The Critical State of Black Women's Health

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Executive Summary

The state of Black women's health is in critical condition, due to the systemic racism, discrimination, and implicit bias that Black women face within the health care system. To combat the intersecting factors that create an inequitable health care experience for Black women, the following aggressive strategies must be implemented.

- Create policies with an intentional racial equity lens
- Continue expanding Medicaid benefits, including postpartum coverage
- Integrate health care access into public schools
- Ensure technological accessibility for Black families
- Increase the number of Black professionals in the medical field
- Improve the quality of care for Black women

This report will provide an overview of the multifaceted issues contributing to the status of Black women's health. It will also highlight health policy areas that require urgent attention and immediate intervention. Lastly, it will offer health policy recommendations targeting the institutions, systems, and previous legislation that have both intentionally and inadvertently harmed Black women's overall health. Our goal is to help inform Arkansans of health policy issues impacting Black women and to create partnerships with other community stakeholders in Arkansas to help increase access to health care and improve the well-being of all Black women. Policymakers, health care providers, and community-based organizations must work together to address the health care inequities that plague Black women.

To combat the factors that create an **inequitable** *health care experience for Black women,* **aggressive strategies** *must be implemented.*

ARKANSAS ADVOCATES FOR CHILDREN & FAMILIES

The Toll of Systemic Racism on Black Women's Health

Racism is deeply ingrained in the fabric of this country. It has been woven into all the structures and systems that Black women must navigate on a daily basis. The American Academy of Family Physicians notes that "systemic racism works by categorizing people based on their race, color, ethnicity, and culture."[1] Resources and societal goods are then allocated to certain groups of people in a way that puts some in a position of privilege without merit and allows others to be oppressed. This is evident within our nation's health care system.

Because of the various intersecting identities of Black women in the United States (race, gender, class, sexual orientation, ability, etc.), they are disproportionately affected by health disparities.[2] Black women experience excess mortality (the number of total deaths is greater than should be expected during a certain timeframe) relative to other women in the country and have shorter life expectancies.[3] They are disproportionately impacted by chronic health conditions such as heart disease, diabetes, stroke, maternal morbidity (disease or medical condition related to pregnancy or childbirth) and mortality, breast cancer, and cervical cancer. Note, this is not an exhaustive list of health conditions that disproportionately affect Black women.

Black women also face racism, discrimination, and unconscious bias when receiving medical care that results in unequal treatment. Black women have had their concerns and symptoms ignored,[4] their pain under-treated,[5] and they are referred less frequently for specialty care.[6] Per the Arkansas Minority Health Commission's Racial and Ethnic Health Disparity Study, significantly higher percentages of Blacks and Hispanics reported being victims of discrimination while getting healthcare compared to their White counterparts.[7] These experiences, coupled with the historic exploitation of the Black community, have created a growing mistrust of medical professionals.[8]

*Black women have **shorter** life expectancies.*

Intertwined Relationship Between Racism and the Social Determinants of Health

Racism has a significant influence over many aspects of Black women's lives, such as housing, education and employment, which in turn can determine health outcomes. The "conditions in which people are born, grow, live, work, and age," combined with the interrelated social and economic systems that individuals must interact with, impact their health.[9] Income levels, educational attainment, race/ethnicity, and health literacy all contribute to people's ability to access health care services and safe housing, both of which are imperative to staying healthy.[10]

The social determinants of health are divided into five domains: Economic Stability; Neighborhood and Physical Environment; Education; Food; Community and Social Context; and Health Care System.

Economic Stability

A person's economic stability plays a large role in their ability to be healthy and stay healthy. Black women earn on average $5,500 less per year than the average woman in the United States.[11] In Arkansas, the median annual income for Black women who work full-time year-round was $28,018 compared to White women who made $33,943 in 2016.[12] Black women are paid 63 cents for every dollar paid to Non-Hispanic White men.[13] Nationally, the median income for Black women is $36,227 per year, which is $21,698 less than the median income for non-Hispanic White men. Black women are 50% more likely than White women to be the primary source of economic support for their families.[14] They also experience higher rates of unemployment and poverty compared to their counterparts.[15]

*Black women are paid **63 cents** for every dollar paid to White men.*

Social Determinants of Health
Kaiser Family Foundation

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code/ geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care
Health Outcomes Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations					

https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Neighborhood and Physical Environment

Housing

An example of how systemic racism influences health outcomes is the now illegal practice of "redlining," which started in the 1930s and denied or selectively raised prices (mortgages, loans, etc.) to residents of redlined neighborhoods.[16] Redlined communities were deemed "hazardous" for lending and were predominantly low- and moderate-income Black neighborhoods. These neighborhoods were outlined in red on maps, and the maps were used to deny mortgages, loans, insurance, and other financial services to residents in those areas and to keep neighborhoods segregated. Arkansas was not exempt from the practice of redlining, especially in its urban communities such as Little Rock, which resulted in highly segregated communities.[17] Little Rock is distinctly separated today by race and socioeconomic status. On the east of I-30 and to the south of I-630, the communities are predominantly Black and have been deprived of necessary economic resources,[18] while the communities to the west of I-430 and north of I-630 are predominantly White and have been equipped economically with an excess of resources. The economic investments in White communities have created lasting effects on the quality of educational systems, neighborhood infrastructures, and healthcare systems.

Redlining reinforced the discriminatory distribution of resources and services and is a significant underlying cause of the poor health outcomes in Black communities. Residential segregation increases incidents of cardiovascular disease among Black adults.[19] Long-term residential segregation is also associated with higher rates of obesity in Black women.[20] Redlining decreased the opportunity for Black families to create wealth and led to the increase of poverty, greater social vulnerability, lower life expectancies, and higher prevalence of chronic diseases.[21]

Housing stability, quality, safety and affordability all affect health outcomes as well. Housing instability is associated with higher rates of physical and mental morbidity and increased rates of mortality.[22] The threat of eviction disproportionately impacts Black women renters. Even though Black women represent less than 1 in 10 of all renters, 1 in 5 renters who are likely to face eviction that could result in homelessness are Black women.[23] Poor housing conditions such as water leaks, poor ventilation, dirty carpets and pest infestations can cause health risks such as mold, mites, and allergies.

