



National Faith in Action Guide on

Maternal Health



The Partnership Center
Center for Faith-based and Neighborhood Partnerships
U.S. Department of Health and Human Services

The United States has a higher maternal mortality rate than nearly any other economically advanced country in our world, and unacceptable disparities in maternal health outcomes.

69.9

Black maternal deaths per 100,000 U.S. live birthsⁱ

Key findings from the Centers for Disease Control and Prevention (CDC) show that non-Hispanic Black women are three times more likely than White women to die from a pregnancy-related cause. Rates for non-Hispanic Black women were significantly higher than rates for non-Hispanic White and Hispanic women.

32.0

Non-Hispanic American Indian or Alaska Native Persons (AI/AN) maternal deaths per 100,000 U.S. live birthsⁱⁱ

Non-Hispanic American Indian and Alaska Native women are two times more likely than White women to die of pregnancy-related causes.ⁱⁱⁱ

26.6

Non-Hispanic White maternal deaths per 100,000 U.S. live births^{iv}

28

**Hispanic maternal deaths per
100,000 U.S. live births^v**

25,000

Women experience severe, unexpected health problems related to pregnancy that may have long-term health consequences every year.^{vi}

Women know their own bodies better than anyone and can often tell when something does not feel right. It's important to encourage partners, friends, family, coworkers, and providers—anyone who supports pregnant and postpartum persons—to really listen to women who say something doesn't feel right. Acting quickly could help save an expectant individual's life.

80%

Preventable maternal deaths

According to the CDC, four in five pregnancy-related deaths are preventable. Maternal mortality and maternal morbidity remain a major public health concern in the USA.^{vii}

All statistics provided are the most recent statistics on maternal health available at the time of publication.

“We imagine a future where every person in the U.S. can have a safe, dignified pregnancy and birth and where equitable access to health care before, during and after pregnancy is a right, not a privilege.”

White House Blueprint for Addressing the Maternal Health Crisis

About Maternal Health

Maternal health refers to the health of persons during pregnancy, delivery, and the postpartum period (typically considered up to a year after the birth of a child). While parenthood is often a positive and fulfilling experience, far too many expectant persons associate it with suffering, ill-health, and even death.

Safe parenthood begins even before conception with good nutrition and a healthy lifestyle. It continues with appropriate prenatal care and preventing problems as they arise. The ideal result is a full-term pregnancy without unnecessary interventions, the delivery of a healthy baby, and a healthy postpartum period in a positive environment that supports the physical and emotional needs of the mother, baby, and family.

Pregnancy and delivery have huge impacts on the physical, mental, emotional, and socioeconomic health of expectant individuals and their families. Pregnancy-related health outcomes can also be influenced by a woman's health and other factors like race, ethnicity, age, and income. Taking the whole person into perspective is an important component of promoting maternal health in our communities.

About Maternal Morbidity and Maternal Mortality

A woman's reproductive system is a delicate and complex system in the body. It is important to take steps to protect it from infection, injury, and complications—including some long-term health problems.

According to the CDC, regardless of income or education level, Black women are three times as likely as white women to die from pregnancy-related complications. AI/AN women are more than twice as likely as white women to die from pregnancy-related complications. These outcomes are largely due to systemic inequities, which create significant disparities in how women experience the healthcare system that can often be a matter of life and death.^{viii}

When it comes to maternal health, there are many factors that contribute to maternal mortality and morbidity. Studies show that an increasing number of pregnant women in the United States have chronic health conditions such as hypertension, diabetes, and chronic heart disease. These conditions may put a woman at higher risk of complications during pregnancy or during the postpartum period.^{ix}

Other contributing factors to maternal mortality include Intimate Partner Violence (IPV), mental health challenges, and Substance Use Disorder (SUD).

