Beyond Statistics: Addressing Racial Disparities in Black Maternal Mortality through the Theory of Fundamental Causes and the Maternal Care and Equity Intervention

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Abstract
Despite advances in medical technology and knowledge, Black women in the United States experience a disproportionately high rate of maternal morbidity and mortality, driven by intersecting structural, institutional, and interpersonal forms of racism. These disparities persist across income and education levels, underscoring the impact of systemic racism and structural inequality rather than individual behavioral factors. The Centers for Disease Control and Prevention (CDC) and other public health authorities have declared this crisis preventable, yet solutions remain fragmented and insufficient. This paper examines the persistent crisis of maternal mortality among Black women in the United States through the lens of the Theory of Fundamental Causes. By analyzing the structural inequities that perpetuate this health crisis, this research identifies key sociocultural, economic, and political determinants that create and sustain maternal health disparities and proposes the Maternal Care and Equity intervention (MCEI), a comprehensive, evidence-based intervention program that addresses both immediate healthcare needs and underlying systemic factors. The Maternal Care and Equity intervention (MCEI) integrates culturally competent clinical practices, policy reforms, digital health innovations, and community engagement strategies. By targeting the social determinants of health and the systemic barriers within maternal health care, the MCEI aims to mitigate racial inequities and improve maternal outcomes for Black women. This article calls for integrated, evidence-informed approaches to policy, practice, and research in addressing racial disparities in maternal health. This research contributes to the broader discourse on health equity by demonstrating how targeted interventions grounded in social theory can dismantle persistent racial disparities in healthcare.

Keywords: *Black maternal mortality, racial health disparities, structural racism, maternal health equity, community-based intervention, health policy reform*

1.0 Introduction

The United States faces a paradoxical reality in maternal healthcare; despite its advanced healthcare system, it continues to grapple with a persistent and troubling issue: racial disparities in maternal mortality. Maternal mortality is on the rise in the United States, and it disproportionately affects black women (Lister et al. 2019). This maternal mortality rate among Black women in the United States represents a stark health disparity that persists across different socioeconomic statuses and is evident in both rural and urban areas. According to the Centers for Disease Control and Prevention (CDC), (Figure 1) Black women are three to four times more likely to die from pregnancy-related causes than white women (CDC, 2023), a statistic that has remained stubbornly consistent for decades despite overall improvements in medical care. The magnitude of this disparity becomes even more troubling when examining

recent data - Black women have a maternal mortality rate of 2.9 times that of White women in the United States (Njoku et al, 2023). Perhaps most alarming is the consistent documentation of Black women reporting being dismissed, ignored, or inappropriately treated when expressing symptoms or concerns during pregnancy and postpartum care (Lister et al., 2019).