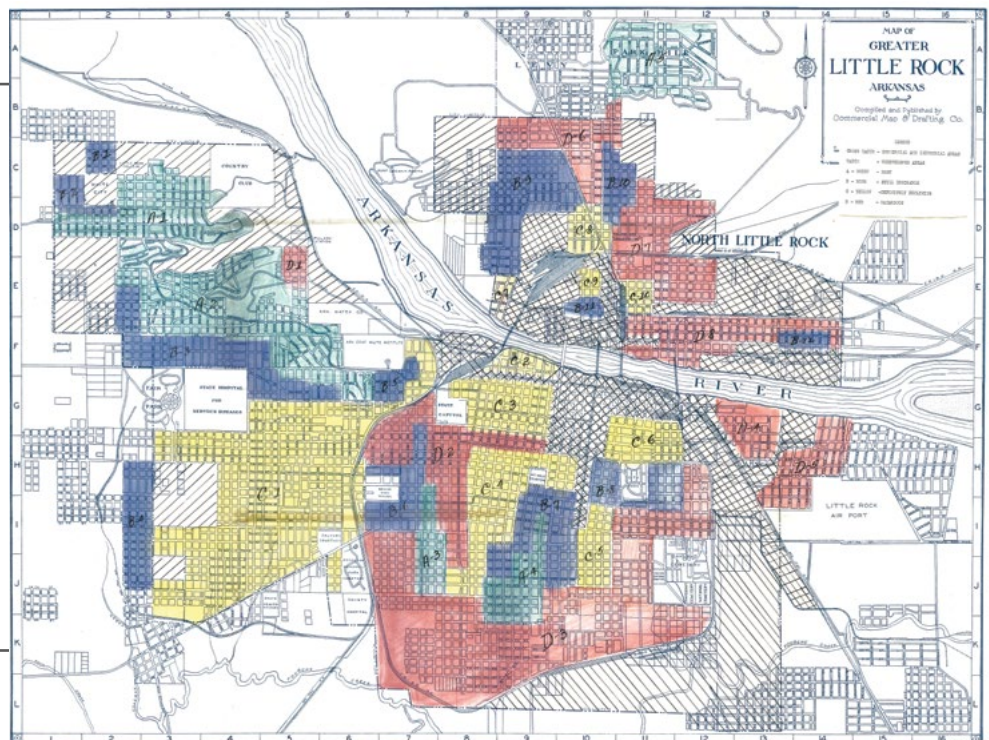## Redlined Little Rock, Arkansas, During the New Deal Era

Little Rock

Areas by Grade

Area	Grade
20%	A "Best"
18%	B "Still Desirable"
27%	C "Definitely Declining"
35%	D "Hazardous"

Demographics

88,039	Total Population (1940)
73.8%	Native-born white
25.1%	African American
1.1%	Foreign-born white

Source: Mapping Inequality Redlining in New Deal America https://dsl.richmond.edu/panorama/redlining/#loc=5/39.1/-94.58

Environment

A healthy environment is important for life expectancy and quality of life. Economically disadvantaged communities are disproportionately affected by adverse environmental conditions.[24] Air pollution, lack of access to health care, infrastructure issues, and water quality are all environmental issues that take a toll on an individual's health.[25] Communities of color have higher exposure to air pollution,[26] are located closer to landfills and hazardous waste sites, are more likely to have higher lead levels,[27] and are disproportionately affected by climate change and water contamination. Increased exposure, increased sensitivity, and reduced adaptive capacity affect vulnerability at different points in the causal chain from climate drivers to health outcomes. In Crossett, Arkansas, a small southeastern town where there are a large number of predominantly African American communities, there were concerns about environmental injustice due to a paper mill and industrial facility.[28] Residents of the community expressed concerns for many years about air emissions and water discharges, which lead to an inspection by the Environmental Protection Agency. The hydrogen sulfide chemical being released has been linked to eye, nose, and throat irritation; headaches; breathing problems; and other potential concerns.[29] Due to the investigation, the company, Georgia Pacific, was required to pay a fine and spend money toward environmental projects targeted to reduce the potential for harmful air emissions and enhance the emergency response capabilities within the community.[30]

Poor water quality is linked to waterborne diseases; blood disorders; cancer; and maternal and infant health consequences such as premature births, low birth weights, increased chance of stillbirth, and high-risk pregnancies.[31] Black women also have the highest risk of preterm delivery due to the environmental effects of climate change.[32] This is extremely problematic for both new mothers and infants.

Education

How much people earn affects where they can afford to live, which then can determine the quality of education resources available. In the city of Little Rock, the effects of residential segregation have left the city divided.[33] White families left the south and southwestern parts of Little Rock for other regions of the city. The schools North of Interstate 630 have more White students, resources, and have better state educational assessments. The schools south of the interstate have more Black students, fewer resources, and have had lower scores on these assessments.[34] Due to residential segregation that led to school segregation, White students who attend schools with more funding and resources have a higher quality of education.[35]

The level of educational attainment achieved plays a role in household income and the ability to create financial security and generational wealth. Parents' wealth shapes their children's educational, economic, and social opportunities, which can, in turn, shape their children's health throughout life.[36] A 2015 report by the Asset Funders Network found significant financial disparities between White women and Black women.[37] The median wealth of White single women is $15,640. Yet, the median wealth for single Black women was only $200. And Black mothers are at an even worse disadvantage due to the "motherhood wealth tax" (the penalization of wages for women for each child they have); they had a median wealth of $0. The wealth disparities across race and gender mean that Black women have less money to support themselves and their family members. This has resulted in sacrifices of the quality of housing, childcare, food and health care.

Food

Inequitable access to healthy food options contributes to health disparities.[38] Greater food access exists in predominantly White and gentrifying neighborhoods (gentrifying is the practice of displacing community members from neighborhoods that were historically excluded from receiving financial resources as wealthier individuals buy out housing and businesses and market them to middle- and upper-class individuals).[39] In contrast, low-income communities of color have experienced more fresh food retailers and full-service supermarkets disappearing from their neighborhoods, which in turn creates food deserts (communities that lack access to affordable and healthy food options). Research has shown that Black communities have the fewest supermarkets at all levels of poverty, while White communities have the most.[40]

Community and Social Context

Different community and social factors also impact Black women's health. For example, stress, marginalization, and discrimination can have devastating effects on an individuals' overall health. *Weathering,* a term coined by Dr. Arline Geronimus, states that the "health of African American women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage."[41] Biomarkers that assess how the body responds to stress, such as cortisol levels, sympathetic nerve activity, blood pressure reactivity, cytokine production, waist-to-hip ratio, and glycated hemoglobin levels (allostatic scores), can be assessed to understand the effects of weathering. In a 2016 study conducted by Dr. Geronimus, they found that Black adults have a higher allostatic score compared to White adults. They also had a greater probability of a high score at all ages, particularly at 35-64 years.[42]

Health Care System

Poor rural and urban communities experience more limited access to health care. There have been 98 complete closures of rural hospital facilities in the country since 2005, mostly in the South. This has caused a decrease in specialty care services in rural communities. Obstetric care has faced several cutbacks, resulting in barriers to maternal care and increased chances of maternal morbidity and mortality.[43] Medicaid expansion has helped Arkansas avoid the high number of hospital closures that neighboring southern states have experienced.[44] In 2019, Arkansas did experience the closure of De Queen Medical Center in Sevier County. This has resulted in community members having to travel more than 30 miles to receive medical treatment with comparable services and qualifications to the De Queen Medical Center.[45] Hospitals within metropolitan cities are also experiencing closures in low-income neighborhoods, where residents have the most health care needs.[46] In addition, the pandemic exposed a major issue with broadband access. Arkansas ranks 50th in connectivity in the country.[47] This impacts the ability for communities to have access to telemedicine services when they live far from facilities that can meet their health care needs.

*Arkansas ranks **50th** in broadband access.*

Health Disparities for Black Women

Heart Disease and Stroke

The term "heart disease" refers to multiple heart conditions (coronary artery disease, heart failure, heart arrhythmias, heart valve disease, etc.).[48] In the United States, and in Arkansas, heart disease and stroke are the number one killers for all women, with Black women disproportionately affected.[49] Heart disease kills around 50,000 Black women a year nationally.

In Arkansas, for Black women aged 20 and older, almost half (49%) have some form of heart disease. Between 2011-2015, the death rate among Black people was 261.2 per 100,000 people, compared to the rate for White people at 215.2.[50] For that same timeframe, the heart disease mortality rate for Black women was 209.1 compared to 171.1 for White women.

