NATIONAL BLACK CHURCH INITIATIVE
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Clinical Trials

AMERICAN CLINICAL HEALTH
DISPARITIES COMMISSION INC.

National Black Breast Cancer Fund (NBBCF)

- An interdisciplinary faith-based team approach in helping to solve the Black Maternal Health Crisis

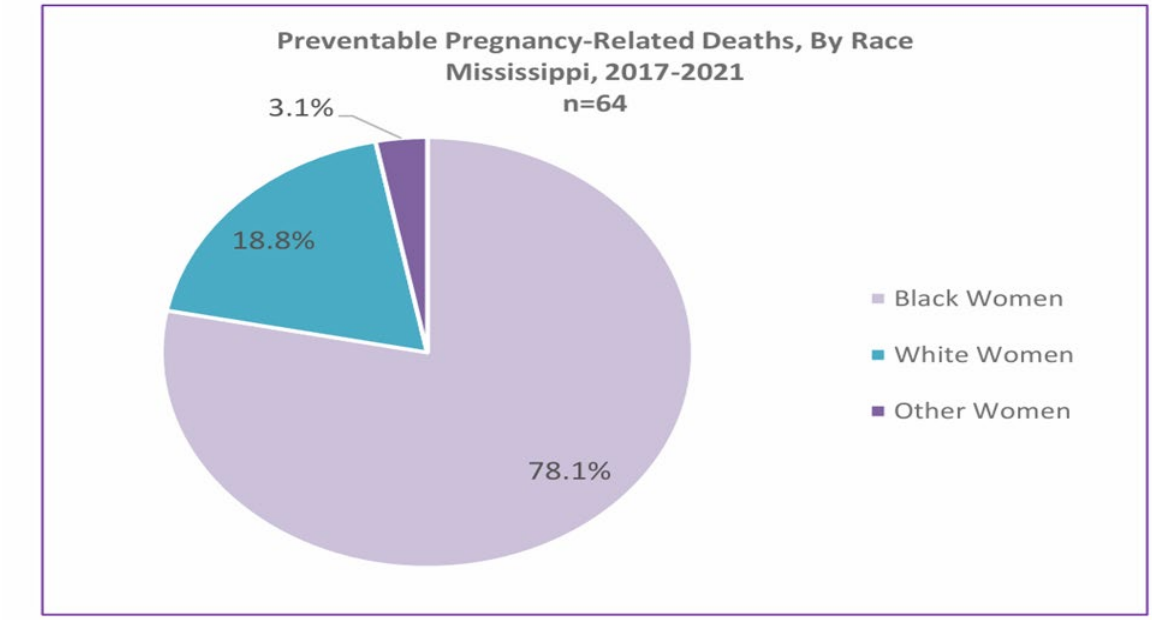
Nurturing Healthy Black Babies

Rev. Anthony Evans, M.Div
President of the National Black Church Initiative

Executive Summary

The National Black Church Initiative (NBCI) is humbly submitting an unsolicited proposal to the state of Mississippi to mitigate, and possibly eliminate, a stubborn and deadly healthcare crisis primarily affecting African American women during pregnancy and after childbirth. NBCI's plan will utilize one of the most effective community-based and clinical approaches possible in an interdisciplinary concentration. Mississippi ranks worst in the nation for maternal health outcomes. With the nation's highest maternal mortality rate in 2021, the state has maintained a devastating landscape for Black women who experience 77.9 percent of pregnancy-related mortalities—nearly five times higher than that for White women (16.9%). The Mississippi State Department of Health (MSDH) reports that 78.1 percent of these deaths were *preventable* for Black mothers (see fig. 1 below).[1] Despite existing state initiatives, prevention has been hard to come by with this disparity. A life-threatening, statewide reality urgently demands a transformative initiative. As a faith-based organization with 30 years of experience implementing successful health interventions in Black communities, NBCI brings unique capabilities and proven methodologies to address one of Mississippi's most pressing public health challenges. NBCI's Black Beautiful Babies Campaign offers a comprehensive, innovative solution that bridges clinical intervention and community empowerment. By leveraging NBCI's extensive network of 150,000 churches and a proven interdisciplinary approach, the program will create a robust support system spanning 10 Mississippi cities as well as local communities.

Fig. 1. Preventable Pregnancy-Related Deaths in Mississippi.



[1] Mississippi State Dept. of Health, "Mississippi Maternal Mortality Report."

