

Review

A Call to Action: Addressing the Public Health Crisis of Racial Inequities in Maternal Mortality and Pregnancy-Associated Breast Cancer

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Abstract

The United States faces a worsening maternal mortality crisis that starkly contrasts with trends in other high-income nations. Maternal mortality rates (MMRs) have more than doubled over the past two decades, rising from 9.65 deaths per 100,000 live births in 1999–2002 to 23.6 in 2018–2021, with approximately 700 deaths annually. Black and American Indian/Alaska Native women experience maternal mortality rates two to three times higher than their White counterparts, reflecting persistent structural inequities rather than biological differences. This narrative review synthesizes current evidence on the underlying drivers of racial inequities in maternal mortality and evaluates evidence-based interventions and policy strategies to address these disparities. A comprehensive literature review between 2000 and 2025 was conducted using databases including PubMed, Scopus, Web of Science, and Google Scholar, focusing on studies examining clinical, social, and structural determinants of maternal health outcomes, as well as evidence-based interventions and maternal health policy. Targeted searches of policy reports and grey literature were also performed to identify relevant policy initiatives and system-level interventions. Key contributors to disparities include underlying health conditions, postpartum mental health inequities, provider shortages, and limited access to postpartum care, with pregnancy-associated breast cancer (PABC) representing a less common but clinically significant risk factor that warrants further investigation in the context of racial inequities. Structural racism and socioeconomic disparities further exacerbate inequities through differential access to care, treatment bias, and barriers to healthcare utilization. System-level challenges, including workforce shortages, maternity care deserts, and the absence of federally mandated paid maternity leave, disproportionately impact marginalized populations. Although policy initiatives such as Medicaid postpartum coverage extensions, the Maternal Health Momnibus Act, and Maternal Mortality Review Committees represent important progress, they remain insufficient without broader structural reform. Evidence-based interventions, including midwife- and doula-led care, community-based peer support, and culturally tailored mental health programs, demonstrate measurable improvements in maternal outcomes. Outcomes of this review highlight the need for a comprehensive, equity-centered approach to reducing maternal mortality disparities, emphasizing structural reform, expanded access to care, strengthened data systems, and community-driven solutions.



Academic Editor: Peter Schmidt

Received: 9 March 2026

Revised: 21 April 2026

Accepted: 27 April 2026

Published: 8 May 2026

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conditions of the [Creative Commons](https://creativecommons.org/licenses/by/4.0/)[Attribution \(CC BY\)](https://creativecommons.org/licenses/by/4.0/) license.**Keywords:** maternal; mortality; disparities; equity; racism; postpartum; pregnancy-associated breast cancer

1. Introduction

The World Health Organization defines maternal mortality as death during pregnancy or within 42 days postpartum due to pregnancy-related causes, excluding accidental or incidental causes. Maternal mortality rates (MMRs) in the United States (US) have shown an upward trend over the past two decades, specifically from 2000 to 2014, and continue to increase in recent years up to 2021 and 2022 [1,2]. According to the Centers for Disease Control and Prevention (CDC), approximately 700 women die each year from pregnancy-related complications, and for every death, more women experience life-threatening conditions. The US ranks poorly among other high-income countries in MMR, and this growing disparity has sparked concern and fueled demands for policy changes and reforms in the healthcare system. Based on National Vital Statistics System methodology, MMRs in the United States have nearly doubled over the past two decades with rates increasing from 9.65 per 100,000 live births in 1999–2002 to 23.6 per 100,000 live births in 2018–2021 [2]. According to the Commonwealth Fund, peer high-income countries report MMRs substantially lower than the U.S. at around 5 deaths per 100,000 live births, with countries like Australia and New Zealand reporting rates as low as two deaths per 100,000 live births [3]. The CDC reports that this increase in the US is due, in part, to improved data collection methods including the implementation of a pregnancy checkbox on death certificates in 2003 which enhanced identification of pregnancy-related deaths but also resulted in misclassification and overcounting [4].

Black and American Indian/Alaskan Native women experience maternal mortality rates two to three times higher than White, Hispanic, and Asian/Pacific Islander women in the United States [5]. Black women in the U.S. have the worst MMR at 49.5 deaths per 100,000 live births in comparison to white, Hispanic, and Asian women with rates of 19, 16.9, and 13.2 deaths per 100,000 live births, respectively. According to 2023 data, non-Hispanic Black women continued to have the highest maternal mortality rate at 50.3 deaths per 100,000 live births. This rate is three times higher than the rate for White women, and significantly higher than Hispanic and Asian women. From 2022 to 2023, the maternal mortality rate dropped for Hispanic women (17 to 12 deaths per 100,000 live births), Asian American women (13 to 11 deaths per 100,000 live births), and White women (19 to 14.5 deaths per 100,000 live births). The rate for Black women increased slightly from 49.5 to 50.3 [2]. A deeper dive into the possible underlying causes of these disparities is urgently needed.

Factors that may be contributing to this substantial racial gap in MMR include differences in quality healthcare, underlying chronic health conditions, structural racism, and implicit bias. While this review centers on maternal mortality as conventionally defined by obstetric and public health standards, it also considers pregnancy-associated breast cancer (PABC) as an extended component of postpartum mortality that contributes to racial disparities. Hence, a complex interplay of underlying health conditions, social injustice, and economic status could be driving this racial inequity in MMR. This multi-layered issue highlights the need for multifaceted interventions addressing healthcare access, quality, postpartum care, and social determinants to reduce preventable deaths. This narrative review synthesizes existing literature to examine the underlying drivers of racial inequities in maternal mortality and to explore potential interventions and policy implications. This review seeks to examine the underlying drivers of this disparity by dissecting each layer and exploring interventions and policy implications.

2. Literature Search Methods

A comprehensive literature search was conducted to identify studies examining racial inequities in maternal mortality and pregnancy-associated breast cancer (PABC). Databases

searched included PubMed, Scopus, Web of Science, and Google Scholar. Search terms consisted of combinations of “maternal mortality,” “pregnancy-associated breast cancer,” “racial disparities,” “health inequities,” “social determinants of health,” as well as terms related to policy and interventions, including “maternal health policy,” “Medicaid expansion,” “postpartum care interventions,” “healthcare access,” “evidence-based interventions,” “midwifery care,” “doula support,” and “maternal health programs.” Articles published in English between 2000 and 2025 were considered. Studies were included if they were peer-reviewed, conducted in human populations, and addressed maternal health outcomes, cancer epidemiology, or structural and systemic determinants of racial disparities. Articles examining interventions, healthcare access, or policy approaches related to maternal health inequities were also included, with relevant sources identified through PubMed, Scopus, Web of Science, and Google Scholar, as well as targeted searches of policy reports and grey literature. Studies were excluded if they were non-peer-reviewed, not available in English, focused on non-human subjects, or did not address maternal health, racial disparities, or relevant systemic factors; editorials, opinion pieces, and studies lacking sufficient methodological detail were also excluded. Studies were screened for relevance to the underlying drivers of inequities, as well as to interventions and policy approaches aimed at reducing disparities. Findings were synthesized using a thematic narrative approach, with emphasis on clinical, structural, and policy-related factors contributing to maternal health inequities. As a narrative review, this study is subject to inherent limitations of non-systematic evidence synthesis, including potential selection bias and heterogeneity in study designs and definitions across the included literature.