Black women are also twice as likely to be at risk for stroke and more likely to die at an earlier age compared to women of other races. Some of the major risk factors for heart disease and stroke are diabetes, smoking, high blood pressure, high blood cholesterol, physical inactivity, obesity, and a family history of heart disease. These risk factors are all more prevalent among Black people compared to White people. High blood pressure is also two to three times greater in Black than White women, disproportionately increasing the risk of heart disease and other serious health conditions.[51]

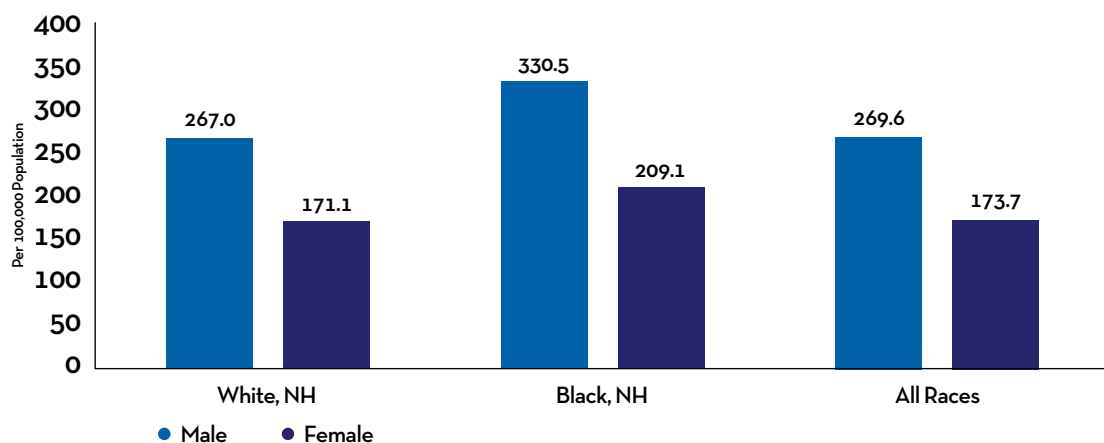### Leading Causes of Death by Black/White Disparity Ratio, Arkansas 2011-2015

	Cause of Death	White Rate	Black Rate	Disparity Ratio	Preventable Deaths Among Blacks
1	HIV	1.2	7.0	5.8	27
2	Homicide	4.4	23.5	5.3	89
3	Diabetes	21.9	51.2	2.3	137
4	Perinatal Conditions	3.4	7.6	2.2	20
5	Hypertension	7.3	15.7	2.2	39
6	Kidney Disease	19.0	36.9	1.9	84
7	Septicemia	14.5	23.9	1.6	44
8	Stroke	46.4	61.9	1.3	73
9	Heart Disease	215.2	261.2	1.2	215
10	Cancer	187.9	212.4	1.1	115

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online
https://www.healthy.arkansas.gov/images/uploads/pdf/2018_Heart_Disease_Mortality_Disparity_Fact_Sheet.pdf

Age-Adjusted Heart Disease Mortality Rates by Gender and Race, Arkansas 2011-2015

The heart disease mortality rates among Black males and females were a little more than one time higher compared to White males and females.
Regardless of race, heart disease mortality rates were significantly higher among males.

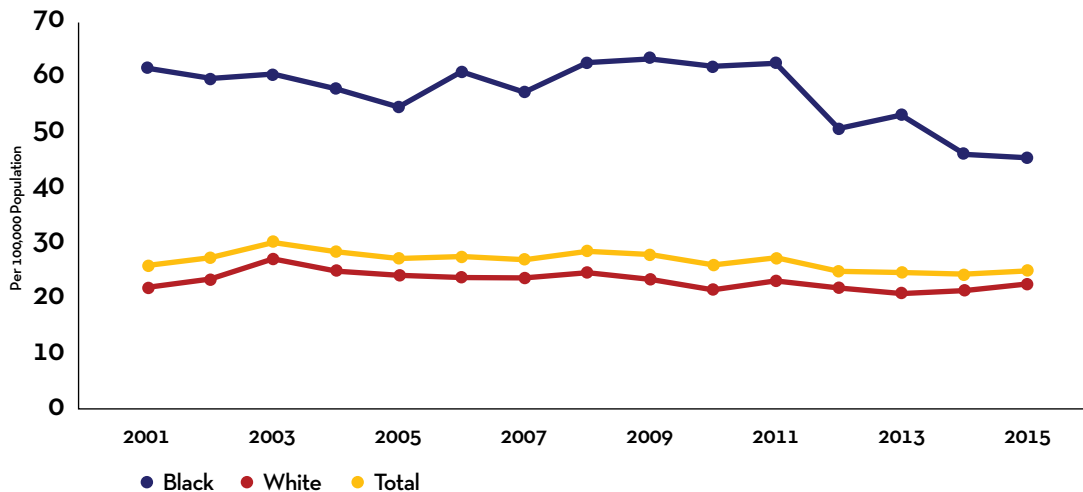|	White, NH	Black, NH	All Races
Male	267.0	330.5	269.6
Female	171.1	209.1	173.7

NH=Non-Hispanic Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online
https://www.healthy.arkansas.gov/images/uploads/pdf/2018_Heart_Disease_Mortality_Disparity_Fact_Sheet.pdf

Diabetes

Diabetes is a condition where the body does not use insulin properly and is unable to manage blood sugar.[52] Without proper management, the chronic condition can cause life-altering effects or be life-threatening. Black adults are 60% more likely than non-Hispanic White adults to be diagnosed with diabetes by a physician.[53] The prevalence of diabetes is twice the rate in Black women than in non-Hispanic White women.[54] Environmental factors contribute to a person developing type 2 diabetes. The daily barriers faced by Black women make it more difficult for them to prevent or manage diabetes.[55] Per America's Health Rankings for 2020, the rate of diabetes in Arkansas was 13.6% compared to the national rate of 10.7%. For Black Arkansans, the rate of diabetes was 18.7% compared to 13.3% for White Arkansans. Also, from 2011-2015, the age-adjusted diabetes mortality rate for Black women in Arkansas was 45.2 per 100,000 compared to 17.9 for White women.[56]
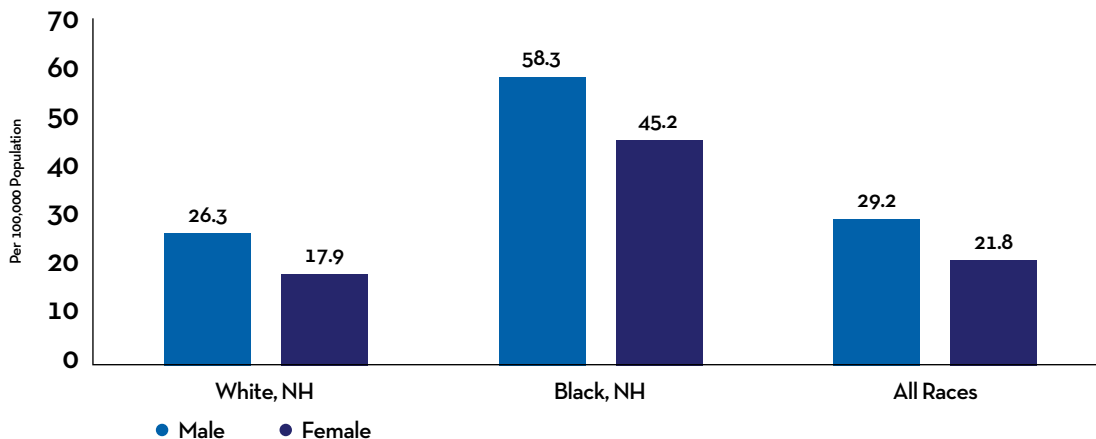
Age-Adjusted Diabetes Mortality Rates by Race, Arkansas 2001-2015

● Black ● White ● Total

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online
https://www.healthy.arkansas.gov/images/uploads/pdf/2018_Diabetes_Mortality_Disparity_Fact_Sheet.pdf

Age-Adjusted Diabetes Mortality Rates by Gender and Race, Arkansas 2011-2015

There were significant differences in diabetes mortality rate by race and gender. Diabetes mortality rates among Black males and females are about two to two and a half times higher compared to White males and females.

