. While the country's political and economic challenges strain its health system, the care is facilitated through networks of grandmothers, neighbors, and spiritual leaders who attend to pregnant women and mothers in ways that foster security, familiarity, and collective wisdom. This comparison illustrates that poverty alone does not explain maternal health disparities but rather the systems and values in place.

Despite fewer resources, Ghana and Haiti provide valuable models of care rooted in community and cultural responsiveness. While not without challenges, these models reflect a communal ethic of care that contrasts sharply with the U.S. model, where mothers are isolated and forced to navigate systems alone. Despite our wealth, we fail to invest in community-based, and culturally competent care.

According to WHO, countries with strong maternal outcomes—like Australia, Canada, and New Zealand—also invest in midwifery, postpartum home visits and universal maternal

coverage.[19] These services are often publicly funded, ensure early detection of complications, offer continuous emotional support, and coordinated care that extend beyond childbirth. Such holistic approaches contribute to significantly lower maternal mortality rates and better long-term health for mothers and infants compared to countries lacking these supports, like the U.S., where the health care system is fragmented and deeply unequal. This evidence highlights the critical role of accessible, community-centered maternal health services in improving outcomes and reducing disparities.

Postpartum and Mental Health: A Neglected Crisis

However, reproductive justice goes beyond the moment of childbirth.

Mental health during and after pregnancy is a critical part of maternal care, yet it remains one of the most neglected aspects of the U.S. system, especially for low-income Black women. The CDC estimates that about 1 in 8 women experience symptoms of postpartum depression within the first year after giving birth, though this is likely underreported among Black women due to stigma, mistrust of providers and systemic neglect.[20] During my postpartum journey, I participated in an intensive outpatient program for postpartum anxiety and depression. However, once it ended, finding a follow-up provider who was culturally competent, accepting new patients and within a reasonable distance became an uphill battle—a common experience for low-income Black mothers. There was no warm hand-off or continuity, just a gap in care. This gap reinforces isolation and systemic neglect that low-income Black mothers typically face.

The case of *Rosie D. v. Romney* (2006) pushed Massachusetts to expand community-based behavioral health services for children.[21] The U.S. District Court ruled that Massachusetts had

[19] The Commonwealth Fund, https://www.commonwealthfund.org
[20] Ctrs. for Disease & Prevention, *Depression During and After Pregnancy*, https://www.cdc.gov/reproductive-health/depression/index.html
[21] *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (2006).

violated federal Medicaid law by failing to provide adequate mental health services to children with serious emotional disturbances. The ruling resulted in the creation of the Children's Behavioral Health Initiative (CBHI) to expand access to appropriate services in community settings. But where is the equivalent for mothers? Why are the same legal protections not extended to postpartum women who continue to suffer without adequate care?

Policy must move beyond "coverage" and ensure continuity, quality, and cultural safety. We need Medicaid policies that extend postpartum mental health coverage to at least three years, requiring mental health screenings at multiple postpartum milestones.

Policy Solutions Toward Reproductive Justice

Addressing these gaps require us to dive deeper into policy solutions rooted in equity and justice. Black women—regardless of poverty levels—should have a right to safe pregnancies, to raise their children in safe, supported environments and to choose how to give birth. To begin closing the gap between policy and justice, I would strongly suggest these policy solutions:

- Extending postpartum Medicaid to three years in all states to reflect to the full arc of recovery and support after childbirth
- Expanding Medicaid coverage to home births and birthing centers
- Funding doula and midwife care through Medicaid
- Expanding access to perinatal mental health care with provider incentives
- Funding Black-led community wellness programs
- Decriminalizing poverty-related parenting issues—including neglect cases linked to housing or lack of childcare
- Centering Black women in policymaking, especially around reproductive health

Conclusion

Laws that force motherhood but abandon mothers deepen racial and economic injustice. My experience navigating Medicaid, birth planning and postpartum recovery shows that autonomy and access are too often treated as luxuries. This paper has argued how structural inequities—through Medicaid limitations, racial bias, and legal barriers—undermine reproductive autonomy for low-income Black women. A true reproductive justice framework demands more than legality; it requires dignity, access, and freedom of choice. Reproductive justice demands not just the right to give birth but the right to thrive in the process and aftermath.