3. A Multi-Layered Public Health Crisis: Medical and Structural Drivers of Racial Inequities in Maternal Mortality

There are multiple factors that potentially contribute to the racial inequity in MMR in the United States, as depicted in Figure 1. The more prominent of these factors include underlying health conditions as well as systemic barriers and challenges within the healthcare system. Systemic issues, such as structural racism, socioeconomic disparities, and unequal access to quality healthcare contribute to the ongoing challenges in addressing maternal mortality. While structural racism is widely recognized as a fundamental driver of racial disparities in maternal health, operationalization and measurement of this construct vary significantly across studies. The evidence base for non-clinical drivers of maternal mortality disparities is heterogeneous, with studies varying in design, population focus, and definitions of exposure, which limits direct comparability across findings.

3.1. Medical Health Conditions

According to the NIH, the leading medical causes of maternal death in the U.S. include cardiovascular conditions, obstetric hemorrhage, infection/sepsis, hypertensive disorders of pregnancy, and cardiomyopathy. Of these, cardiovascular disease is the most common cause, accounting for approximately one-third of pregnancy-related deaths [6]. Black women are disproportionately affected by hypertensive disorders, cardiomyopathy, and mental-health-related deaths [7]. Hypertensive disorders of pregnancy (HDPs) are one of the leading causes of maternal mortality in the United States, with Black women experiencing disproportionately higher rates of HDP-related deaths and morbidity [6,8]. HDPs are documented in approximately 1 in 5 delivery hospitalizations among Black women [8].

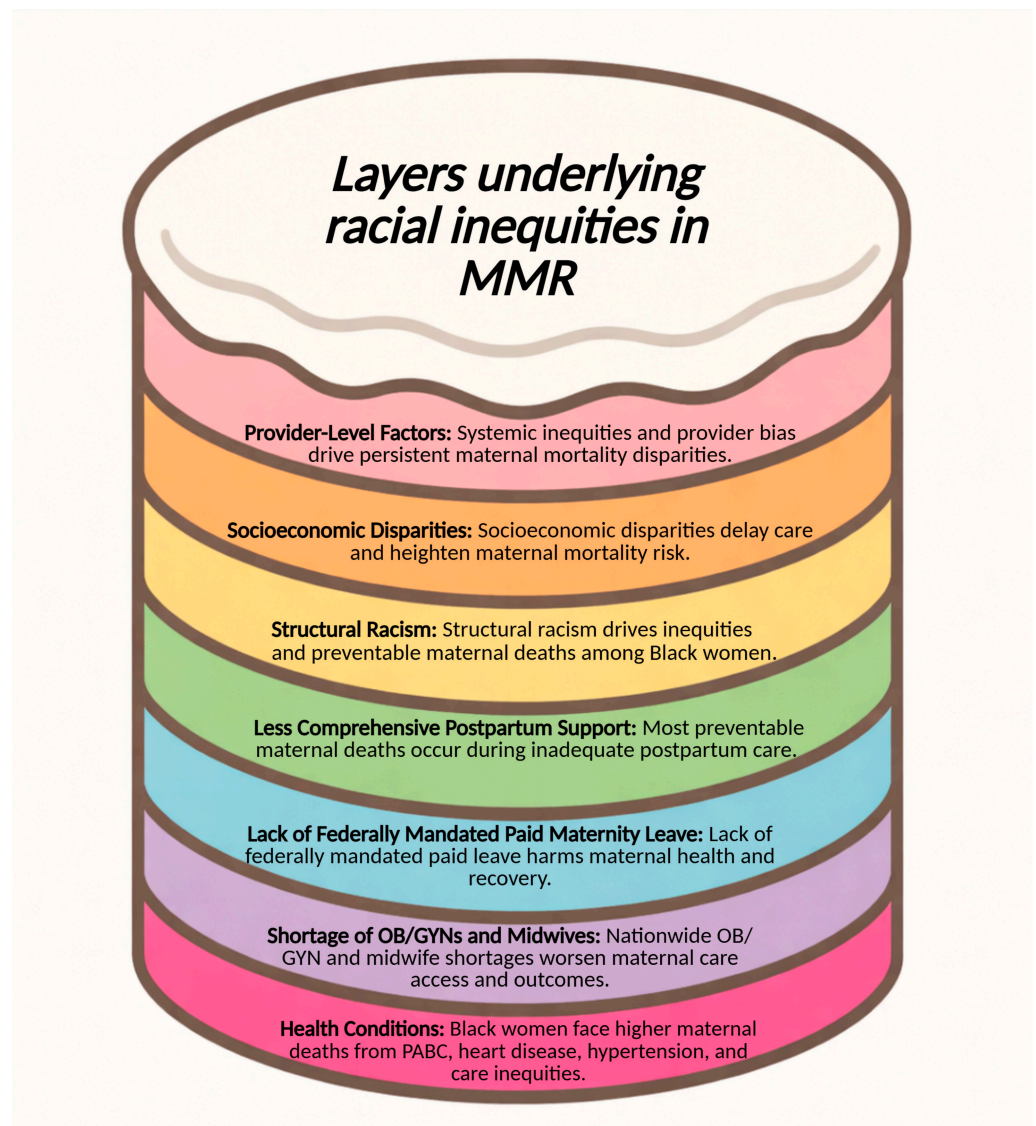


Figure 1. Multilevel factors underlying racial inequities in maternal mortality. Model developed by authors based on literature synthesis. Created in BioRender. Jackson, B. (2026). <https://BioRender.com/2tj3978> (accessed on 4 April 2026).

Cardiovascular disease is often pre-existing (e.g., chronic hypertension, congenital heart disease, ischemic disease) but can also manifest as pregnancy-specific cardiac syndromes such as peripartum cardiomyopathy (PPCM). PPCM disproportionately affects Black women, who not only have higher incidence, but also worse outcomes compared to White women [9,10]. Hypertensive disorders may reflect pre-existing chronic hypertension or pregnancy-induced forms such as pre-eclampsia/eclampsia. Chronic hypertension itself affects an estimated 15–19% of reproductive-age Black women, much higher than among White women, and contributes to both morbidity and mortality [8]. Obstetric hemorrhage remains a leading cause of maternal death, with estimates suggesting it accounts for roughly 27% of pregnancy-related deaths nationally [7]. Similarly, infection and sepsis contribute to nearly 12% of pregnancy-related deaths, often in the postpartum period [11].

Black women have a higher baseline prevalence of hypertension, obesity, diabetes, and cardiovascular risk factors [7,8]. For non-preexisting pregnancy-related conditions, inequities in monitoring, screening, and quality of care are implicated. Black women are more likely to deliver in lower-resourced hospitals, face delays in escalation of care, and experience diagnostic overshadowing and bias in clinical encounters [7,11].