● Male ● Female

NH=Non-Hispanic Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database
https://www.healthy.arkansas.gov/images/uploads/pdf/2018_Diabetes_Mortality_Disparity_Fact_Sheet.pdf
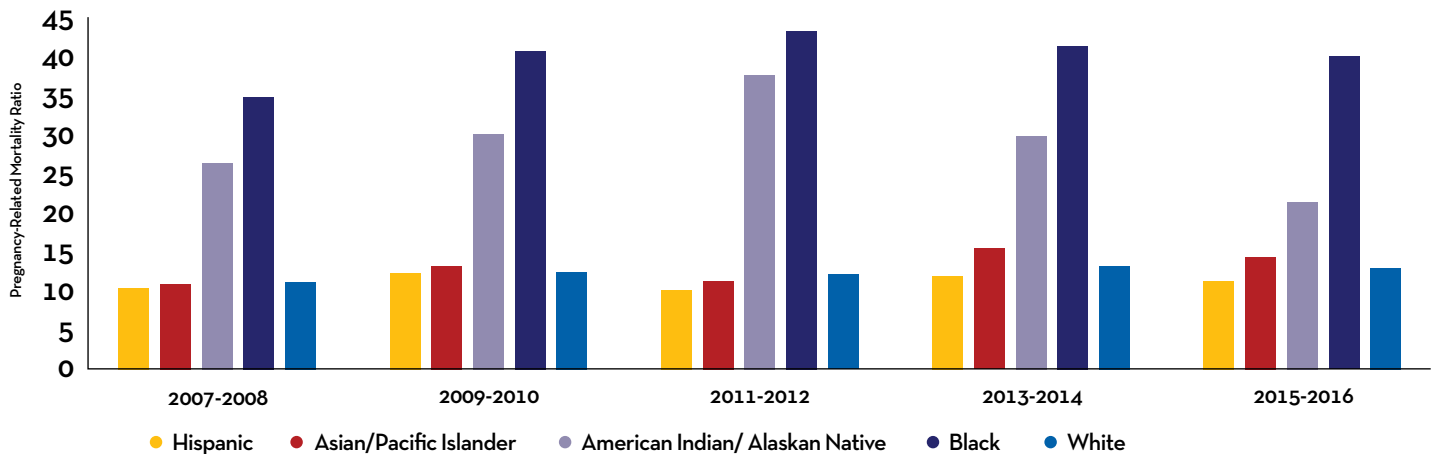
Maternal Morbidity and Mortality

Black women are more likely to have a high-risk pregnancy because they are more likely to have a pre-existing chronic illness prior to becoming pregnant.[57] Black women are three to four times more likely than White women to experience a pregnancy-related death.[58] Black women are also significantly more likely to have a severe maternal morbidity event (life threatening maternal condition associated with childbirth) at the time of delivery, 2.1% greater than that of White women.[59] In 2018, Black women in Arkansas were 2.2 times as likely to die from pregnancy-related causes than White non-Hispanic women.[60]

Also, Black infants are the most at risk of dying within 28 days after discharge from the medical setting or suffering neonatal morbidities in the time between birth and discharge. Black infants are also at twice the risk of death compared with White infants within their first year of life. Alarmingly, Black infants only represent 15% of all births in this country, but they represent 29% of total deaths in the first year.[61] In Arkansas, the infant mortality rate is 6.9 per 1,000 live births compared to the nation's infant mortality rate of 5.6.[62]

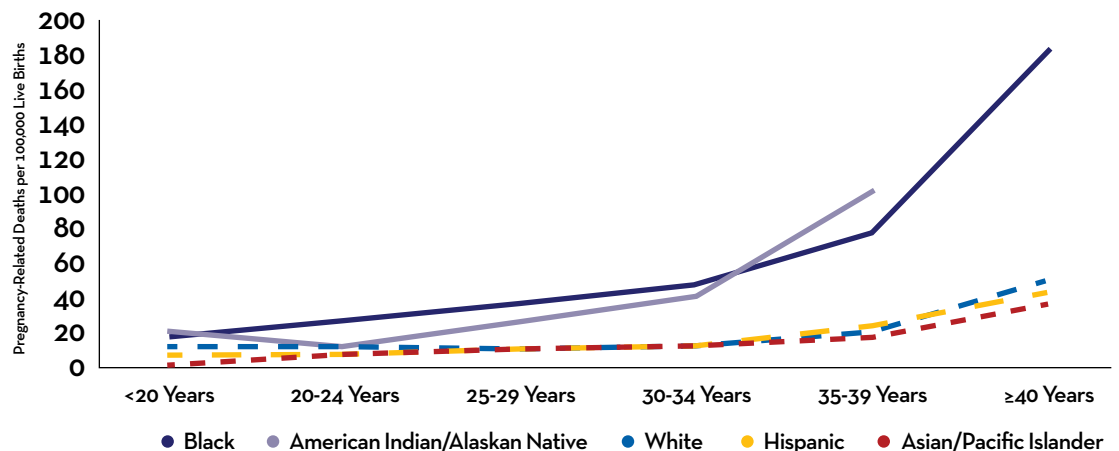## Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016

Data confirms significantly higher pregnancy-related mortality ratios among Black women. These gaps did not change over time.

https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html
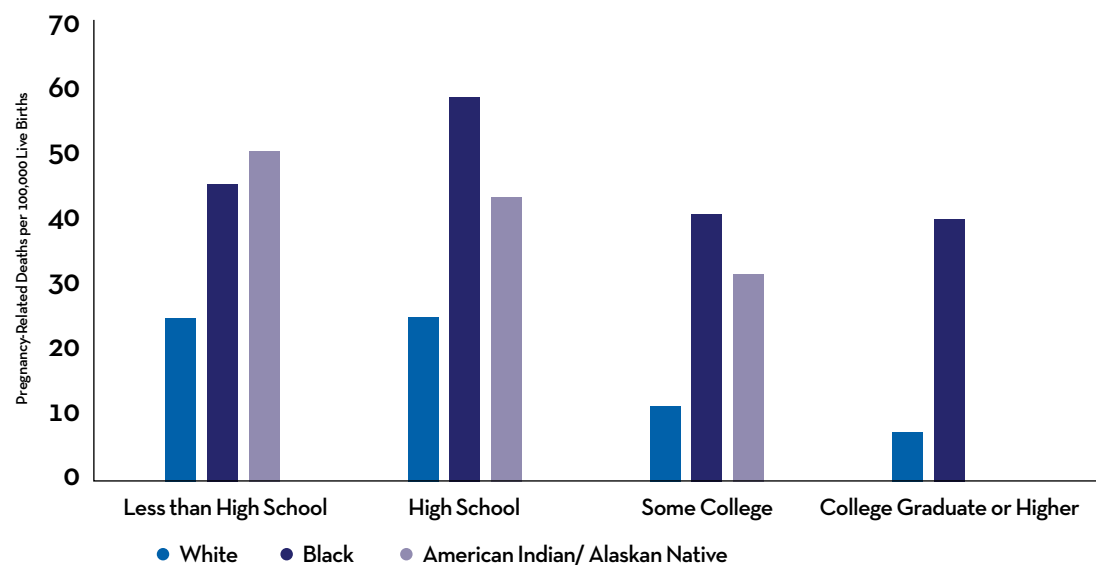
Disparities by Age