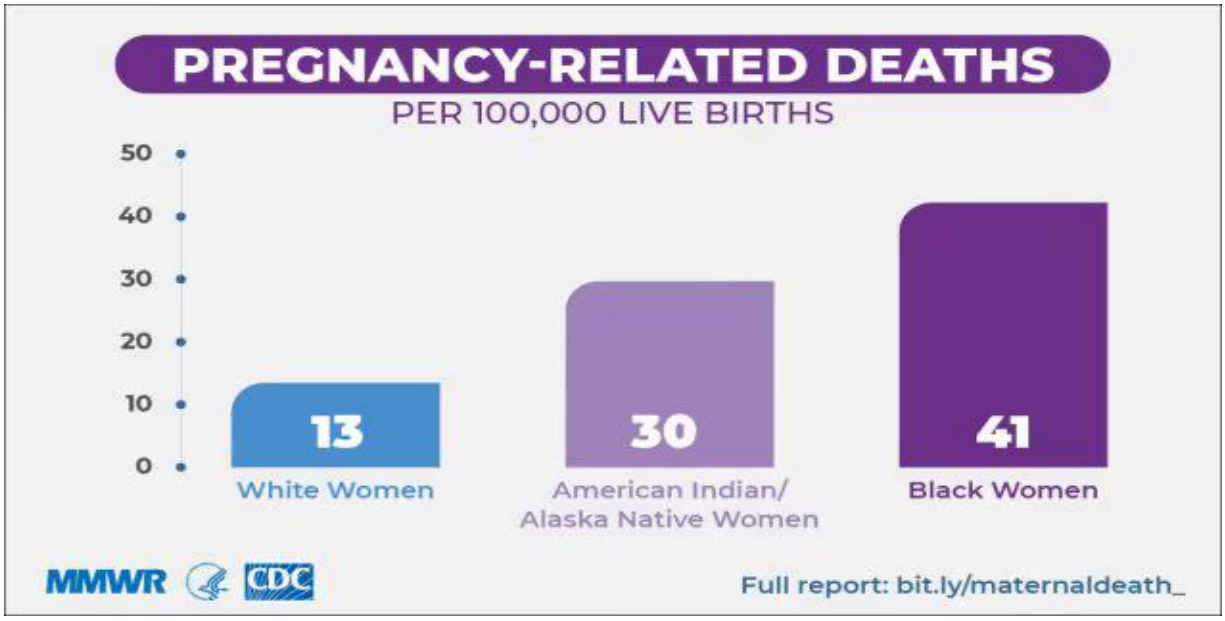

Figure 1: Graph Showing Disparities in Maternal Mortality by Race

The consequences of maternal mortality extend far beyond individual tragedy. Addressing the maternal mortality disparity among Black women is a pressing public health issue because maternal death has significant social and economic impacts and is not just a devastating event for families and communities, and future generations but also reflects broader failures in healthcare delivery and social justice.

This paper examines these systemic inequities in maternal health outcomes through three interconnected lenses:

- An analysis of current statistical data demonstrating the scope and persistence of racial disparities in maternal mortality
- An application of the Theory of Fundamental Causes to understand why these disparities persist despite medical advances
- An examination of the complex interplay of sociocultural, economic, and political factors that create and maintain these disparities

Building on this analysis, we propose the Maternal Care and Equity Intervention (MCEI), a comprehensive intervention program designed to address both immediate healthcare barriers and underlying structural inequities. By targeting multiple levels of intervention - from individual provider behavior to institutional practices to policy advocacy - the MCEI offers a framework for creating sustainable improvements in maternal health outcomes for Black women.

2.0 Scope and Magnitude of Maternal Health Disparities

2.1 Statistical Evidence of Disparity

The statistical evidence documenting racial disparities in maternal mortality presents a disturbing pattern of inequity in American healthcare. According to the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists, Black women face dramatically higher risks during pregnancy and childbirth compared to their white counterparts.

In 2021, the maternal mortality rate for Black women reached 69.9 deaths per 100,000 live births - nearly four times the rate of 18.2 for white women (CDC, 2023). This disparity represents one of the widest racial gaps in any public health metric in the United States. Particularly concerning is that this disparity has widened rather than narrowed over time, despite increased awareness and targeted interventions.

These statistics become even more striking when compared internationally (Table 1). The maternal mortality rate for Black women in the United States exceeds that of many developing nations (World Bank, 2023), placing one of the world's wealthiest countries in the disturbing position of having a subset of its population experiencing third-world maternal health outcomes (Table 1). Even more telling is that these disparities persist across socioeconomic levels - Black women with college degrees and middle to high incomes still face significantly higher risks than white women with less education and lower incomes (Howell, 2018).