Currently, several risk stratification and monitoring methods are in place, but implementation remains uneven. Maternal Mortality Review Committees (MMRCs) provide case-level analysis of deaths to identify preventable factors [11]. Hospital-level quality initiatives such as the California Maternal Quality Care Collaborative (CMQCC) have developed evidence-based toolkits for hemorrhage, HDP, and sepsis, which have reduced morbidity where implemented [7]. Obstetric Early Warning Systems (EWS), including MEOWS and Maternal Early Warning Criteria, are validated tools that have demonstrated improvements in timely recognition of clinical deterioration [12,13]. In addition, the American College of Obstetricians & Gynecologists (ACOG) 2025 guidance calls for more tailored prenatal care delivery that incorporates risk stratification and explicitly addresses social determinants of health [14]. Despite these tools, inequities persist, and improvements are directly needed in preconception chronic disease management, universal adoption of quality clinical practices and protocols, standardized early warning systems, and extended postpartum follow-up, particularly for Black women who remain at the highest risk [7,8,11].

3.2. Postpartum Depression and Structural Factors

Postpartum depression (PPD) has emerged as one of the most pervasive yet under-addressed dimensions of maternal morbidity in the United States, revealing deep fissures in how social inequities are embodied as psychological distress. The postpartum period, often framed as a time of healing, becomes for many women of color a site of compounded trauma—where medical neglect, social isolation, and cultural stigma intersect. PPD disproportionately affects women from marginalized communities. CDC national surveillance data show that 16.3% of Black mothers, 13.8% of Hispanic mothers, and 11.7% of White mothers reported depressive symptoms after giving birth, with rates highest among American Indian/Alaska Native mothers (21.8%) and lowest among Asian/Pacific Islander mothers (8.0%). Longitudinal data confirm these disparities: between 2010 and 2021, the prevalence of PPD diagnoses rose substantially for all groups, reaching ~22% among Black mothers (a 140% increase), ~19% among Hispanic mothers (110% increase), and ~13.8% among Asian/Pacific Islander mothers (a 280% increase) [15]. Despite facing higher risk, Black and Hispanic women are less likely to be diagnosed and treated for PPD. In one large study of low-income mothers, only 4% of Black women and 5% of Latinas initiated treatment postpartum, compared with 9% of White women [16]. These inequities stem from intersecting barriers: socioeconomic stressors such as housing and food insecurity, higher rates of obstetric complications, reduced access to consistent postpartum care, stigma around mental health, and lack of culturally competent or language-accessible resources. Additionally, Black women frequently report mistrust in the medical system and negative birthing experiences, which can intensify psychological distress and reduce engagement with care [17]. These disparities in prevalence, diagnosis, and treatment demonstrate how postpartum depression disproportionately affects Black and other minoritized women, contributing to racial inequities in maternal morbidity and mortality.

3.3. Shortage of OB/GYNs and Midwives

There is a growing shortage of midwives and obstetricians contributing to maternal healthcare access and outcomes. Mostly, these shortages are due to an aging workforce, high rates of burnout, and policy changes [18]. Midwives have been playing a crucial role in improving maternal and infant health outcomes for centuries, and their impact remains well documented in modern care. Evidence shows that midwife-led care is associated with lower rates of cesarean delivery, preterm birth, low birth weight, and infant mortality, as well as higher breastfeeding rates and reduced healthcare costs [19]. In rural areas, where more than half of U.S. counties lack hospitals with obstetric services, midwives are

often the only maternity providers, yet their workforce remains limited [20]. Nationally, certified midwives attend only ~12% of U.S. births, compared to much higher proportions in many other high-income nations [21]. The U.S. has only ~4 midwives per 1000 live births, below the recommended benchmark of 6 per 1000 [22]. According to the American College of Nurse-Midwives, there are currently about 14,200 certified nurse-midwives/certified midwives in the country, but the number of training programs is small, and some are pausing admissions as they transition to doctoral requirements, increasing both cost and time for students. These barriers, along with limited clinical placements and high tuition, have slowed the pipeline of new midwives. Compounding the workforce shortage are regulatory restrictions in many states that limit midwives' scope of practice, financial barriers to training, and the profession's lack of diversity—over 90% of midwives are White, despite evidence that racially concordant care improves outcomes for Black and Hispanic patients. Public mindset also plays a role; the medicalization of childbirth in the 20th century marginalized community-based and Black midwives, leaving lasting mistrust and underutilization [22]. Doula, who provide non-clinical support, further improve outcomes: studies show doula care reduces cesarean deliveries, preterm births, low birth weight, postpartum depression, and even lowers costs of care [23].

Additionally, high levels of stress, burnout, and emotionally demanding work contribute to both OB/GYNs and midwives reducing their practice or leaving the profession [18]. According to the American Medical Association, there was a 7% decrease in the number of obstetricians between 2010 and 2022 due to attrition, and in 2023, applications to OB/GYN residency programs decreased 5.2% overall. Shortages of OB/GYNs and midwives have created maternity care deserts where women experience poorer health before pregnancy and receive less prenatal care. Workforce shortages and maternity care deserts disproportionately impact Black and underserved communities, exacerbating racial disparities in access to quality maternal care and associated outcomes [24]. Between 2010 and 2022, more than 500 hospitals in the United States closed their obstetric units, including over 200 rural hospitals. These closures have driven more obstetricians out of rural areas and deepened existing care deserts [25].

3.4. Lack of Federally Mandated Paid Maternity Leave

The United States is the only industrialized, high-income nation without federally mandated paid maternity leave. As a result, many postpartum women are forced to return to work before their bodies have fully healed, increasing the risk of complications due to inadequate recovery time. This burden falls disproportionately on under-resourced communities, where individuals are less likely to receive employer-provided paid leave because they are more often employed in lower-wage jobs. The absence of paid maternity leave disproportionately affects women in lower-income and marginalized communities, particularly Black women, thereby contributing to racial inequities in postpartum health and maternal mortality [26]. The primary law governing maternity leave in the United States is the Family and Medical Leave Act (FMLA) of 1993. The FMLA entitles eligible employees to up to 12 weeks of unpaid, job-protected leave per year. To qualify, employees must have worked for their employer for at least one year, completed at least 1250 h of work in the previous 12 months, and be employed at a worksite with 50 or more employees within a 75-mile radius [27]. Paid maternity leave has been shown to reduce postpartum maternal depression and intimate partner violence while strengthening infant attachment and supporting healthy child development. It also lowers infant mortality rates and decreases the likelihood of mother and infant rehospitalizations [28]. Some women do not take maternity leave due to concerns about career advancement, maintaining status, and potential long-term negative effects on wages [27].