Challenges In Rural Communities

As described by the Centers for Medicare and Medicaid Services and their report “[Improving Access to Maternal Health Care in Rural Communities](https://bit.ly/47kVT7h)” available at <https://bit.ly/47kVT7h>^x, rising maternal mortality rates and the disproportionate affect they have on Black and AI/AN women is of great concern in rural communities. A lack of access to high quality maternal health services in rural communities is the result of many factors. These factors include hospital and obstetric department closures, workforce shortages, and access to care challenges. These access challenges can result in a number of negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression. These health disparities affect AI/AN and women of color disproportionately.^{xi}

With the high rate of hospital closures in rural communities, fewer than 50% of rural women have access to perinatal services within a 30-mile drive from their home and more than 10% of rural women must drive 100 miles or more for these services. These conditions affect access to care before, during, and after pregnancy. They are more pronounced in the Black and Hispanic communities and disproportionately affect low-income women.^{xii}

In an ideal maternal health system, all women would have access to comprehensive, seamless medical care with links to behavioral, economic, and social supports. Additionally, they would be engaged with this system before, during, and after pregnancy. Across the United States, many women are not receiving care in this ideal system, and women in rural communities face unique challenges that make it harder for them to receive appropriate care, or any care at all in some cases.

These gaps in maternal health care clearly affect access to labor and delivery services. They also affect access to care before and after pregnancy and comprise one set of factors associated with a range of infant and maternal health outcomes in rural America, such as maternal mortality.

Using maternal mortality as one proxy for overall maternal health, there are 29.4 maternal deaths per 100,000 in the most rural areas versus 18.2 in urban areas.^{xiii}

Furthermore, between 10% and 40% of women do not complete a postpartum visit. Similar to barriers in accessing prenatal care, many women who live in rural areas may not receive the recommended postpartum care or follow-up visits due to geographic isolation, limited transportation, or lack of childcare, among other reasons. As with prenatal care, women of color in rural communities face barriers to access including lack of a primary care provider, avoidance of medical care due to cost, and experiences of discrimination.

Intimate Partner Violence

Intimate Partner Violence (IPV) is abuse or aggression that occurs in an intimate relationship, which includes current and former spouses as well as dating partners. IPV can vary in severity and frequency. It can range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years.^{xiv}

IPV during pregnancy is a serious public health issue with significant negative health consequences for women and children. Research has shown that between 3% and 9% of women experience abuse during pregnancy.^{xv} IPV is also connected to other forms of violence and adverse economic consequences. In their report, "[A Comprehensive Review of Intimate Partner Violence During Pregnancy and Its Adverse Effects on Maternal and Fetal Health](#)," experts highlight how IPV can cause physical, sexual, emotional, and financial distress. Its consequences can be severe, with adverse effects on maternal and fetal health including an increased risk of preterm birth, low birth weight (LBW), fetal injury, maternal depression, anxiety, post-traumatic stress disorder (PTSD), and even maternal death.^{xvi}

IPV during pregnancy is influenced by a range of individual, relationship, community, and societal factors. Understanding these factors can help identify women who are at increased risk of experiencing IPV during pregnancy and develop effective interventions. IPV can be prevented, and it is essential that interventions and resources are tailored to meet each women's individual needs.^{xvii} Health care providers recognize that there are opportunities during health screenings, prenatal care, and even physician visits to identify signs of IPV. These signs may include "insufficient or inconsistent prenatal care, poor nutrition, inadequate weight gain, substance use, [and] increased prevalence of depression"^{xviii} both during pregnancy and in the postpartum period.

For more information about how to address IPV, consider the CDC's guide, "[Preventing Intimate Partner Violence Across the Lifespan](#)," from CDC available at bit.ly/3uin4i6.

Maternal Mental Health

Maternal depression is a prevalent problem during the perinatal period, when women of child-bearing age are at the highest risk for their first depressive episode. CDC research shows about 1 in 8 women with a recent live birth experience have symptoms of postpartum depression.^{xix}

Postpartum depression (PPD) is depression that occurs after having a baby. Estimates of the number of women affected by postpartum depression differ by age, race, ethnicity, and state. You can view a state's prevalence of postpartum depressive symptoms by using the [CDC's Pregnancy Risk Assessment Monitoring System](#) (PRAMS) available at <https://www.cdc.gov/prams/prams-data/selected-mch-indicators.html>. PPD is a mood disorder that affects approximately 10–15% of adult mothers yearly, with depressive symptoms lasting more than 6 months among 25–50% of those affected. It often occurs within a few months to a year after birth.^{xx}

PPD symptoms include depressed mood, anxiety, guilt, irrational fears, anger, and difficulty bonding with the infant.^{xxi} The good news is that depression and postpartum depression is treatable. If you know of an expectant individual who is experiencing depression, please help them text or call the Maternal Mental

Health Hotline at 1-833-9-HELP4MOMS (1-833-943-5746), which is available in English and Spanish. TTY Users can use a preferred relay service or dial 711 and then 1-833-943-5746. Keep in mind that the Maternal Mental Health Hotline is not intended as an emergency response line and individuals in a behavioral health crisis should continue to contact the National Suicide Prevention Lifeline at 988, if needed.