Table 1: Maternal Mortality Ratio modelled estimate per 100,000 live births

Country	*Year*	*Deaths per 100,000 live births*
United States	2023	17
Ukraine	2023	15
Turkey	2023	15
Sri Lanka	2023	18
Moldova	2023	19
Malaysia	2023	26
Lebanon	2023	15
Mexico	2023	42
Monaco	2023	5
United Kingdom	2023	8
Italy	2023	6
Japan	2023	3
Germany	2023	4
Norway	2023	1
France	2023	7

2.2 Analysis of Contributing Factors

The factors contributing to these disparities form a complex web of biological, social, and structural determinants:

i. Access to Quality Care: Black women disproportionately live in medically underserved areas with limited access to high-quality maternal healthcare facilities. Even when physically accessible, these facilities often lack adequate resources, experienced providers, or culturally competent care models. In rural areas, especially, the closure of obstetric units has created "maternity care deserts" that disproportionately affect communities of color (MacDorman et al., 2016).

ii. Chronic Conditions and Comorbidities: Black women experience higher rates of conditions that complicate pregnancy, including hypertension, diabetes, and cardiovascular disease. However, research indicates that these comorbidities only partially explain outcome disparities. When controlling for these conditions, significant racial disparities persist, suggesting that differential treatment within the healthcare system plays a substantial role (Bateman et al., 2010).

iii. Quality of Care Disparities: Evidence consistently shows that Black women receive different—and often inferior—treatment within healthcare settings. This includes delays in diagnosis, inadequate pain management, and failure to recognize and respond to emerging complications such as preeclampsia and postpartum hemorrhage. These disparities in care quality occur across all types of healthcare facilities, regardless of the institution's overall quality metrics (Berg et al., 2011).

iv. Stress and Weathering: The cumulative physiological burden of chronic stress associated with experiencing racism—what researchers term "weathering"—creates biological vulnerability that can complicate pregnancy and childbirth. Research indicates that this chronic stress activation may contribute to higher rates of preterm birth, low birth weight, and maternal complications among Black women (Wang et al., 2020).

These factors interact synergistically, creating a perfect storm of vulnerability for Black mothers navigating pregnancy and childbirth in the American healthcare system. Understanding these interactions requires a theoretical framework that can account for the persistence of health disparities despite medical advances—a framework provided by the Theory of Fundamental Causes.

3.0 Methods

To develop a comprehensive and impactful intervention addressing racial disparities in maternal mortality, a multi-method, evidence-informed approach was employed. This methodology combined theoretical analysis, literature synthesis, and intervention design rooted in public health equity principles.

i. Literature Review and Evidence Synthesis: An extensive literature review was conducted using peer-reviewed articles, government health statistics, and policy reports published within the last ten years. Key databases such as PubMed, JSTOR, and the CDC's Maternal Mortality Data portal were searched using terms like "Black maternal mortality," "racial health disparities," "systemic racism in healthcare," and "maternal health interventions." Studies were selected for their relevance to structural determinants of maternal mortality, effectiveness of interventions, and focus on racially marginalized populations, especially Black women.

ii. Theoretical Framework: The Theory of Fundamental Causes (Link & Phelan, 1995) served as the guiding framework. This theory posits that social conditions such as access to resources—income, education, power, and social connections—fundamentally shape health outcomes. Guided by this theory, the intervention was designed to address structural inequities that persist even when proximal risk factors are managed through medical advances.

iii. Community-Informed Insight: Although this paper did not include primary data collection, it drew on community-based participatory research (CBPR) literature to incorporate insights from Black women's lived experiences. Published qualitative studies and community needs assessments informed culturally relevant components such as peer support networks, free doula services, and mental health supports.

iv. Intervention Design: The intervention, Maternal Care and Equity Intervention (MCEI) was developed using a logic model to map inputs, activities, outputs, and outcomes. MCEI components were selected based on empirical support and alignment with public health best practices. These components include implicit bias training for healthcare providers, telehealth expansion, culturally competent care protocols, and community-based supports. Implementation considerations such as geographic equity, resource allocation, and provider accountability were integrated into the design.

v. Implementation and Evaluation Framework: An equity-centered implementation plan was proposed, emphasizing systemic integration, stakeholder engagement, and continuous quality improvement. Though no formal evaluation was conducted for this paper, a mixed-methods evaluation framework was outlined. Quantitative measures would include changes in maternal mortality ratios disaggregated by race, while qualitative methods would capture patient experiences and provider perspectives through interviews and focus groups. Continuous assessment and adaptive feedback mechanisms were proposed to ensure responsiveness and sustainability.