3.5. Lack of Comprehensive Postpartum Support

The postpartum period, often called the “fourth trimester”, is a critical time for maternal recovery and health. Nearly two-thirds of pregnancy-related deaths in the U.S. occur during the postpartum period (within the first 42 days after delivery), and an additional share occur in the late postpartum period (43–365 days); CDC data show that about 21.4% of pregnancy-related deaths occur 7–42 days postpartum and 11.7% occur 43–365 days postpartum [7]. In the United States postpartum care has traditionally been limited to a single visit around six weeks after delivery, but the ACOG now recommends ongoing contact with a care provider in the first three weeks after birth and a comprehensive visit no later than 12 weeks postpartum. According to the ACOG, despite these recommendations, as many as 40% of women do not attend a postpartum visit, with non-attendance most common among younger, lower-income, and Medicaid-insured patients, factors that compound existing disparities.

Most pregnancy-related deaths are preventable: CDC and MMRC analyses estimate that over 80% of pregnancy-related deaths could be prevented with timely, evidence-based care and systems improvements. Closing this gap requires expanding the landscape of postpartum support across multiple domains. A comprehensive postpartum support system must address multiple interconnected domains. Clinical follow-up and surveillance should begin with early postpartum contact, via phone, video, or in-person visits, to screen for hemorrhage, preeclampsia, infection, cardiopulmonary complications, and mental-health deterioration, with standardized early warning criteria and rapid escalation pathways in place to respond to emerging risks [29]. Home-based care and continuity are also essential; routine home visits by midwives, nurses, or community health workers allow assessment of wound healing, blood pressure, bleeding, breastfeeding, mood, and broader social needs, an approach successfully implemented in Scandinavian countries [30–32]. Mental-health screening and treatment access are critical components, requiring universal evaluation for postpartum depression and anxiety, timely linkage to culturally competent therapy or pharmacologic treatment, and utilization of telehealth when in-person care is impractical [29]. According to the Commonwealth Fund, social supports and wraparound services, including lactation support, doula care, contraception counseling, childcare, transportation, and referrals for housing or food assistance, further enhance maternal recovery and engagement with care. Finally, workforce and equity investments are necessary to strengthen the midwifery and community-based provider pipeline, increase diversity among practitioners, ensure reimbursement for essential services, and expand the scope of practice for home- and community-based care, all of which collectively help reduce disparities in postpartum outcomes [30–32].

International models illustrate scalable solutions: Nordic countries (Sweden, Norway, Denmark) offer universal parental leave, near-universal midwife-led postpartum home visits, and integrated maternal health systems that improve early detection of complications, maternal mental health, and satisfaction [30–32]. Urgently needed U.S. policy shifts include nationwide 12-month postpartum Medicaid coverage, reimbursement for home visits and doula services, scaling midwifery and community health worker training pipelines, mandatory equity audits of postpartum care quality, and employer- or state-level paid parental leave policies. Together, these reforms could reduce preventable postpartum morbidity and deaths, narrow racial and socioeconomic gaps, and move U.S. postpartum care closer to models that demonstrate better outcomes [33].

3.6. Structural Racism

Structural racism is a social determinant built from discriminatory policies, institutional practices, and societal norms. It is the basis of disparities in access to and quality

of care, and health outcomes amongst Black women and other underserved populations. Even when socioeconomic and insurance status is similar, Black women face three to four times higher risk of pregnancy-related deaths compared to White women, an indication that systemic factors beyond individual risk predominantly influence outcomes [34]. According to Yale Medicine, most maternal deaths stem from patient concerns being ignored or disregarded leading to severe consequences of illnesses that could have otherwise been prevented. A major consequence of structural racism is the detrimental lack of trust in medical professionals leading to a delay in patients seeking lifesaving treatment [35].

3.7. Socioeconomic Disparities

Another social determinant of health that can lead to a delay in seeking care is socioeconomic disparities. Low income is a critical risk factor for maternal mortality, as it influences access to timely and quality health care during pregnancy and childbirth. The United States is one of the only high-income nations that does not offer universal health care, making income a crucial determinant of access to quality healthcare leading to an increase in maternal mortality rates in lower income and rural communities. The “three delays” is a common concept used to describe the influences income has on maternal mortality; they include delays in deciding to seek care, delays in reaching healthcare facilities, and delays in receiving adequate care once at a facility. Delays in seeking healthcare stem from both distrust in the healthcare system and fears of high medical costs. A study conducted by the US Department of Health and Human Services found that lower education and rural residence status were associated with 50–114% higher maternal mortality risks [36]. Racial and ethnic minorities often receive lower-quality healthcare than White individuals, even when insurance, income, age, and clinical needs are comparable. Black and Hispanic women, in particular, are more likely to deliver in high-morbidity hospitals, which places them at higher risk of complications and adverse outcomes [37]. Beyond individual income, systemic economic and geographic inequities shape who survives childbirth in America. According to the CDC, Black women with college degrees face higher maternal mortality than White women without high school diplomas, underscoring that structural racism magnifies, and often overrides, the protective effects of education and income.

3.8. Provider-Level Factors

Mistreatment and poor communication in maternity care are commonly reported and more frequent among people of color; the CDC identifies respectful, equitable care as a core component of prevention. The ACOG suggests an undersupply of maternity care providers, particularly midwives, and a lack of workforce diversity exacerbates these challenges, contributing to inconsistent care quality and hindering equitable access to essential services. Addressing these provider-specific deficiencies through improved training, bias awareness, and workforce expansion is crucial for enhancing maternal health outcomes and reducing disparities [38–40].

4. Overlooked but Not Unseen: Pregnancy-Associated Breast Cancer and Maternal Mortality Risk in Black Women

Pregnancy-associated breast cancer (PABC) is a relatively rare but important driver of maternal morbidity and mortality that should be considered within the broader context of racial inequities in maternal mortality. Although less common than other underlying conditions, PABC is associated with a more advanced stage at diagnosis and poorer outcomes, particularly among Black women. These disparities reflect structural inequities in access to timely diagnosis and care within the healthcare system that significantly contribute to racial inequities in MMR.

4.1. *Pregnancy-Associated Breast Cancer (PABC)*

Definitions of pregnancy-associated breast cancer (PABC) vary across studies, particularly in the postpartum time window considered (ranging from 1 to 10 years), which contributes to heterogeneity in reported incidence, staging at diagnosis, and survival outcomes. Pregnancy-associated breast cancer (PABC) is most commonly defined as breast cancer diagnosed during pregnancy or within 10 years postpartum, although definitions vary across studies, contributing to heterogeneity in reported incidence and outcomes [41–44]. Breast cancer is the most frequently diagnosed malignancy during pregnancy. However, PABC is rare at the population level, with estimated incidence ranging from 15 to 40 cases per 100,000 pregnancies depending on the postpartum window used and population studied [42,45], patients diagnosed with PABC experience worse survival outcomes compared with women diagnosed with breast cancer outside the pregnancy context. Population-based analyses demonstrate pregnant patients with breast cancer face an approximate twofold higher risk of death compared to non-pregnancy-associated breast cancer after adjustment for age and stage, while postpartum-diagnosed breast cancer is also associated with significantly elevated mortality risk [46,47]. Meta-analytic data similarly indicate increased overall and cancer-specific mortality among women with PABC relative to non-PABC controls [41]. Although these data reflect oncologic mortality rather than pregnancy-related maternal death as defined in obstetric surveillance systems, the increased mortality risk during and following pregnancy underscores the relevance of PABC to maternal morbidity and mortality frameworks. Importantly, PABC encompasses two clinically and biologically distinct entities: breast cancers diagnosed during pregnancy and those diagnosed in the postpartum period. Growing evidence suggests that women diagnosed with breast cancer within five years postpartum have a 2.8 times higher risk of metastasis and a 2.7 times higher mortality risk compared to women without prior pregnancies [48]. Despite this, maternal mortality frameworks have historically focused on obstetric and cardiovascular causes of death within 42 days postpartum, often excluding malignancies diagnosed after delivery or attributing them to non-pregnancy-related causes [49]. As a result, PABC, especially postpartum breast cancer, has been insufficiently integrated into contemporary maternal mortality prevention strategies.