Inequities increase by age, with the disparity for Black women older than 30 years four to five times that of their White counterparts.

https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html

Disparities By Education Level

The Pregnancy-Related Mortality Ratios for Black women with at least a college degree was five times as high as White women with a similar education.
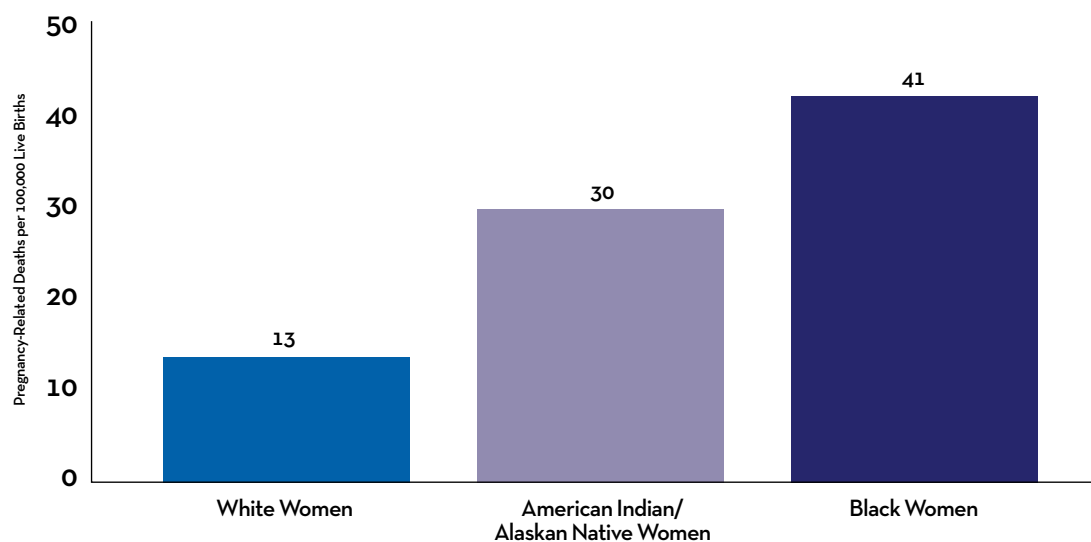

White • Black • American Indian/ Alaskan Native

https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html

Infant Mortality Rate

per 1,000 births

6.9

5.6

Source: March of Dimes—2021 March of Dimes Arkansas Report Card https://www.marchofdimes. org/peristats/tools/reportcard. aspx?frmodrc=1&reg=05

Pregnancy-Related Deaths per 100,000 Live Births

Black women faced higher maternal mortality rates than non-Hispanic White women.

Source: Centers for Disease Control & Prevention
https://patientengagementhit.com/features/first-do-no-harm-combatting-black-maternal-health-disparities

Cancer

Breast Cancer

Cancer is the second leading cause of death in the United States.[63] Black women are 40% more likely to die of breast cancer than White women.[64] They are also twice as likely to die if they are over 50 years of age. In 2014-2015, Arkansas's incidences of new cases of breast cancer were 118.3 per 100,000 in Black women compared to 110.4 in White women.[65] Also, the breast cancer death rate for Black women in Arkansas was 29.8 per 100,000 compared to 18.9 for White women.

Black women have the lowest survival rate at each stage of diagnosis. They are also more likely to be diagnosed with triple-negative breast cancer, a form of breast cancer that can only be treated with limited types of medications. Black women are more likely than women of other races to be diagnosed later in their breast cancer stage. This is sometimes linked to a lack of health insurance.[66]

Cervical Cancer

Black women in this country die from cervical cancer at more than two times the rate of White women.[67] The death rate from cervical cancer for Black women is 41% higher than that of White women. The five-year relative survival rate is 58% for Black women compared to 68% for White women. Black women are also more likely to be diagnosed with advanced cervical cancer than any other racial group. The average age of diagnosis for Black women is 51 years, compared to 48 years for White women. More Black and Hispanic women get HPV-associated cervical cancer than women of other races or ethnicities.[68]

The incidence and mortality of cervical cancer disparities are preventable, and both are associated with socioeconomic status, access to treatment, and utilization of care.[69] In Arkansas, the incidence of new cases of cervical cancer was 9.7 per 100,000 in Black women compared to 8.3 in White women for 2014-2015.[70] The death rate for Black women was not available for that timeframe.

Policy Alternatives and Recommendations

These devastating disparities are the result of long-established public policies, and they can be reversed by implementing aggressive health strategies today. Policymakers, health care professionals and communities must work together to improve Black women's health. Black women face systemic racism and discrimination within and outside the health care system. To create a health care system that equitably serves Black women, targeted approaches are critical.

Below are policy strategies and recommendations that Arkansas can adopt to reverse health care disparities for Black women.

Create policies with an intentional racial equity lens

To create meaningful changes within the health care system and in health outcomes for Black women, we must address how structural racism is embedded in our state and national systems. Lawmakers must acknowledge how entangled racism is within our society, systems and institutions. Policies must be targeted to erase racism within the systems that affect health outcomes in Black women. Eliminating racial disparities in systemic and community resources will improve health outcomes, not only for Black women, but for all Arkansans. Policies must be developed with an intentional Racial Equity lens, questions asked during the decision-making process. The purpose of this lens is to recognize and address how institutions may advance or impede efforts to become more equitable, become more action-oriented to eradicate disparities due to systemic oppression and racism, and identifying and addressing barriers that impact historically excluded groups.[71] Doing this will result in equitable outcomes and access within education, community, housing, environmental, legal and economic systems — all of which shape health, well-being and overall quality of life.

Arkansas needs to ensure its minimum wage keeps pace with the cost of living. Increasing the minimum wage to a livable wage will help to address the adverse health effects of poverty.[72] Black and Latinx women comprise about twice as big a share of low-wage workforce positions and are more likely than White workers to earn poverty-level wages.[73] They are also, in general, far more likely than White women to earn poverty-level wages. A livable wage will allow Black women to meet minimum standards of living such as food, shelter, clothing, transportation, childcare, and medical and health costs.