Initiating the conversation regarding postpartum depression can be uncomfortable. However, it's important not to tiptoe around the topic. The HHS Office of Women's Health offers insightful ways to start the conversation in their article "[Tips for Supporting Someone with Postpartum Depression](https://bit.ly/3TIQQdK)" available at <https://bit.ly/3TIQQdK>. It is important to talk about PPD with compassion and kindness, acknowledging that PPD challenges are common, and women may not be aware of their PPD symptoms. PPD symptoms can be difficult to identify, as some symptoms overlap with fatigue and or stress. The article advises one of the best ways to begin the conversation is to start by expressing your care and concern. Use "I" statements to avoid sounding like you're blaming or judging her. Listen as she responds without interrupting. Additional "I" statement tips include:

- "I know everyone is focused on the baby, but I want to hear about you."
- "I notice you're having trouble sleeping, even when the baby sleeps. What's on your mind?"
- "I know a new baby is stressful, but I am worried about you. You do not seem like yourself. Please tell me how you are feeling."
- "I really want to know how you're feeling, and I will listen to you."

Additionally, you may learn more about the signs and symptoms for new mothers experiencing a mental health crisis in your community and family by using resources available through the [Mayo Clinic](https://bit.ly/3GshgbB) at bit.ly/3GshgbB.

Maternal Substance Use Disorder

Alcohol and drug use by pregnant women is known as maternal substance use disorder. It is a serious problem with long-lasting effects and consequences for a child's social, emotional, and cognitive development. Heroin, methadone, and heavy alcohol consumption during pregnancy are associated with lower birth weight and central nervous system (CNS) dysfunction.^{xxii} Babies born to mothers who use cocaine during pregnancy, for example, are often delivered prematurely, have low birth weights, smaller head circumferences, and are shorter in length than babies born to mothers who do not use cocaine.^{xxiii} Mothers with SUD have higher rates of reported child abuse, neglect, and placement of children into foster care.^{xxiv}

According to a study by researchers at the National Institute on Drug Abuse (NIDA), available at bit.ly/48cZzZo, [overdose deaths increased in pregnant and postpartum women from early 2018 to late 2021](https://bit.ly/48cZzZo). The NIDA research highlights that while treatment is available to pregnant women, significant barriers such as penalization, stigma, discrimination, and limited socioeconomic resources may obstruct the path to care for pregnant women struggling with substance use disorder. This study further reveals the

significance of reducing the barriers and stigma that surround maternal substance use disorder. Reducing any of these barriers can provide an opening for pregnant individuals to seek and receive evidence-based treatment and social support to sustain their health and the health of their child.^{xxv}

Learn about the impact of maternal SUD and the withdrawal or abstinence symptoms that may develop after birth by using resources available through the [National Center on Substance Abuse and Child Welfare](https://bit.ly/3RI2t1W) at <https://bit.ly/3RI2t1W>.

Why Do Expectant Individuals Not Receive the Care They Need?

Many different factors and circumstances can impact a pregnant person's decision to seek care. According to [health.gov](https://www.health.gov), Social Determinants of Health (SDOH) are conditions in an environment that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions include where people are born, live, learn, work, play, worship, and age. Some SDOH include housing, racism and discrimination, education and literacy skills, income, access to quality food, and air and water quality. Challenges related to poor SDOHs can also contribute to wide-ranging health disparities and inequities. These are all elements that can impact an expectant individual's decisions to seek care. A person with low income may not have resources to pay for care. A person of color may have experienced care from a physician with low or no cultural competency that discourages her from continuing care.