4.2. *Racial Disparities in PABC*

Pregnancy-associated breast cancer (PABC) is increasingly recognized as biologically aggressive. PABC is associated with higher tumor grade, advanced stage at diagnosis, and more frequent lymph node involvement compared with breast cancer in non-pregnant or nulliparous women. Women with PABC are also typically younger at diagnosis and exhibit higher odds of developing aggressive breast cancer subtypes compared with age-matched non-PABC cases [50,51]. PABC is more likely to present as hormone-receptor negative and triple-negative subtypes, all of which are linked to a poorer prognosis [50–52]. Moreover, breast cancers diagnosed soon after childbirth have been associated with substantially elevated risks of metastasis and mortality relative to cancers in nulliparous women, reflecting adverse biology in the postpartum microenvironment [53]. Black women in the US are disproportionately affected by biologically aggressive breast cancer phenotypes. They have higher incidence of estrogen receptor-negative (ER-) and triple-negative breast cancers compared with White women and are more likely to be diagnosed at a younger age [54,55]. They are also more likely to be diagnosed with advanced-stage disease and experience higher rates of lymph node involvement and distant metastasis at presentation [56,57]. Aggressive subtypes contribute to reduced survival, as these tumors lack hormone targets and often respond poorly to standard therapies [58]. Epidemiologic data consistently reveal

higher breast cancer mortality among Black women after adjusting for stage and subtype, indicating contributions from both biologic and socioeconomic factors [56].

Thus, racial disparities have been documented in PABC. In a large retrospective cohort, Rodriguez et al. evaluated PABC survival and reported significantly poorer overall survival among Black women compared with White women, even after controlling for clinical and treatment factors, suggesting that Black race is independently associated with worse PABC prognosis [59]. Similarly, Gooch et al. examined PABC cases in a contemporary multi-institutional cohort and found that Black women with PABC presented with more advanced disease and experienced higher frequency of adverse pathologic features compared with women of other races. While overall mortality differences in this cohort were not large, the study underscored that Black race was associated with a trend toward worse outcomes and more aggressive disease at presentation [60]. Collectively, these studies suggest racial disparities in PABC are an important underlying factor contributing to increased risk of maternal mortality in Black relative to White pregnant women.

Racial differences in reproductive factors, such as parity and breastfeeding patterns, may also contribute to the racial divergence in PABC. Parity and breastfeeding have complex relationships with breast cancer risk and subtype distribution. Parity is associated with a long-term protective effect against hormone-receptor-positive cancers but has been linked to increased risk of ER-negative and triple-negative subtypes when unaccompanied by breastfeeding [61,62]. Specifically, women who have given birth but never breastfed tend to have higher odds of ER-negative and triple-negative breast cancer, which are particularly aggressive. Breastfeeding is protective against ER-negative and triple-negative disease, with this effect observed across multiple racial groups [62]. Black women in the United States have higher average parity and shorter interpregnancy intervals compared with White women, increasing cumulative exposure to the high-risk postpartum window [63]. In contrast, breastfeeding is less common and of shorter duration among Black women, largely due to structural and systemic barriers to lactation support [64,65]. Together, higher parity combined with lower breastfeeding duration may increase the likelihood of postpartum breast cancer and aggressive tumor subtypes among Black women, potentially contributing to racial disparities in PABC incidence and outcomes. Recent population-based analyses estimate that supporting breastfeeding could substantially reduce incidence of aggressive subtypes and thereby attenuate racial disparities in breast cancer outcomes, and therefore PABC outcomes [62].

4.3. Racial Disparities in PABC Care

Multiple mechanisms link PABC to increased risk of pregnancy-related and postpartum mortality, particularly during the late postpartum period. In addition to cancer-specific risks, PABC during pregnancy is associated with increased maternal vulnerability to severe obstetric complications, including sepsis, thromboembolism, and acute respiratory distress, which can further elevate maternal morbidity and mortality [43,66]. Diagnostic delay is a central concern. Physiologic breast changes during pregnancy and lactation can mask malignancy, and breast symptoms are frequently attributed to benign pregnancy-related conditions, resulting in delayed clinical evaluation [41,45]. Qualitative and observational studies describe diagnostic dismissal of breast complaints in pregnant and postpartum patients, contributing to later-stage disease at diagnosis [47,67]. Delays may also occur at multiple points along the diagnostic and treatment pathway, including postponed imaging, hesitancy to perform biopsies during pregnancy, and prolonged intervals between diagnosis and treatment initiation [41,68].

Racial differences in access to timely breast cancer diagnosis and care may further exacerbate disparities in PABC-associated maternal mortality. Black women consistently experience longer intervals from abnormal screening to diagnostic evaluation and biopsy compared with White women, a difference that is not fully explained by socioeconomic factors and may reflect structural barriers within the healthcare system. For example, Black women have significantly longer times from screening to diagnostic imaging and from imaging to biopsy, delays that have been linked to more advanced tumor stage at diagnosis and higher mortality [69,70]. Persistent diagnostic and treatment delays, including prolonged time between diagnosis and treatment initiation, contribute to later stage presentation and reduced survival, particularly among patients with aggressive disease subtypes more common in racially minoritized populations [70]. These systemic delays, combined with challenges in postpartum care continuity, represent important contributors to the higher maternal mortality observed among Black women with PABC. For patients diagnosed during pregnancy, treatment options may be constrained by concerns about fetal exposure, leading to modified chemotherapy regimens or deferral of certain therapies until postpartum, which may adversely affect maternal outcomes [41,47].