Per the 2020 ALICE (Asset Limited, Income Constrained, Employed) Report for Arkansas, a household survival budget (what it would cost to afford the basic household necessities) would require a single adult to make $18,240 annually, which equates to an hourly wage of $9.12. For a family of four in Arkansas it would require an annual income of $46,812, which is $23.41 for one parent or $11.71 if both parents work. For a household stability budget (income needed to support and sustain an economically viable household with a 10% savings plan and cost of employer-sponsored insurance), it would require a family of four to have an annual income of $80,676. For a two-parent family, each parent would have to earn $20.17 per hour, or one parent would have to earn $40.34 per hour.[74]

"A socioeconomic factor such as the increase in the number of single-parent, African American female-headed households, in which the wage-earner makes less than the white female, can lead to a decrease in health care coverage due to the rising costs of insurance premiums," said Este Frazier, Interim Director of the Arkansas Minority Health Commission, in an interview. "Additionally, awareness and chronic disease prevention and management, not covered by Medicaid benefits, leave the condition untreated, which is another determinant of health disparity among African American women. However, health awareness, detection, and prevention can bridge the gap between black women and white women as far as equitable health care is concerned."
(E. Frazier, personal communication, September 29, 2021).

To create meaningful changes we must address **structural racism.**

*Arkansas ranks **5th worst** in maternal mortality.*

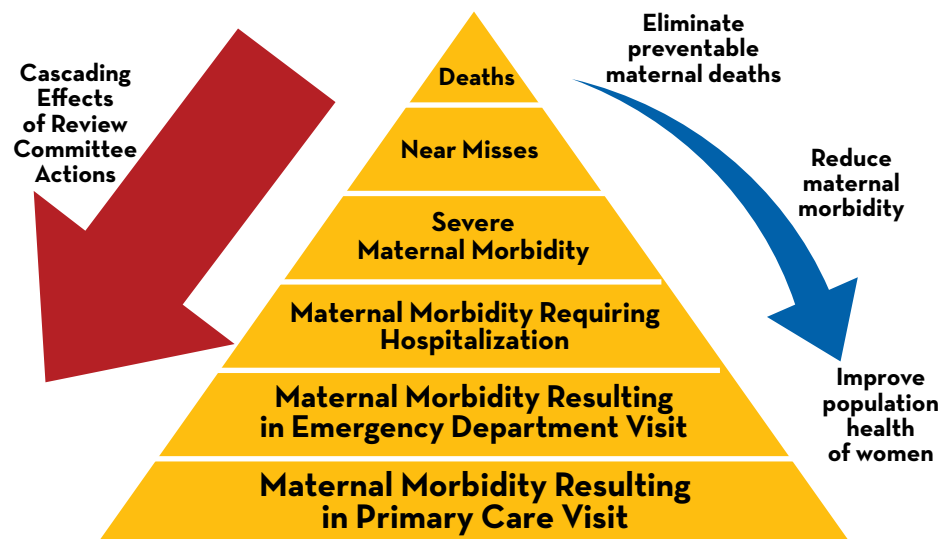### Continue expanding Medicaid benefits, including postpartum coverage

Policymakers in Arkansas have advocated for the health of Arkansans by choosing to expand Medicaid. Arkansas is one of the 39 states that opted for expansion. It's important for Arkansas legislators to continue to support Medicaid expansion due to its ability to aid in creating equitable outcomes for Black women. "We must ensure states have adequate funding in Medicaid to expand and provide black women with services such as breast care and diabetes education, management, and care, without the limitation of physician visits," Frazier states (E. Frazier, personal communication, September 29, 2021).

Currently, Arkansas ranks 5th worst in maternal mortality rate in the country. To address the health crisis, the Arkansas Legislature passed Act 829 in 2019, to establish a state maternal mortality review committee to begin investigating maternal deaths in 2020.[83] The Arkansas Maternal Mortality Review

Committee was developed to identify factors contributing to poor maternal health outcomes within the state.[84] Their role is to identify areas of improvement and provide recommendations that will lead to a decrease in rates of maternal mortality and morbidity.

Many rural counties throughout the country have closed their obstetric services. This has resulted in reduced access for rural women and babies to appropriate care within their immediate community. Lack of accessibility to maternal health care disproportionately affects Black women's health.[88] In Arkansas, many rural communities with high poverty have limited access to specialized maternal-fetal medicine. This can result in high-risk pregnancies and low-birthweight babies, partially due to preterm births. In 2018, Arkansas ranked 8th worst in the nation for percent of low-weight births, 9.4%, compared to 8.3% for the country.[89] The percent of live births born preterm to Black women in Arkansas from 2017-2019 was highest (15.5%) compared to White women (10.8%)

Power of MMRCs

Maternal mortality review has existed in the United States for more than a century. Originally, these committees were composed primarily of medical professionals, particularly obstetricians. Today, MMRCs have expanded their membership to include a vast array of professionals and partners engaging with and serving women during pregnancy and the year postpartum. Collectively, they examine patient, family, community, provider, facility, and system factors that led to a woman's death. The goal of maternal mortality review is not merely to prevent maternal death, but to put in place recommendations for actions that support health and wellness during pregnancy, childbirth, and postpartum.

Source: Arkansas Department of Health
https://www.healthy.arkansas.gov/programs-services/topics/arkansas-maternal-mortality-review-committee

and all other counterparts during that time. It's important that communities of color have access to reproductive health care. Funding for programs such as the High-Risk Pregnancy Program through the University of Arkansas for Medical Sciences is essential in Arkansas.[90] This program's mission is to ensure that every woman in Arkansas at risk of complications during pregnancy receives the best perinatal care through the utilization of telemedicine technology.

To further commit to addressing the maternal mortality and morbidity crisis within the state, policymakers should extend the current postpartum Medicaid health coverage from 60 days to a full 12 months. Postpartum coverage for a full year is important to help address recovery from childbirth, follow up on pregnancy complications, management of chronic conditions, access to family planning, and mental health concerns.[85] The Congressional Budget Office estimates that the combined federal and state cost to provide 10 additional months of Medicaid coverage would be about $1,500 per person in 2022.[86] There is a need for greater acceptance of the fact that postpartum care may require multiple follow-up visits past the current 60-day window of coverage. This is extremely important for Black women because one-third of maternal deaths occur in the postpartum period.[87] Arkansas lawmakers providing postpartum coverage for a full year would show their commitment to reducing pregnancy- and postpartum-related mortality and morbidity for mothers of color.

Integrate health care access into public schools

Another way to increase positive outcomes for Black women is to improve access to health care services starting at an earlier age. In an interview with Tracey McElwee, Ph.D., LMSW, an Arkansas community advocate for Black women's health, Dr. McElwee stated:

"One of the great things that Arkansas is doing is that there are School-based Health Centers (SBHC). They are in partnership with the Arkansas Department of Public Health. I believe prior to this year, 36 public schools in the state had these school-based

health centers. Recently, this school year, four additional schools received grants. When I think about those school-based health centers, these are centers that can serve as education and intervention for these young girls and teens before they go to a doctor or have to see a doctor regarding their menstrual cycle. Even though they are in about 40 schools right now, it would be great if there could be some type of Arkansas rule now, where every Arkansas public school has a program like that because then those programs are going to have nurses and medical teams and there could be segments of that medical team that focus on early detection, early education, and early prevention of womb health issues (T. McElwee, personal communication, September 16, 2021)."