4.0 The Theory of Fundamental Causes: A Framework for Understanding Persistent Disparities

To understand and address the racial disparities in maternal health, we apply the Theory of Fundamental Causes (Link & Phelan, 1995), which offers a robust framework for understanding racial disparities in maternal mortality by focusing on systemic inequalities that persist despite advances in medical care and technology. This theory diverges from traditional biomedical models by focusing not on proximate risk factors but on the underlying social conditions that consistently produce health inequities across different diseases, populations, and periods.

The core proposition of the theory is that certain social conditions - particularly socioeconomic status and racial stratification such as such as income, quality healthcare, education, power, economic stability, and social support act as "fundamental causes" of disease because they determine access to resources that can be deployed to avoid risks or minimize the consequences of disease once it occurs. The theory explains why disparities persist even as specific risk factors or diseases change over time: those with greater access to resources like knowledge, money, power, prestige, and beneficial social connections can better protect their health regardless of the particular mechanisms linking social advantage to health outcomes. Applied to maternal mortality disparities among Black women, the Theory of Fundamental Causes illuminates several key dynamics:

- Resource Inequity: The fundamental cause of racial disparities in maternal mortality lies in the inequitable distribution of resources essential for good health, as Black women disproportionately face barriers to quality prenatal and postpartum care, health insurance, and access to high-performing healthcare facilities. Wealth and education often mitigate health risks, yet systemic racism limits the benefits of these resources for Black women. e.g., Black women with advanced education or higher incomes still face disproportionately high maternal mortality rates due to systemic inequalities embedded

in healthcare delivery. This explains the counterintuitive finding that Black women with college degrees still face higher maternal mortality risks than white women without high school diplomas (Shah et al., 2021).

- Social and Economic Inequalities: Black women are overrepresented in lower-income brackets and often reside in under-resourced communities with limited access to healthcare facilities or maternal health support services such as doulas and midwives, further increasing risks during pregnancy and childbirth. These economic constraints, coupled with systemic inequities in employment and housing, create environments that exacerbate health vulnerabilities.

- Institutional Racism in Healthcare Delivery: The theory highlights how racial bias, both implicit and explicit, operates within healthcare institutions to create different treatment experiences for Black women. When Black women report pregnancy symptoms or complications, their concerns are more likely to be dismissed, minimized, or inadequately addressed, leading to delayed diagnosis and treatment of life-threatening conditions. This institutional racism represents a fundamental cause that persists regardless of individual provider intentions or institutional quality metrics.

- Environmental Factors: Environmental factors such as poor air quality, exposure to industrial pollutants, and unsafe housing conditions contribute to chronic health conditions like hypertension and asthma, which complicate pregnancies. Access to clean water, nutritious food, and safe environments—critical determinants of health—are often lacking in marginalized neighborhoods, exacerbating disparities.

- Adaptive Capacity of Privilege: As healthcare advances emerge to address maternal complications, white women typically benefit first and most substantially from these innovations. This occurs through multiple mechanisms: new treatments and protocols are often developed and tested primarily in facilities serving predominantly white populations; information about advances spreads through networks that disproportionately exclude Black communities; and financial barriers may limit access to cutting-edge care. This pattern of differential benefit from medical advances helps explain why the racial gap in maternal mortality has widened rather than narrowed despite overall improvements in maternal care.

- Cumulative Disadvantage: The theory emphasizes how disadvantages accumulate across the life course, creating heightened vulnerability during pregnancy. Black women experience the cumulative physiological burden of chronic stress associated with racial discrimination - a phenomenon researchers term "weathering" - which creates biological vulnerability to pregnancy complications. This cumulative disadvantage extends across generations, as maternal health outcomes influence the health of future generations, perpetuating cycles of disadvantage and poor health outcomes.