Improving maternal health is only possible if we address the systemic racism that is entrenched not only in our health care system but also, as stated in the [Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government](https://bit.ly/3NNe2DL) available at <https://bit.ly/3NNe2DL>, in our laws, public policies, and public and private institutions. The Administration's Blueprint for Addressing the Maternal Health Crisis points out that systemic barriers, together with a failure to recognize, respect, and listen to patients of color, has meant that Black and AI/AN women, regardless of income or education, experience a greater share of these grave outcomes. These outcomes are made worse when mothers are housing-insecure, hungry, reside in areas with toxic environmental chemicals, face financial instability, lack workplace protections and benefits, and/or are repeatedly exposed to crime and violence, including sexual assault, domestic violence, and other forms of gender-based violence. Health disparities in many or all of these areas disproportionately affect women from communities of color and rural communities.

Some factors that prevent persons from receiving or seeking care during pregnancy and childbirth are:

- Cost of care
- Transportation
- Lack of information
- Inadequate services
- Racism and discrimination



How Can Lives of Expectant Individuals Be Saved?

80% of pregnancy-related deaths, which can occur up to one year after delivery, are preventable.^{xxvi}

The health-care solutions to prevent or manage complications are well known. All expectant individuals need access to prenatal care in pregnancy, skilled care during delivery, and support in the weeks and months after delivery. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death. For example, severe bleeding after birth can result in death of the mother within two hours if she is unattended by skilled health professionals. Infection after delivery can be eliminated if good hygiene is practiced and if early signs of infection are recognized and treated in a timely manner.

Maternal Health is About the Whole Family!

All members of a family are part of the childbearing experience. It is not only the pregnant individual who goes through emotional distress but so do the father and the children. Child-bearing is a family affair! Once the announcement has been made that someone is expecting, all lives in the family change. Each person in a family adapts to the new addition to the family recognizing that each can experience their own levels of depression, anxiety, and other emotional and psychological challenges.

The Legacy: Katrina DeLynn Robinson

Written by Shiriki Davis as a letter to her sister

Katrina DeLynn Robinson was a daughter, mother, and she was my sister. Katrina received her bachelor's degree from the University of North Texas, worked at a local news station, and was active in her faith. Yet, Katrina's greatest desire was to become a mother. In 2006 her dream came true. Katrina became pregnant and during her early months radiated with health and happiness.

As Katrina entered her final trimester of pregnancy, things began to get complicated. At a baby shower, several noticed that Katrina had excessive swelling. Katrina immediately contacted her OB/GYN and a decision was made to deliver the baby early. Katrina was in labor over 20 hours before a Cesarean was performed to deliver her son. The baby needed immediate attention and my sister was exhausted. I remember her asking in a whispered voice, "Did I do good?" and we affirmed her with love, hugs, and kisses.

Katrina and her son were surrounded by family who encouraged and supported their recovery. However, in the days following the delivery, Katrina wasn't the same. She was constantly short-winded, exhausted, and didn't want company. Over the next three days in the hospital, she consistently informed her nurses caring for her and her OB/GYN that she was not well. The on-call OB/GYN read her chart and told the nurses Katrina was dealing with post-partum depression—and not to bother him with this patient anymore. Katrina called our father and said, "Dad, I feel like if I go to sleep, I will never wake up!"

On May 6, 2007, Katrina was moved to the ICU. Immediately upon her arrival, her condition worsened. After four weeks of fighting a good fight, surrounded by family and friends, Katrina was taken off the ventilator and passed away.

Racial disparities exist as it pertains to Black women and the health care they are provided during pregnancy. Black women are three to four times more likely to have barriers to obtaining adequate quality of care. Katrina had insurance, was at a top-rated hospital, was well educated, and came from a strong family background of support. She just didn't receive the health care or attention she should have received as it pertained to her specific health care needs and concerns. She had all the social equity a patient should need to receive quality treatment and care—but Katrina is Black. There is a disparity in the number of diversified physicians in this health care area of specialty, there is unacknowledged racial discrimination that exists, and there needs to be more education and awareness to bridge this gap in our healthcare systems across the nation. Black women's maternal healthcare is a priority that needs to be addressed immediately. As Katrina's only sister, sibling, I am working to keep her legacy alive.

In Loving memory, your sister,
Shiriki Davis

What Can Pregnant People and Their Families Do?