Current SBHCs help provide primary health services (physical, mental health, and/or dental) to children and school staff.[75] SBHCs connect students and families to local resources at an early age to focus on promoting wellness and preventing disease. SBHC is associated with improved access and utilization of health care services, improved academic outcomes[76] and overall improved mental health.[77]

Ensure technological accessibility for Black families

Another way to improve access to the health care system is ensuring technological accessibility for Black families. In Arkansas, living in an area with a greater concentration of African American residents is linked to a higher digital divide. In contrast living in areas with a larger proportion of Caucasian residents is linked to a smaller digital divide.[78] "Digital divide" refers to the gap between individuals who have less access to computers and/or the internet in society due to socioeconomic status, living in rural communities, age, and ability.[79] For example, in the predominately African American town of Hughes, within St. Francis County, there are some of the highest digital divide index levels. The availability and quality of internet services are limited within this community. It is also important for health care providers to decrease any challenges that could prevent people with disabilities, older adults, people with limited English proficiency, and/or limited digital literacy from accessing medical services.[80]

In an interview with Gloria Richard-Davis, MD, Executive Director, Division of Diversity, Equity, and Inclusion at the University of Arkansas Medical School, Dr. Richard-Davis explained the importance of technological equity:

"When we think about access we are going to see much more of a digital divide. We are seeing it in our educational system, we've lost a whole year of learning in this country and for some students, they had no access to online learning. It's the broadband access, it's the devices, but it's also the knowledge base to even be able to utilize those services, and then for health care, there is coverage for it" (G. Richard-Davis, personal communication, September 27, 2021).

During the pandemic, insurance providers expanded coverage for telehealth services due to federal and state policy changes.[81] This helped Arkansans in rural parts of the state access care without traveling to larger cities or forgoing treatment.[82]
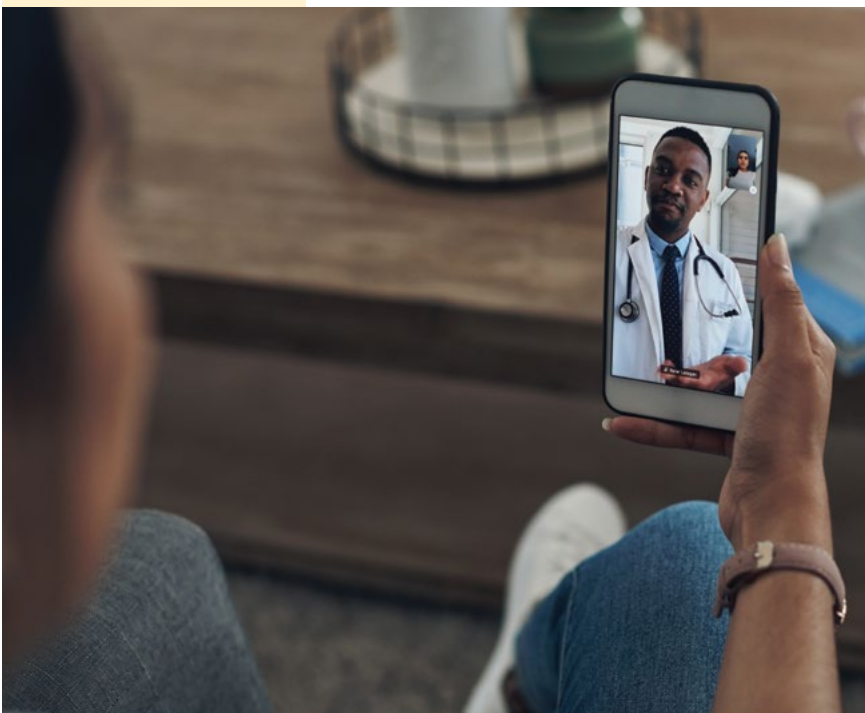
"They enacted some emergency coverage for telehealth during covid but is that going to continue? We don't know. Your policies need to address that and make those opportunities long-standing but at the same time open up access to underserved communities to remote care because they have such issues with transportation already. If they had broadband

and they had a device, we could get past some of the transportation barriers that we have," said Dr. Richard-Davis (G. Richard-Davis, personal communication, September 27, 2021).
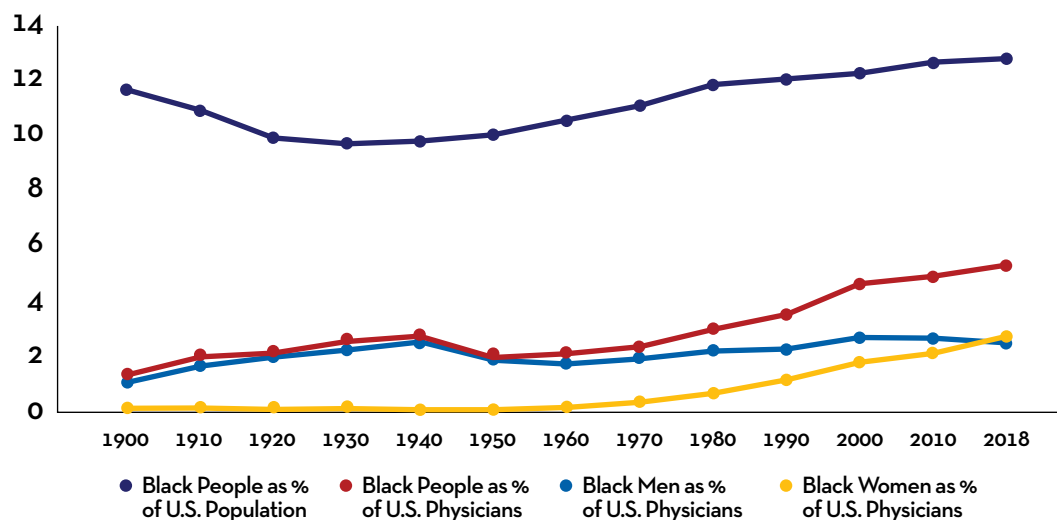
Increase the number of Black professionals in the medical field

Within the medical field, there is a lack of Black health care providers in the United States. A study conducted by the University of California Los Angeles found that the proportion of Black physicians in this country has only increased by 4% over the past 120 years. In 2018, only 5.4% of physicians were Black (2.6% Black men and 2.8% Black women).[91] Having a doctor who looks like you is important to building trust between patients and providers. Dr. Richard-Davis shared that, "A part of what I do is try to diversify the health care workforce, which I think is really critical in addressing a lot of this. So, there is a need for policies to increase access for our students of color to be able to afford to apply to medical school. Some of the statistics that we are looking at are only 5% of medical students come from lower socioeconomic families. Everybody else is coming from families of privilege, so what does that translate into? In terms of the way that they view health care? So, we have got to diversify the workforce... If you don't have people who see the world as the underserved see it, you will not find solutions, they can't even think of it" (G. Richard-Davis, personal communication, September 27, 2021).

The Arkansas Minority Health Commission is also working to help increase the number of Black physicians in Arkansas. Frazier stated, "In addition to there being health disparities in African Americans collectively, the Arkansas Minority Health Commission saw a disparity in the number of minorities pursuing careers in a health-related field. Because of this, the Commission decided to offer the Minority Health Workforce Diversity Scholarship to minority students. We wanted to see more minority health care workers, doctors, and nurses in the workforce, in which minorities, specifically Black women receiving treatment will feel comfortable in expressing their

**Proportion of Black people in the U.S. population overall
and the percentage of physicians who are Black, 1900 through 2018**

Source: Dan Ly/UCLA Health https://newsroom.ucla.edu/releases/proportion-black-physicians-little-change

inquiries about certain disease factors and ailments. The minority physician or health care worker will be more understanding, because of the knowledge they may have of the traditions, ethnicity, and lifestyle of the African American female" (E. Frazier, personal communication, September 29, 2021). Additional state funding needs to be allocated to help increase the number of Black professionals in the medical field to create a more diverse workforce.