By focusing attention on these fundamental causes rather than merely proximate risk factors, the theory provides a roadmap for effective intervention. It suggests that meaningful reductions in maternal mortality disparities require addressing the underlying inequities in resource distribution, institutional practices, and structural racism, not merely improving individual risk factors or clinical protocols. This theoretical framework directly informs our proposed

Maternal Care and Equity Intervention, which targets these fundamental causes through multi-level interventions.

5.0 Sociocultural, Economic, and Political Determinants of Maternal Health Disparities

Maternal health disparities, particularly among marginalized groups such as Black women, are complex issues rooted stem from interconnected sociocultural, economic, and political factors. These determinants do not operate in isolation but interact in complex ways to create systemic barriers that limit access to quality healthcare, perpetuate harmful stereotypes, and exacerbate health inequities, and understanding these interconnected determinants is essential for developing effective interventions, comprehensive interventions like the proposed Maternal Care and Equity Intervention.

5.1 Sociocultural Determinants of Maternal Health Disparities

a. Implicit Bias and Stereotyping: Healthcare providers, like all individuals, absorb cultural stereotypes that may unconsciously influence clinical decisions and their treatment of Black women, leading to disparities in diagnosis, treatment, and pain management. Research documents how racial bias affects the assessment of patient pain, credibility of symptom reporting, and treatment recommendations. Black women frequently report having their symptoms dismissed or minimized, particularly pain or distress signals that might indicate serious complications. This dismissal creates dangerous delays in the diagnosis and treatment of conditions like preeclampsia, where timely intervention is critical (Howell, 2018).

b. Historical Trauma and Medical Mistrust: The history of medical exploitation of Black women in gynecology, from the surgical experimentation on enslaved women by J. Marion Sims to the Tuskegee Syphilis Study, has created intergenerational patterns of medical mistrust. This mistrust can manifest as delayed care-seeking, incomplete disclosure of symptoms, or reluctance to follow treatment recommendations. Healthcare systems rarely acknowledge or address this historical context, further perpetuating communication barriers between providers and Black patients (Lister et al., 2019).

c. Cultural Competence: Current medical education and training programs inadequately prepare health providers to deliver culturally appropriate care to diverse populations, resulting in communication failures, misunderstandings about cultural practices related to pregnancy and childbirth, and insensitivity to cultural preferences for care delivery which compounded by language barriers or limited health literacy, these competence gaps c significantly compromise care quality and patient safety. Additionally, societal norms and stigma around seeking mental health or maternal health services can delay critical care interventions.

5.2 Economic Determinants

a. Insurance Coverage and Financial Barriers: Black women are disproportionately represented among lower-income groups of the uninsured and underinsured, even with the expansion of Medicaid under the Affordable Care Act, significant coverage gaps remain, particularly in states that opted out of expansion, many of which have large Black populations. Limited coverage creates barriers to accessing comprehensive prenatal care, specialty consultations, and postpartum follow-up, and the standard six-week insurance coverage for postpartum care fails to address the fact that over one-

third of maternal deaths occur between 6 weeks and one year after delivery (MacDorman et al., 2016).

b. Geographic and Transportation Barriers: Hospital closures and consolidation have created "maternity care deserts," particularly in rural areas and urban communities with high concentrations of Black residents, resulting in longer travel distances that create significant barriers, especially for women with limited transportation options or inflexible work schedules and can be life-threatening in emergencies when time-to-treatment directly impacts survival.

c. Employment and Economic Insecurity: The stress of financial insecurity itself negatively impacts maternal health outcomes through both direct physiological mechanisms and indirect behavioral pathways like delayed care-seeking. Black women are overrepresented in low-wage jobs without paid leave or schedule flexibility, forcing difficult choices between economic survival and necessary prenatal care and the absence of universal paid family leave in the United States hereby particularly disadvantages Black women, who often must return to work shortly after delivery despite higher rates of complications requiring recovery time.