The postpartum period itself represents a uniquely high-risk window for cancer progression and mortality. Postpartum breast cancer has been consistently associated with increased metastatic potential and worse survival compared with breast cancers diagnosed in nulliparous women or outside the postpartum context [47,48,71]. This period also coincides with fragmentation of care, loss of insurance coverage, and reduced clinical surveillance following the traditional six-week postpartum visit [49,72]. In the United States, where postpartum care is often limited and poorly coordinated, the “fourth trimester” represents a critical but underutilized window for cancer detection and intervention. Failure to adequately monitor and address breast symptoms during this period may contribute to preventable late maternal deaths attributable to malignancy. Additionally, significant racial disparities persist in postpartum care access and quality in the United States, which may contribute to inequities in both pregnancy-associated breast cancer (PABC) outcomes and maternal mortality. Black women are less likely to attend timely postpartum visits and more likely to experience insurance loss, care fragmentation, and unmet health needs during the first year after delivery [72–74]. Given that the postpartum period represents a high-risk window for both breast cancer progression and late maternal death, reduced clinical surveillance and barriers to diagnostic evaluation may delay recognition of breast symptoms and oncology referral in Black patients [47,49]. While evidence consistently demonstrates poorer outcomes among Black women with PABC, the extent to which disparities are driven by biological versus structural factors remains an area of ongoing investigation.

5. A Multi-Targeted Framework to Addressing Racial Inequities in Maternal Mortality

The literature on intervention is characterized by a mix of established policy evaluations and emerging or proposed strategies, with varying levels of empirical validation. Despite advancements in healthcare, the racial inequities in maternal mortality persist, underscoring the urgent need for comprehensive and targeted strategies to address this growing issue. A holistic plan involves implementing strategies, as shown in Figure 2, that improve healthcare quality and access, diversify the maternal care workforce, and strengthen data collection and quality measures.

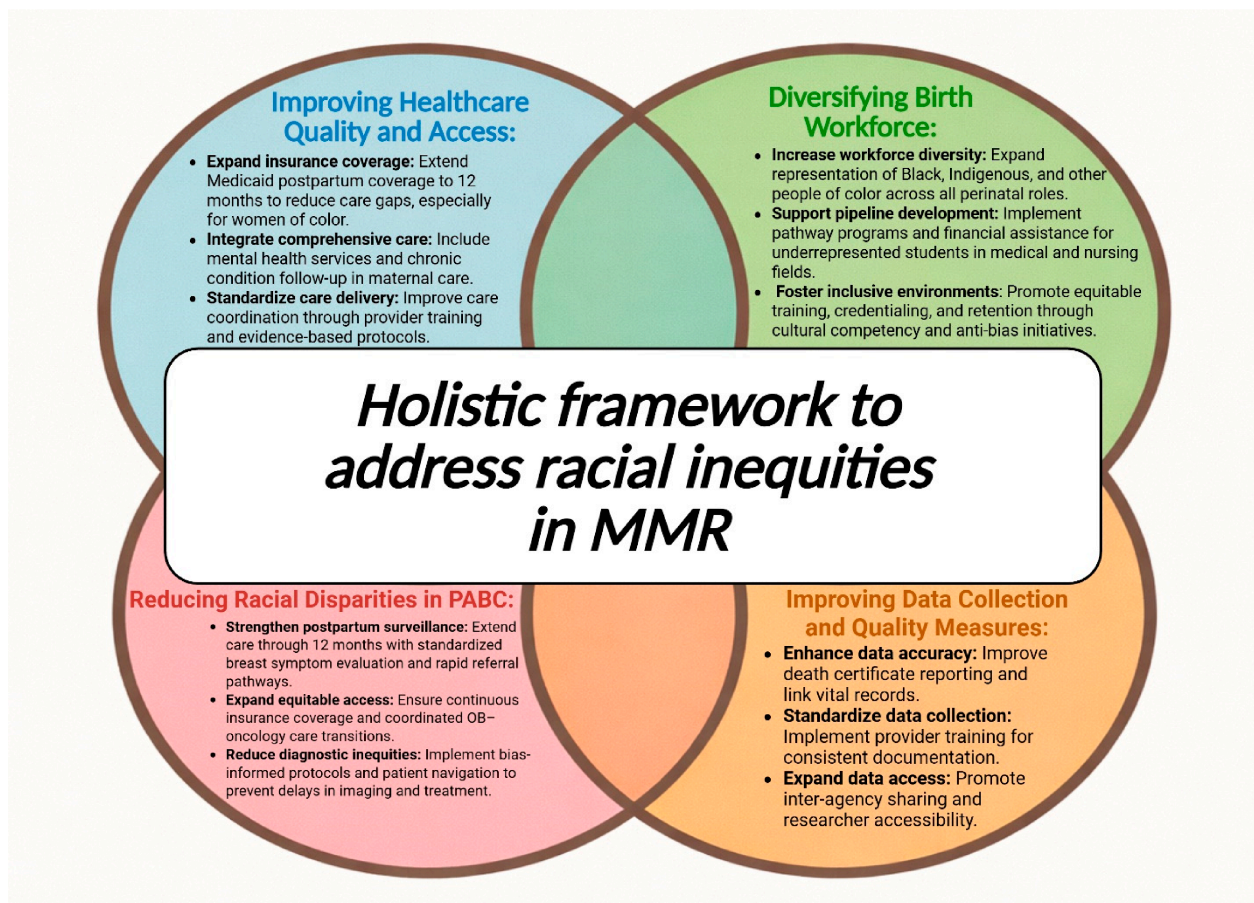


Figure 2. A holistic framework to address racial inequities in maternal mortality. Model developed by authors based on literature synthesis. Created in BioRender. Jackson, B. (2026). <https://BioRender.com/2tj3978> (accessed on 4 April 2026).

5.1. Improving Healthcare Quality and Access

Disparities reflect deep structural inequities—systemic racism, policy exclusion, chronic underfunding of Black-led care, and marginalization of Black voices in health leadership [75]. Black and American Indian/Native American people are more likely to deliver in hospitals with fewer resources and worse quality scores even when a higher-quality facility is nearer [76]. Expanding access to healthcare services, particularly through initiatives like Medicaid expansion, is crucial. Medicaid covers a significant portion of births nationally, and extending postpartum coverage to a full year can prevent many individuals from losing coverage in the months after delivery. As of August 2024, 47 states and the District of Columbia have implemented a 12-month postpartum coverage extension [77]. The National Academy for State Health Policy states this extension is particularly beneficial to women of color, who are more likely to experience gaps in insurance coverage. Additionally, integrating mental health care into maternal health services and extending postpartum follow-up for chronic conditions can significantly improve outcomes in the United States [78,79]. According to the CDC, hospitals and healthcare systems can further strengthen maternal care by standardizing care coordination and enhancing both prenatal and postpartum care delivery through extensive training and the implementation of evidence-based protocols that ensure consistent, high-quality care across diverse patient populations [80].

5.2. Diversifying Birth Workforce

A diverse maternity care workforce is essential for achieving birth equity and improving maternal health outcomes. Research demonstrates that patients often experience better outcomes when their providers share their racial or ethnic background or speak the same language. Increasing the representation of Black, Indigenous, and other people of color within the perinatal workforce, including doctors, nurses, midwives, and doulas, can foster trust, strengthen communication, and help reduce racial disparities in maternal healthcare. Some strategies for diversifying the workforce include: implementing pathway programs and financial support to provide academic, financial, and social support to underrepresented students and help them enroll and succeed in medical and nursing programs, and creating inclusive environments that support training and credentialing for doulas and midwives. Equally important is ensuring that all staff are committed to eliminating inequities, which is essential for retaining a diverse healthcare workforce [81].