Pregnant or recently pregnant people go through many changes. Changes are normal, but some could be warning signs for complications or more serious problems. The CDC’s “Hear Her” campaign (www.cdc.gov/hearher) offers resources to improve communication around pregnancy and postpartum concerns. Serious pregnancy-related complications and deaths can occur, but many can be prevented if the warning signs are recognized and help is given early.

Tips for pregnant and recently pregnant women:

- Talk to a healthcare provider if anything doesn’t feel right or is concerning.
- Seek immediate care if you experience any urgent maternal warning signs available at bit.ly/MOMSwarningsigns, including severe headache, extreme swelling of hands or face, trouble breathing, heavy vaginal bleeding or discharge, and overwhelming tiredness. These symptoms could indicate a potentially life-threatening complication.
- Document and share your pregnancy history during each medical care visit for up to one year after delivery.
- Maintain ongoing healthcare and social support systems before, during, and after pregnancy.

Tips for healthcare providers:

- Help patients, and those accompanying them, understand the urgent maternal-warning signs, and when to seek medical attention right away.
- Help patients manage chronic conditions or conditions that may arise during pregnancy such as hypertension, diabetes, or depression.
- Take each patient concern seriously and address all of them.
- Provide all patients with respectful care.
- Identify and address unconscious bias in healthcare and improve delivery of quality prenatal and postpartum care.

Recommendations for Faith and Community Leaders

Maternal health is an indicator of a nation's health. Given how much faith leaders value our mothers and children, it is vital that everyone help combat this crisis.

The [White House Blueprint for Addressing the Maternal Health Crisis](https://www.whitehouse.gov/blueprints/maternal-health/) available at bit.ly/maternalblueprint, has identified five priorities to address our maternal health crisis. They are:

1. Increase Access to and Coverage of Comprehensive High-Quality Maternal Health Services, Including Behavioral Health Services.
2. Ensure Those Giving Birth are Heard and are Decisionmakers in Accountable Systems of Care.
3. Advance Data Collection, Standardization, Harmonization, Transparency, and Research.
4. Expand and Diversify the Perinatal Workforce.
5. Strengthen Economic and Social Supports for People Before, During, and After Pregnancy.

See below for some ideas on how faith and community leaders can get involved. Starting today, determine what you are able to do to support maternal health.

Talk about Maternal Health with your Congregation and Community

As appropriate to your faith tradition, include any of these points in a sermon and other communications with your congregation. You may also include these points in your bulletin announcements. Consider your own faith tradition and how you can affirm the role of parent and motherhood.

Build Community Capacity to Support Pregnant Women

The saying—"it takes a village to raise a child"—can also be said about maternal health care. In order for there to be changes in current outcomes, it will take a village comprised of obstetricians, doctors, midwives, doulas, faith communities, nonprofit and for-profit sectors, and families playing their roles in supporting pregnant women. Encourage and advocate for health systems to expand and diversify the perinatal workforce incorporating critical practitioners (such as licensed midwives) and community-based workers (such as doulas) into the maternal care system.

Celebrate the Role of Doulas in the Community

One way to provide support to pregnant women is through doula services. Doulas are nonclinical birth workers trained to provide continuous physical, emotional, and informational support to women in the prenatal, birth, and postpartum periods. Unlike licensed midwives, doulas do not provide clinical support, but instead serve as guides, advocates, and emotional support for mothers as they navigate the maternal health system. As described in the [White House Blueprint for Addressing the Maternal Health Crisis](#), research shows that doulas are associated with lower rates of maternal and infant health complications, lower rates of preterm birth and low birth weight infants, and lower rates of Cesarean sections, among other benefits. Moreover, women with doula support regularly report higher levels of emotional satisfaction with their birthing experience and also attest to developing positive relationships with their doulas over the course of their pregnancy. Host events in your community celebrating the role of doulas and increase awareness of the services they provide.

Encourage Community and Congregation Members to Become Doulas

Community members are being trained to become doulas, who provide continuous physical, emotional, and informational support to an expectant individual before, during, and after childbirth to help her achieve the healthiest, most satisfying experience possible. For example, [Healthy Start Programs](#) are hiring, training, certifying, and compensating community-based doulas in areas with high rates of adverse maternal and infant health outcomes. Learn more at bit.ly/3sAsBQM.