5.3 Political Determinants

a. Policy Fragmentation: Maternal health policies in the United States are fragmented across federal, state, and local jurisdictions, creating geographic variability in care access and quality. This fragmentation particularly disadvantages Black women, who disproportionately live in states with weaker maternal health infrastructure and more restricted healthcare access. The failure to establish national standards for maternal healthcare results in inconsistent implementation of evidence-based practices known to reduce mortality, and policies aimed at systemic change, such as the Black Maternal Health Momnibus Act, aim to address these gaps but face implementation challenges.

b. Inadequate Research Funding: Despite the clear disparities in maternal health outcomes, research specifically examining Black maternal health has been chronically underfunded. This funding gap limits the development of tailored interventions addressing the unique needs of Black women during pregnancy and postpartum. Additionally, clinical trials in obstetrics have historically underrepresented Black women, creating gaps in evidence about treatment efficacy across different populations.

c. Political Representation: The limited representation of Black women in healthcare leadership, policy development, and medical research means their perspectives and experiences remain marginalized in decision-making about maternal healthcare delivery. This representation gap perpetuates systems designed around the needs and experiences of white women, failing to address the specific challenges faced by Black mothers.

6.0 Evidence-Based Intervention Program: The Maternal Care and Equity Intervention (MCEI)

The racial disparities in maternal health outcomes demand a comprehensive, evidence-based, multifaceted strategy that addresses both immediate healthcare needs and systemic inequities. For this paper, we propose the Maternal Care and Equity Intervention (MCEI) framework (Figure 2). The Maternal Care and Equity Intervention (MCEI) represents a multi-faceted approach to maternal healthcare delivery, specifically addressing the disproportionate mortality rates among Black women.

6.1 Theoretical Foundation and Design Principles

The MCEI is explicitly grounded in the Theory of Fundamental Causes, recognizing that effective interventions must address the underlying social inequities that consistently produce health disparities. This theoretical grounding informs several key design principles:

- Multi-level intervention: The MCEI operates simultaneously at individual, institutional, community, and policy levels to address the complex determinants of maternal health disparities.
- Cultural centeredness: Rather than simply adapting mainstream approaches, the MCEI centers the lived experiences, values, and perspectives of Black women in program design and implementation.
- Community partnership: The intervention employs community-based participatory approaches that engage Black women as partners rather than passive recipients in designing and implementing interventions.
- Sustainability focus: All components include mechanisms for sustainable funding, institutional integration, and ongoing evaluation to ensure long-term impact beyond initial implementation.
- Intersectional approach: The MCEI recognizes that Black women's maternal health experiences are shaped by multiple intersecting identities and addresses the specific needs of subgroups (e.g., rural Black women, Black immigrant women, LGBTQ+ Black women).