5.3. Improving Data Collection and Quality Measures

Improving data collection and quality measures is crucial for understanding and addressing the root causes of racial inequity in maternal mortality rates. Comprehensive, reliable data are essential for understanding the complex factors contributing to these deaths and for developing effective prevention. Key strategies for improving data collection include enhancing data sources and collection processes and improving data accessibility. Comprehensive data sources provide a multi-source approach that allows for a more accurate identification and comprehensive review of deaths. Additionally, the National Vital Statistics System relies primarily on death certificates, which are frequently inaccurate; one study identified errors in nearly 53% of certificates. Implementing training programs to ensure providers complete death certificates accurately and consistently is therefore essential [82]. Requiring state health departments to link death certificates, birth certificates, and fetal loss certificates would enable more accurate tracking of deaths across postpartum timeframes [83]. To strengthen data accessibility, initiatives should focus on improving inter-agency data sharing and expanding researcher access to maternal health data, thereby facilitating more comprehensive analyses and evidence-based interventions.

5.4. Reducing Racial Disparities in PABC

Reducing racial disparities in pregnancy-associated breast cancer (PABC) requires multilevel strategies that address delayed diagnosis, inequities in postpartum care, and structural barriers to treatment. Standardized evaluation of breast symptoms during pregnancy and the first postpartum year is critical, as postpartum breast cancers, particularly those diagnosed within five years of delivery, are associated with increased risk of metastasis and mortality [72,73]. Black women experience higher rates of advanced-stage presentation and mortality from breast cancer, reflecting both aggressive tumor biology and inequities in access to timely diagnosis and treatment [47,74]. Improving continuity of postpartum care, extending insurance coverage through 12 months postpartum, integrating multidisciplinary obstetric–oncology care models, and strengthening linkage between cancer registries and maternal health surveillance systems are essential steps to mitigate delays and improve outcomes [47,49,74]. Addressing structural inequities in access to lactation support, diagnostic evaluation, and oncology care delivery is fundamental to narrowing racial disparities in PABC incidence and mortality.

While extending postpartum Medicaid coverage to 12 months represents a critical step in improving maternal health outcomes, it remains insufficient to address the prolonged risk window associated with pregnancy-associated breast cancer (PABC), which has been defined in studies to include cancers diagnosed several years after delivery and is asso-

ciated with poorer prognosis compared to non-PABC cases. Meta-analyses indicate that PABC diagnosed postpartum is linked with increased mortality and reduced survival, and definitions of PABC extending up to five to six years postpartum better capture elevated risk in some populations [41,84]. Addressing this gap requires a shift toward longitudinal care models that integrate routine breast health assessments into primary and preventive care beyond the first postpartum year and strengthen continuity of insurance coverage, as interruptions in coverage are linked to delays in diagnosis and treatment initiation. Enhanced coordination between obstetric, primary care, and oncology services is also needed to ensure timely evaluation of breast symptoms across the extended postpartum period. Targeted interventions for high-risk populations, particularly Black women who face disproportionately greater barriers to timely diagnosis and high mortality from breast cancer, are essential. Additionally, improved linkage between cancer registries and maternal health data systems could facilitate earlier detection and surveillance of long-term outcomes [85,86]. Expanding care models beyond the traditional postpartum framework is therefore critical to reducing racial disparities in PABC-related morbidity and mortality.

6. Changing the Policy Landscape: Can We, the People, Be the Change?

The current maternal mortality policy landscape in the United States, as illustrated in Figure 3, is multifaceted, addressing both the clinical and systemic social determinants of maternal health. Despite technological advancements, maternal mortality rates remain high, with policies focusing on improving access to care, reducing disparities, and addressing social and economic barriers. Programs like California Maternal Quality Care Collaborative and AIM safety bundles have shown reductions in severe maternal morbidity [87]. Yet, equity gains are uneven and often fail to target the underlying power imbalances [88].



Figure 3. Legislative and policy measures to address racial inequities in maternal health. Model developed by authors based on literature synthesis. Created in BioRender. Jackson, B. (2026). <https://BioRender.com/2tj3978> (accessed on 4 April 2026).

6.1. Abortion Laws and Reproductive Rights

According to the Kaiser Family Foundation (KFF), since the 2022 supreme court overruling *Roe v. Wade* took away the constitutional right to abortion, 12 states have imposed bans on total abortion laws, and many others have introduced severe restrictions which heighten maternal health risks [89]. Abortion bans reduce practitioners' ability to provide crucial life-saving care such as miscarriage management and emergency obstetric treatments, resulting in higher rates of complications, sepsis, and maternal deaths. According to an April 2025 analysis by the Gender Equity Policy Institute (GEPI), Texas experienced a 56% rise in maternal mortality in the first full year of its abortion ban, including a 95% increase among white women. GEPI also reported that, compared to supportive states, those with abortion bans have nearly double the maternal mortality rates, with Black women disproportionately affected. The analysis further noted that these bans have contributed to the expansion of maternity care desert, counties where obstetric care, birth centers, OB/GYNs, and certified nurse midwives are scarce or absent [90]. These deserts are a result of obstetricians and midwives leaving restrictive states or avoiding entering training programs in such states. Abortion restrictions exacerbate structural inequalities, restrict provider practice, reduce access to critical maternal health services, and widen racial disparities in maternal mortality [91].

6.2. Maternal Mortality Review Committees

Maternal Mortality Review Committees (MMRCs) are multidisciplinary groups established at state or local levels in the United States to conduct comprehensive reviews of maternal deaths occurring during pregnancy or within one year postpartum [92]. According to the ACOG, their mission is to understand the causes and circumstances of maternal deaths, identify patterns of risk, missed signals, and prevention opportunities, to develop actionable recommendations that prevent future deaths and improve maternal health outcomes. The ACOG also notes some challenges affecting MMRC effectiveness which include: funding across states, inconsistent data availability and reporting practices, biased political interference, lack of provider awareness, and gaps in representation [93]. MMRCs are essential to maternal mortality prevention in the US by comprehensively reviewing maternal deaths, identifying preventable factors, and providing actionable recommendations. Their approach offers valuable insights that drive improvements in maternal health care and reduce disparities. Strengthening MMRC operations and ensuring consistent support are crucial in realizing their full potential impact [93].

6.3. Maternal Health Momnibus Act

According to the Black Maternal Health Caucus, the Maternal Health Momnibus Act is a legislative package of 13 bills aimed at addressing racial disparities in maternal health outcomes for women. These bills target issues such as social determinants of health, health-care workforce development, and care for vulnerable populations. The Momnibus Act is currently the only legislation in Congress that comprehensively addresses the maternal health crisis in the U.S., and since 2023, the Caucus has secured over \$200 million in federal funding to support these initiatives [94].