Support Groups for Pregnant Mothers

Houses of worship and communities can start a group like Sister Friends Detroit where members can coach and mentor expectant mothers. Other programs like the Moms2B program established by the Ohio State University provide weekly education and support sessions to promote healthy lifestyle choices and connect moms to support services. Programs like these provide support to individuals who are pregnant and to their families. Learn more about [Sister Friends Detroit](#) at bit.ly/3q8chpa and about [Moms2B](#) at bit.ly/3QribO5.

Expand Support for Pregnant Women in Rural Areas

Houses of worship and other communities can use their cars or vans to transport pregnant women in rural areas to their prenatal and postpartum appointments. Parishioners and others can volunteer to do the same, and partner with a local Federally Qualified Health Center (FQHC) to let them know these services are being offered.

Become a Safe House for Pregnant Mothers

“Safe Houses” are a national network of community-embedded direct service providers for pregnant and postpartum women. Visit the [Perinatal Safe Spots Page](https://perinataltaskforce.com/safe-spots) at <https://perinataltaskforce.com/safe-spots> to view current safespots. The Safe Spots are the roots of the National Perinatal Task Force, modelling the vision and birthing a just and loving world through practice. Developing Safe Spots are eligible to receive technical support and training to own and operate an official Safe Spot.

Host Community Baby Showers

Congregations, community members, and local partners can join together to host community baby showers to supply families with free baby supplies like clothes, diapers, and toys, and [maternal wellness resources](#) like information about mental health providers, vaccinations, substance use disorder treatments, prenatal care assistance, sleeping, lactation, and birthing techniques. Learn more at bit.ly/3lgWdaE.

Connect Pregnant Persons to Maternal Mental Health Hotline

The Maternal Mental Health Hotline is a new, confidential, toll-free hotline for expecting and new mothers experiencing mental health challenges. The hotline offers a range of support, including brief interventions from trained counselors who are culturally and trauma-informed, as well as referrals to both community-based and telehealth providers as needed. Call **1-833-9-HELP4MOMS** or **1-833-943-5746**. Learn more at <https://mchb.hrsa.gov/national-maternal-mental-health-hotline>.

Invite, Include, and Support Fathers

[Fatherhood.gov](https://fatherhood.gov) is a national resource for fathers, practitioners, federal grantees, states, and the public at-large who are serving or interested in supporting strong fathers and families. Resources are available to support the whole family.

Partner with your Local Health Care Provider

In many cases, your local health care providers—including your federally qualified health center (FQHC) (<https://findahealthcenter.hrsa.gov/>) and hospital health systems—offer opportunities to support maternal health in the community—such as [Me & My Baby](https://bit.ly/3MWN8aM) (bit.ly/3MWN8aM) at Yale-New Haven Hospital caring for uninsured expectant individuals or [Mercy Hospital’s Catherine’s Light](https://bit.ly/3iiD0L2) (bit.ly/3iiD0L2) program in Arkansas that addresses behavioral health needs, including addiction. For additional connections, email us at partnerships@hhs.gov.

Promote Vaccinations

Pregnancy makes people more susceptible to influenza that can be severe enough to cause hospitalization. Those with COVID-19 appear to be at a greater risk for complications and health risks from the virus. For example, whooping cough is a serious disease that can be deadly for babies. Pregnant persons can protect their babies by getting a Tdap vaccine while pregnant. Learn more and encourage expectant parents, families, and community members to get the vaccines needed to protect the babies in their care. (bit.ly/3wuUiLJ)

Play a Pre-recorded PSA During Your In-house Announcement or Post on Social Media

Email us at partnerships@hhs.gov for PSA. Use #SupportHealthyMoms to promote maternal health on social media platforms.

Use any of these ideas?