6.2 Core Components of the Maternal Care and Equity Intervention (MCEI)

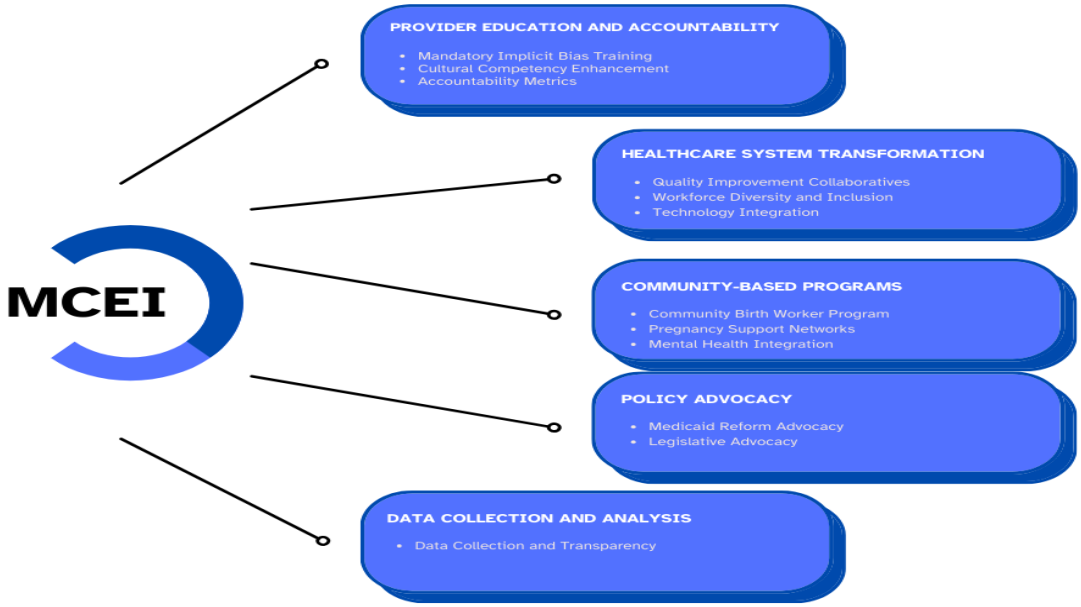

Figure 2: The Maternal Care and Equity Intervention (MCEI) Framework

6.2.1 Provider Education and Accountability

a. Mandatory Implicit Bias Training: All maternal healthcare providers must complete evidence-based training on recognizing and mitigating implicit bias in clinical decision-making. Unlike typical diversity training, this component employs validated protocols with demonstrated efficacy in changing provider behavior. Key elements include case-based learning using scenarios derived from Black women's actual experiences, simulated patient encounters with standardized patients from diverse backgrounds, regular refresher sessions rather than one-time interventions, and integration with clinical supervision and performance evaluation.

b. Cultural Competency Enhancement: Beyond basic cultural competency, this component develops providers' capacity for cultural humility—the ongoing process of self-reflection, critical consciousness about power imbalances, and commitment to addressing inequities. Programming includes immersive community experiences in the neighborhoods served by their facilities, partnership with Black doulas and midwives to incorporate traditional knowledge, training in trauma-informed care addressing historical and contemporary trauma, and mentorship programs pairing providers with experienced practitioners skilled in equitable care delivery.

c. Accountability Metrics: This component establishes standardized metrics for evaluating provider performance on equity indicators, including patient-reported experience measures specific to respectful, culturally appropriate care and analysis of treatment disparities within provider practices, regular chart audits assessing adherence to evidence-based practices across patient populations, and 360-degree feedback incorporating perspectives of patients, peers, and community partners.

6.2.2 Healthcare System Transformation

a. Quality Improvement Collaboratives: Maternal healthcare facilities participate in learning collaboratives implementing evidence-based protocols specifically addressing common causes of Black maternal mortality like standardized assessment and management protocols for hypertensive disorders of pregnancy, hemorrhage response protocols with mandatory simulation training, early warning systems for identifying deteriorating maternal conditions, and discharge planning and follow-up protocols addressing postpartum complications.

b. Workforce Diversity and Inclusion: This component addresses representation gaps in the maternal healthcare workforce through partnerships with historically Black colleges and universities to strengthen pipeline programs, financial support for Black students pursuing careers in maternal healthcare, mentorship programs supporting the retention and advancement of Black healthcare professionals and institutional climate assessments identifying barriers to inclusion and advancement.

c. Technology Integration: The intervention leverages technology to extend care access and monitoring telehealth platforms, providing specialty consultation for high-risk pregnancies, remote monitoring devices for blood pressure and other vital signs, mobile health applications providing culturally tailored education and symptom tracking, and virtual support groups addressing isolation and mental health needs.