6.4. Medicaid Coverage Expansion Postpartum

According to the KFF, Medicaid finances about 4 in 10 births in the United States, and federal law mandates that states provide pregnancy-related Medicaid coverage through 60 days postpartum. KFF reports that after this 60-day cutoff, many women lose medical coverage which leads to loss of access to care necessary for postpartum depression cases. In 2021, states were given the option to extend postpartum Medicaid coverage from 60 days

to 12 months, a policy designed to improve maternal health outcomes and reduce racial disparities in maternal mortality. As of January 2025, KFF notes that 49 states and the District of Columbia have implemented the 12-month coverage extension, with Wisconsin offering only 90 days of coverage [95].

The U.S. maternal mortality policy landscape reflects a growing recognition of the urgent need for systemic change. While progress has been made through legislative efforts like the Momnibus Act and expanded Medicaid postpartum coverage, these advances exist alongside deeply concerning challenges, including restrictive abortion laws, gaps in MMRC infrastructure, and persistent racial disparities. The effectiveness of maternal mortality prevention hinges not only on access to clinical care but also on our commitment to addressing the broader sociopolitical factors that shape health outcomes. Continued investment in evidence-based policy, data transparency, and equitable care delivery will be essential to reversing maternal mortality trends and protecting the lives of birthing people across the country [96].

6.5. Successful Policy Models

Community-based, culturally aligned models, such as the Shades of Blue Project, the Irth app, and culturally tailored peer support programs, offer real hope in addressing maternal health disparities. These initiatives center the voices and experiences of marginalized communities, providing support that is both accessible and culturally relevant.

Shades of Blue Project: Founded by Kay Matthews in Houston, this nonprofit organization focuses on improving maternal mental health outcomes for Black and brown birthing people. Through its “Acknowledge, Respect, and Support” method, the project aims to transform how healthcare professionals engage with patients, emphasizing empathy and cultural competence. The initiative includes support groups, therapy sessions, and educational resources, addressing the unique challenges faced by these communities [97].

Irth App: The Irth app serves as a “Yelp-like” platform, allowing Black and Brown birthing people to find and leave reviews of prenatal, birthing, postpartum, and pediatric care providers. Developed by Narrative Nation, this digital tool empowers users to make informed decisions about their healthcare by sharing and accessing experiences within their communities [98].

Programs that incorporate peer support and mobile health (mHealth) strategies have shown promise in enhancing perinatal mental health outcomes. These interventions leverage the power of shared experiences and culturally sensitive approaches to provide emotional support and practical guidance, reducing isolation and improving overall well-being [99].

Collectively, these models demonstrate the effectiveness of community-driven, culturally competent care in improving maternal health outcomes. They highlight the importance of integrating cultural understanding and community involvement into healthcare strategies to address disparities and promote equity. By strengthening trust, improving care navigation, and encouraging earlier engagement with postpartum health services, these approaches may also support earlier recognition and evaluation of breast symptoms during the postpartum period, a critical window for the detection of pregnancy-associated breast cancer. Although several interventions show promise, there remains limited longitudinal evidence evaluating their sustained impact on racial disparities in maternal outcomes.

7. Conclusions: Action for Change

The United States faces a maternal health crisis that is both preventable and deeply rooted in structural inequities. Despite medical advances and growing awareness, maternal mortality rates continue to rise—particularly for Black and Indigenous women. This public

health emergency is not simply the result of isolated clinical failures. Rather, disparities stem from intersecting clinical, structural, and social drivers—including differential quality of care, “maternity care deserts,” cumulative stressors, and systemic racism within health systems. Adopting an intersectional lens is essential to understanding why Black women in the U.S. face disproportionately higher maternal mortality rates than White women. Intersectionality recognizes that systems of oppression do not act independently but intersect to shape lived experiences and health outcomes. For Black women, this means that maternal health risks cannot be explained by race or gender alone; rather, they emerge from the combined effects of racial bias in medical care, structural inequities in access to resources, economic instability, and social stress rooted in discrimination. Black women are more likely to experience both under-treatment and dismissal of symptoms during pregnancy and postpartum, outcomes reinforced by implicit bias in healthcare systems. They are also more likely to live in environments with limited healthcare infrastructure, fewer maternity care providers, and higher exposure to chronic stressors linked to racism, all of which elevate physiological and psychological risk during pregnancy.

Addressing this crisis requires more than expanding coverage or improving hospital protocols; it demands a fundamental shift toward equity-driven solutions. Power must be redistributed, not just resources, by investing in Black-led, culturally safe care models and elevating community knowledge. Structural racism must be measured, not just outcomes, prompting a rethinking of research priorities, funding, and accountability structures. Proven interventions need to be scaled urgently, including comprehensive postpartum Medicaid coverage, doula access, standardized safety bundles, and peer-led postpartum support programs. These efforts should also include strengthening postpartum surveillance and improving pathways for timely evaluation of breast symptoms, particularly during the first year after delivery when pregnancy-associated breast cancer (PABC) may emerge. Equity must be embedded at every level, clinical care, health systems, policy, and research, without tokenism or delay.

To reverse the maternal mortality crisis, we must dismantle structural racism, realign care around equity, and center the voices of those most harmed. Institutions must recognize that maternal health outcomes are shaped not only by what happens in the delivery room but also by the cumulative impact of social determinants, historical injustices, and ongoing disparities in care. Moving forward, we must continue investing in data-driven strategies, strengthen maternal health infrastructure such as MMRCs, and fully support comprehensive legislation like the Momnibus Act. Most importantly, we must build a healthcare system where every person, regardless of race, income, or geography, has the opportunity to experience a safe and dignified birth. The lives of birthing people depend on it. These recommendations are grounded in the existing literature but should be interpreted as interpretive synthesis rather than definitive causal conclusions.

Author Contributions: Conceptualization, B.J. and N.J.; Writing—Original Draft Preparation, B.J.; Writing—Review and Editing, B.J., N.J. and P.R.; Visualization, B.J.; Supervision, N.J. All authors have read and agreed to the published version of the manuscript.

Funding: This review was supported by the National Cancer Center (NCC) under Award Number P067152. The funder had no role in the design of the study; collection, analysis, or interpretation of data; or in writing the manuscript.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: Data supporting the findings and conclusion are available upon request from the corresponding author.

Acknowledgments: During the preparation of this work the author(s) used ChatGPT (OpenAI), based on the GPT 5.3 model, to support drafting, language refinement, and structural organization of the manuscript. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the published article.

Conflicts of Interest: The authors declare that they have no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

MMR	Maternal Mortality Rates
PABC	Pregnancy-Associated Breast Cancer
PPD	Postpartum Depression
HDP	Hypertensive Disorders of Pregnancy
PPCM	Peripartum Cardiomyopathy
EWS	Early Warning Signs
MEOVS	Modified Early Obstetric Warning System
ACOG	American College of Obstetricians and Gynecologists
MMRCs	Maternal Mortality Review Committee(s)
CDC	Centers for Disease Control and Prevention
NIH	National Institutes of Health
FMLA	Family and Medical Leave Act
KFF	Kaiser Family Foundation
CMQCC	California Maternal Quality Care Collaborative

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