THE REALITY of Pregnancy for BIPOC Parents

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On January 28, 2017, just three weeks after giving birth, Dr. Shalon Irving died in her home. While pregnant, Irving had kept a close watch on her health, as a blood clotting disorder created daily discomfort and pain. She gave birth safely at 37 weeks, but her blood pressure was still irregular. Despite repeatedly returning to her physicians, Irving collapsed just five hours after a medical visit. She died at 36.

Irving did everything right in her pregnancy. She visited her obstetrician and created a descriptive plan for before, during and after her pregnancy. She took her medication and all the necessary precautions concerning her lifestyle. By all accounts, Dr. Shalon Irving should have survived.

Irving was a human and parent that the healthcare system failed—but she is not alone. Heather Dobbs nearly died from a hemorrhage, and doctors were forced to take drastic measures and remove her uterus. Heather Lavender lost her son after intense blood loss, and a hysterectomy had to be performed. Candice Williams suffered a heart attack five days after giving birth. While at the hospital, the doctors diagnosed the attack as spontaneous coronary artery dissection (SCAD) and focused on the prevention for another attack rather than operate. Anner Porter brought her symptoms of numbness and exhaustion to her OB-GYN, only to be advised to intake more iron. Two days later, her heart failed, and she almost died. To this day, Porter suffers from heart complications. These testimonies, recounted by National Public Radio and ProPublica, show the pervasive problem that is plaguing parents across the nation.

Although the general American public would like to think that maternal deaths by racism are a thing of the past, the United States has increasing and apparent inequalities. There is an epidemic surrounding pregnancy and reproductive health care for women of color in America. A Black woman is 243% more likely to die from maternal causes than a white woman, according to the Centers for Disease Control and Prevention (CDC). From 2007 to 2016, the CDC also found that the pregnancy-related mortality ratio for Black women with a college degree was 5.2 times greater than white college-educated women. Furthermore, diseases such as hemorrhage, cardiomyopathy and hypertensive disorders are more likely to kill pregnant Black and Indigenous women than white women.

These statistics and stories provide the obvious conclusion that Black and Indigenous people of color (BIPOC) are facing a greater chance of maternal mortality than their white counterparts. It is important to remember that this issue is held up by systemic racism, and that toppling it down will require a nationwide breakdown of various barriers that prevent BIPOC from receiving adequate care. There are multiple possible solutions to this problem, all of which will be great endeavors but necessary to implement. Adequate health insurance is vital for pregnant women. Prenatal care and prevention techniques can inhibit the majority of maternal deaths. The American Journal of Public Health found that from 2014 to 2016, states that expanded Medicaid saw infant mortality rates drop. Thirty-nine states, including D.C., have accepted Medicaid expansion. Advocates say it's time for the remaining 12 to follow suit. Increased access to healthcare can begin to break down the system that allows BIPOC mothers to be mistreated throughout their pregnancies.

Another solution is increasing access to reproductive healthcare, specifically in underserved communities. Reproductive healthcare is not just birth control and abortion—it also includes cancer screenings, family planning counseling, sexually transmitted infection (STI) screening, prenatal care and post-natal care. However, women of color in poverty do not always have access to such services, which feeds into the maternal mortality rate. According to the Center for American Progress, "planned pregnancies are associated with better health outcomes than unplanned pregnancies." Therefore, it is critical that more state and federal funds go to increasing the quantity and quality of reproductive healthcare clinics and hospitals.

Like the solution of increasing funding for reproductive healthcare, there are many ways to decrease and diminish the probability of racial prejudice in the medical field. One such way is to increase employment of physicians and nurses from the same racial and cultural background as patients. For this to happen, however, we must get rid of the systematic barriers that prevent BIPOC from entering higher education, such as student loans and poorly-funded public schools.

Another way to diminish racial biases in healthcare is to train medical professionals to be patient-centered. This can be done in medical school and during residency programs. Lowering the rate of racial and cultural insensitivity is one of the ways to lower the rates of maternal mortality in the U.S.

When looking at the best possible solution for high rates of maternal mortality among BIPOC, it is important to ask which solution will not only decrease the statistics, but also address the systemic racism and history that have kept the rates so high. Without concrete legislation, most efforts will be in vain. Action from the state and federal levels can implement multiple solutions that can save multiple lives. However, it is important to match training and discussion with laws and regulations. In order for America to move forward and protect BIPOC parents and children, change must be executed immediately.