Improve the quality of care for Black women

Policymakers should be working to address necessary changes that promote health equity. To improve the quality of care provided to Black women, policymakers must invest funding to ensure standardized practices and interventions that address racism and bias. Health care professionals exhibit the same levels of implicit bias as those in the wider population.[92] As Dr. McElwee shared, "You have to work with the people who are running these systems. These people have implicit bias, we all have implicit bias, if anybody says that they don't have implicit bias then they are refusing to accept the way in which they view the world" (T. McElwee, personal communication, September 16, 2021). These biases are likely to influence a physician's diagnosis, treatment options, and level of care a patient receives.[93]

Dr. McElwee added, "We know that we have systemic racism there...We know that practices differ for people based on the color of their skin. That just goes back to centuries of racism having given Black women this fake badge of honor as being more resilient and stronger than white women. That has come with many negative health outcomes from the cradle to the grave" (T. McElwee, personal communication, September 16, 2021).

"Medical professionals at all levels should be required to take implicit bias training," said Dr. Richard-Davis. "That should be mandatory for every health care provider. It's not going to fix it but at least it raises the issue so that you can start the conversation. You can start to have the conversation around what additional training does one need to really begin to get at and mitigate against the biases we come with."

Medical providers should also be required to undergo periodic cultural humility training that can help to improve the patient health care experience. Leading with a cultural humility frame means that medical professionals do not make assumptions or stereotype others based on their culture and background.[94] Cultural humility focuses on developing a set of skills that can be used to address individuals from any culture by encouraging lifelong learning, reflection, and diminished power dynamics

There is a lack of Black health care **providers.**

within interactions.[95] Using this evidence-based approach helps reduce unconscious biases because providers take each individual at face value, without any preconceived notions, which can help reduce health disparities for Black women.

Another way to improve the quality of services provided to Black women in the health care setting is altering the delivery and payment method of treatment of services. Traditionally, there has been a fee-for-service model in which medical providers are paid for each service.[96] This model rewards health care providers for the number of patients served, rather than the quality of service received. It results in inefficiency, poor service, and negative outcomes for Black women.

An alternative payment model that would work effectively with a cultural humility approach would be patient-centered medical homes (PCMH).[97] This delivery model is relationship-based and oriented toward treating the patient as a whole person. All the patient's medical providers can coordinate care through a wraparound approach to address the patient's unique needs, culture, values and preferences. In addition, patients' families serve as valued members of the care team, and everyone works cohesively to support patients i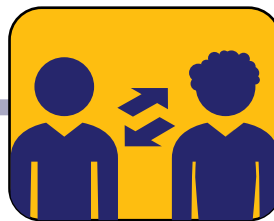n learning and managing their care at the level they feel is appropriate. Patient-centered care is associated with higher quality, better patient satisfaction with services, and a reduction in avoidable, costly visits to the emergency room.[98]

The Arkansas Medicaid PCMH Program is a key component of the Arkansas Health Care Payment Improvement Initiative.[99] It is working to transform the health care system by controlling unsustainable growth in costs and rewarding providers who consistently deliver high-quality, coordinated, cost-effective care to patients. The Arkansas Medicaid PCMH Program found there was an increase in the rate of physician visits and decreases in inpatient admissions and expenditures among Medicaid beneficiaries after one year compared to practices that transitioned into PCMHs in later years.[100] PCMHs should not be an option but instead serve as the standard for Medicaid recipients' medical treatment to ensure quality of care.
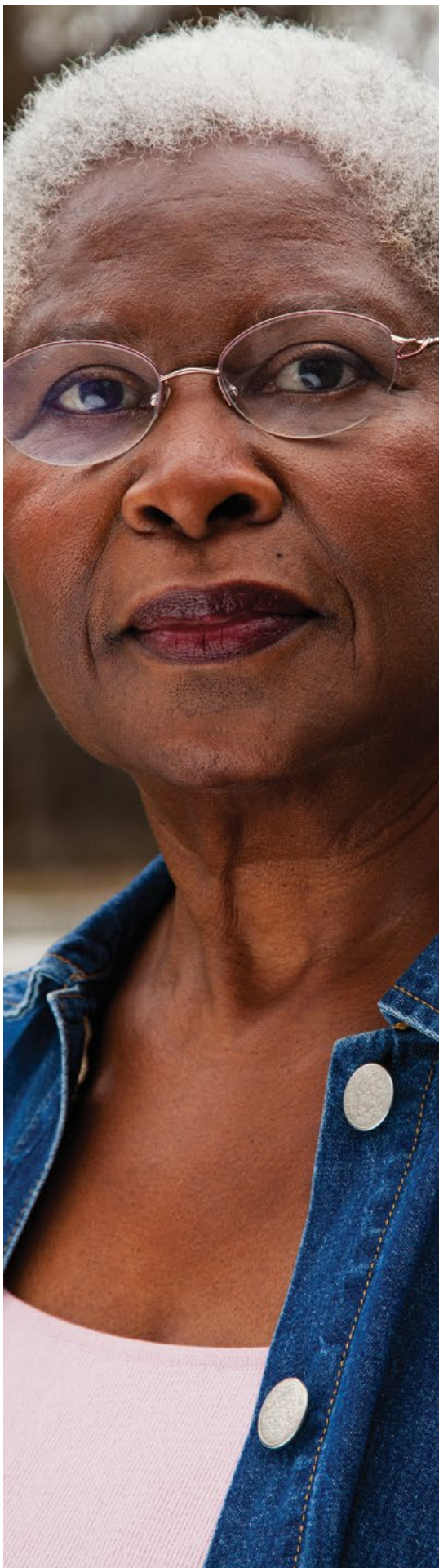
Cultural Humility: What You Can Do

Be aware that we all often make assumptions about others based on their culture and background.

Ask open questions and practice reflective listening. Others are the experts on their own lives.

Realize that you have the opportunity to practice cultural humility during interactions with everyone, not just during patient interactions.

Source: Penn Medicine: Center for Health Equity Advancement https://www.chea.upenn.edu/cultural-humility/

Conclusion

In 2019, Arkansas was 49th in health rankings, meaning that the "state has some of the most significant health challenges for women and children."[101] The past two years of the COVID-19 pandemic have certainly not improved those issues.

To ensure that all Arkansans can live healthy, positive lives, policies need to be created to address the disparate health outcomes for Black women. This country has a long-standing history and present-day relationship with racism, to the detriment of Black women. Systemic racism and biases within health care systems have resulted in inequitable and sometimes fatal health outcomes for Black women.

As a state, Arkansans must not only recognize this history and the current disparities, but we must focus directly on eliminating these racial biases. To better understand how health inequities are affecting Arkansas, there is also a need for more high-quality disaggregated data that spans across race, gender, and other intersectional factors to provide a clear picture of each and every one of us.

Arkansas can and should develop policy solutions that will address social determinants of health and improve access to affordable and high-quality health care for Black women throughout the state.

Arkansans must recognize history and current disparities and **focus directly** *on eliminating racial biases.*

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