Tell us what is working to support Expectant Mothers
via email at partnerships@hhs.gov or via Twitter [@HHSPartnership](https://twitter.com/HHSPartnership)

References

- U.S. Department of Health and Human Services, “Fact Sheet: Celebrating Black History Month 2022” Available at <https://www.hhs.gov/about/news/2022/02/02/fact-sheet-celebrating-black-history-month-2022.html>
- U.S. Department of Health and Human Services, “Remarks by Secretary Xavier Becerra at the Health Affairs Journal Virtual Symposium on Racism and Health” Available at <https://www.hhs.gov/about/news/2022/02/08/remarks-by-secretary-xavier-becerra-health-affairs-journal-virtual-symposium-on-racism-health.html>
- The West Virginia Conference of the United Methodist Church, “Maternal Health” retrieved from https://www.wvumc.org/wp-content/uploads/2019/02/Social-Action_Maternal-Health.pdf
- The National Perinatal Task Force, <https://perinataltaskforce.com/>
- Center for Disease Control and Prevention, <https://www.cdc.gov>

Endnotes

- i Centers for Disease Control and Prevention, “Maternal Mortality Rates in the United States, 2021.” Retrieved from <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>
- ii Centers for Disease Control and Prevention, “Pregnancy Mortality Surveillance System.” Retrieved from <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>
- iii Centers for Disease Control and Prevention. “Disparities and Resilience among American Indian and Alaska Native People who are Pregnant or Postpartum.” Retrieved from <https://www.cdc.gov/hearher/aian/disparities.html>
- iv Centers for Disease Control and Prevention, “Maternal Mortality Rates in the United States, 2021.” Retrieved from <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>
- v Ibid
- vi 2022 National Healthcare Quality and Disparities Report [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2022 Oct. MATERNAL HEALTH. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK587184/>
- vii Centers for Disease Control and Prevention. “Pregnancy-Related Deaths in the United States.” Retrieved from <https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html>
- viii Centers for Disease Control and Prevention, “Women’s Reproductive Health” retrieved from <https://www.cdc.gov/reproductivehealth/womensrh/index.htm>
- ix Centers for Disease Control and Prevention, “Pregnancy Mortality Surveillance System” retrieved from <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>
- x All references for this section are from the CMS report mentioned in the text.
- xi Centers for Medicaid and Medicare, “Improving Access to Maternal Health in Rural Communities: An Issue Brief.” Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>
- xii Centers for Medicaid and Medicare Services. “Improving Access to Maternal Health Care in Rural Communities.” Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>
- xiii Ibid
- xiv Center for Disease Control and Prevention, “Fast Facts: Preventing Intimate Partner Violence.” Retrieved from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>
- xv Alhusen, Jeanne, et. al. “Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes” J Womens Health (Larchmt) 2015 Jan 1; 24(1): 100–106. doi: 10.1089/jwh.2014.4872

- xvi Agarwal S, Prasad R, Mantri S, Chandrakar R, Gupta S, Babhulkar V, Srivastav S, Jaiswal A, Wanjari MB. A Comprehensive Review of Intimate Partner Violence During Pregnancy and Its Adverse Effects on Maternal and Fetal Health. *Cureus*. 2023 May 20;15(5):e39262. doi: 10.7759/cureus.39262. PMID: 37342735; PMCID: PMC10278872.
- xvii Ibid
- xviii Ibid
- xix Centers for Disease Control and Prevention. "Depression among Women." Retrieved from <https://www.cdc.gov/reproductivehealth/depression/index.htm>
- xx Beck CT, Records K, Rice M. Further development of the postpartum depression predictors inventory-revised. *J Obstet Gynecol Neonatal Nurs*. 2006;35(6):735–745. doi: 10.1111/j.1552-6909.2006.00094.x.
- xxi Substance Abuse and Mental Health Services Administration. "Background Information on Maternal Depression." Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/md_background_information.pdf
- xxii Indian Health Service, "Maternal Substance Use Disorders." Retrieved from <https://www.ihs.gov/asap/providers/maternaladdiction/>
- xxiii Ibid
- xxiv Indian Health Service. "Maternal Substance Use Disorders | Information and Tools for Providers ([ihs.gov](https://www.ihs.gov))." Retrieved from <https://www.ihs.gov/asap/providers/maternaladdiction/>
- xxv National Institutes of Health. "Overdose deaths increased in pregnant and postpartum women from early 2018 to late 2021." Retrieved from <https://www.nih.gov/news-events/news-releases/overdose-deaths-increased-pregnant-postpartum-women-early-2018-late-2021>
- xxvi Centers for Disease Control and Prevention. "Four in 5 pregnancy-related deaths in the U.S. are preventable." Retrieved from <https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html>