6.2.3 Community-Based Programs

a. Community Birth Worker Program: This component trains and deploys community birth workers, including doulas, perinatal community health workers, and lactation consultants from within the Black communities for free doula services throughout pregnancy, labor, and the postpartum period, advocacy training to help birthing people navigate healthcare systems, integration of doulas into clinical care teams with formalized roles and sustainable funding mechanisms through Medicaid reimbursement and private insurance coverage

b. Pregnancy Support Networks: This component creates infrastructure for community-based social support, like peer support throughout pregnancy and postpartum, fatherhood/partner engagement programs prepare non-birthing parents for supportive roles, intergenerational mentoring connecting new mothers with experienced community elders, and resource navigation assistance addressing social determinants of health.

c. Mental Health Integration: This component addresses the often-neglected mental health aspects of maternal care for screening and treatment protocols for perinatal mood and anxiety disorders, trauma-informed mental health services addressing both historical and contemporary trauma, integration of mental health providers within obstetric care settings, and group-based interventions that build resilience and coping strategies

6.2.4 Policy Advocacy

a. Medicaid Reform Advocacy: This component advocates for policy changes addressing coverage gaps through extending postpartum Medicaid coverage to one year, enhancing reimbursement for comprehensive prenatal and postpartum care, expanding coverage for support services, including doulas and home visits, and removing administrative barriers disproportionately affecting Black women.

b. Legislative Advocacy: This component builds political will for structural change by supporting the Black Maternal Health Momnibus Act and similar legislation, developing model legislation addressing social determinants of maternal health, building advocacy coalitions centering Black women's leadership, and training Black women as effective policy advocates.

6.2.4 Data Collection and Analysis

a. Data Collection and Transparency: This component addresses critical information gaps by standardizing the collection of race/ethnicity data in maternal health records, mandating the reporting of maternal mortality and severe maternal morbidity by race/ethnicity, and publicizing dashboards tracking equity metrics across healthcare systems and providing community oversight of data interpretation and use.

6.3 Implementation Strategy and Evaluation

The MCEI proposes a phased implementation strategy beginning with pilot sites in communities with the highest disparities, followed by staged expansion. Implementation will follow established quality improvement methodologies with rapid cycle evaluation and adaptation. Evaluation will employ a comprehensive framework assessing and tracking process metrics like implementation fidelity, reach, and participant engagement; outcome metric like changes in maternal mortality, severe maternal morbidity, and near-miss events disaggregated by race/ethnicity; experience metrics such as assessing patient and provider experiences

through validated instruments and program sustainability indicator such as monitoring institutionalization of changes, ongoing funding, and policy adoption.

7.0 Conclusion

The racial disparities in maternal mortality among Black women in the United States are neither accidental nor immutable but represent a profound social justice imperative. As this paper has demonstrated, these disparities emerge from complex interactions between individual, institutional, and structural factors that systematically disadvantage Black women navigating pregnancy and childbirth.

The Theory of Fundamental Causes provides a powerful framework for understanding why these disparities persist despite overall advances in maternal healthcare. By highlighting how unequal distribution of resources such as knowledge, money, power, prestige, and beneficial social connections consistently produces health inequities, the theory directs attention beyond proximate risk factors to the underlying social conditions that must be transformed to achieve lasting change.

The Maternal Care and Equity Intervention (MCEI) represents a comprehensive response to this challenge, targeting interventions across multiple levels to address both immediate healthcare failures and underlying structural inequities while offering a pathway forward by aligning theory, evidence, and practice to transform maternal health outcomes for Black women in the United States.

Several limitations, such as the complexity of the proposed intervention, which requires substantial resources and coordination across multiple sectors, resistance to change by deeply entrenched structural racism, and the evaluation of complex interventions, must be acknowledged. Despite these limitations, the moral urgency of addressing Black maternal mortality demands ambitious action as the lives of Black mothers and the well-being of their families and communities depend on transforming a healthcare system that has failed them for generations. By addressing the fundamental causes of these disparities rather than merely their symptoms, the approach outlined in this paper offers a path toward a future where all women, regardless of race, can experience pregnancy and childbirth with dignity, safety, and support.

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