The Black Beautiful Babies Campaign will serve 2,000 pregnant African American women in each city and rural area through a three-tiered support system of: (1) clinical care providers and trained perinatal professionals; (2) the Faith Safety Net with its 20,000 community volunteers providing comprehensive services; and (3) church-based resource centers offering health education, counseling, and practical assistance. A primary goal is to encircle every pregnant Black woman with a culturally aligned, continuous care network during pregnancy, the birth experience, and the first two years postpartum. The Campaign will connect expectant mothers with obstetric, pediatric, mental health, and midwifery providers. Its dedicated support teams will assist women with their medical needs, and provide practical help for them with transportation, nutrition, and safety, too. NBCI recognizes that reducing daily stressors that can directly impact maternal and infant well-being is essential for program success.

The Black Beautiful Babies Campaign is a church-centered model designed to eliminate preventable maternal deaths by building a coordinated system of care to support Black mothers while addressing the social determinants that contribute to maternal health disparities. NBCI's track record of successful health initiatives, including comprehensive programs in immunization, cardiovascular health, mental health awareness, and substance abuse prevention, demonstrate our capacity to effectively manage large-scale interventions like the Black Beautiful Babies Campaign. This initiative represents an unprecedented opportunity for Mississippi to lead the nation in addressing Black maternal mortality through a proven, community-based approach.

This initiative builds on systems that already exist—churches, community leadership, Medicaid, and state health institutions—while meeting the needs and attacking the problems that are driving preventable maternal deaths. With a clear evaluation plan, statewide scalability, and a sustainable funding strategy that includes Medicaid reimbursement and new and existing public health programs, this initiative offers Mississippi a viable plan for saving mothers' lives. The Black Beautiful Babies Campaign offers Mississippi a transformative model for addressing one of the state's primary public health challenges, and it promises to create a replicable framework for reducing Black maternal mortality nationwide.

Introduction

The National Black Church Initiative (NBCI) is a coalition of 150,000 African American and Latino churches, constituting 27.7 million members, working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. NBCI's mission is to provide critical wellness information to all of its members, congregants, churches, and the public. The National Black Church Initiative's methodology utilizes faith and sound health science. Our purpose is to partner with major organizations and officials whose main mission is to reduce racial disparities in the variety of areas cited above. NBCI offers faith-based, out-of-the-box, cutting-edge solutions to stubborn economic and social challenges. Credible statistical analysis, science-based strategies and techniques, and effective methods govern NBCI's programs.

Our size makes us one of the largest distribution networks in the United States. This enormous network has the reach to deliver solutions to every metropolitan and rural area in the country where African Americans reside. At the core of NBCI's methodology lies a sophisticated integration of clinical approach and community service delivery structure.

NBCI's clinical approach addresses health disparities through several evidence-based measures. These include providing health education, implementing preventive action, managing diseases, promoting clinical trials, and understanding risks and benefits. Our strategy also emphasizes data collection to guide efforts, improve healthcare access, and analyze and publish findings that inform the community and shape future initiatives. These steps form a comprehensive framework for advancing a National Black Health Agenda. NBCI's hierarchical service delivery structure mobilizes resources and implements programs effectively across the U.S. by dividing the country into five geographic areas, each led by a Faith Command Leader. Within these areas, strategically placed "key churches" serve as hubs, with surrounding "cluster churches" collaborating to disseminate information and execute initiatives.

Our organization's approach is fundamentally interdisciplinary and holistic. We recognize that health outcomes are not isolated medical events but intricate tapestries woven from social, economic, and environmental threads. This understanding drives NBCI's interdisciplinary framework in tackling health disparities through interconnected, complementary programs. Currently, NBCI runs successful initiatives spanning immunization, clinical trials, cardiovascular health, physical fitness, mental health awareness, and maternal care. Our public health programs include breast and prostate cancer education, rapid response to the opioid crisis, and tobacco/alcohol cessation programs specifically designed for African American communities.

This interconnected web of programs reflects NBCI's understanding that improving health outcomes, particularly with critical issues such as maternal mortality, requires a multi-faceted approach to address both immediate medical needs and underlying social determinants of health. Our success in implementing these diverse yet interconnected initiatives uniquely positions us to address complex health challenges in the African American community.

Crisis Statement

As shown on the map in figure 2, Mississippi and its neighbors stand at the epicenter of America's maternal mortality crisis. Mississippi actually recorded the highest maternal death rate in the nation in 2021, ranked last for women's healthcare, and is "suffering from an extreme shortage of maternity care providers like doctors and certified nurse midwives, with 60.4 providers per 100,000 women aged 15 to 44, a rate roughly 18 percentage points lower than the national average."[2] Mississippi's crisis disproportionately affects Black women, who face a devastating pregnancy-related mortality rate of 77.9 percent.[3] As a state with a large Black population (1,098,675 people, or 37.1% of the state's total),[4] and a deep-rooted faith community, Mississippi presents both an urgent challenge and a unique opportunity for the National Black Church Initiative's intervention.

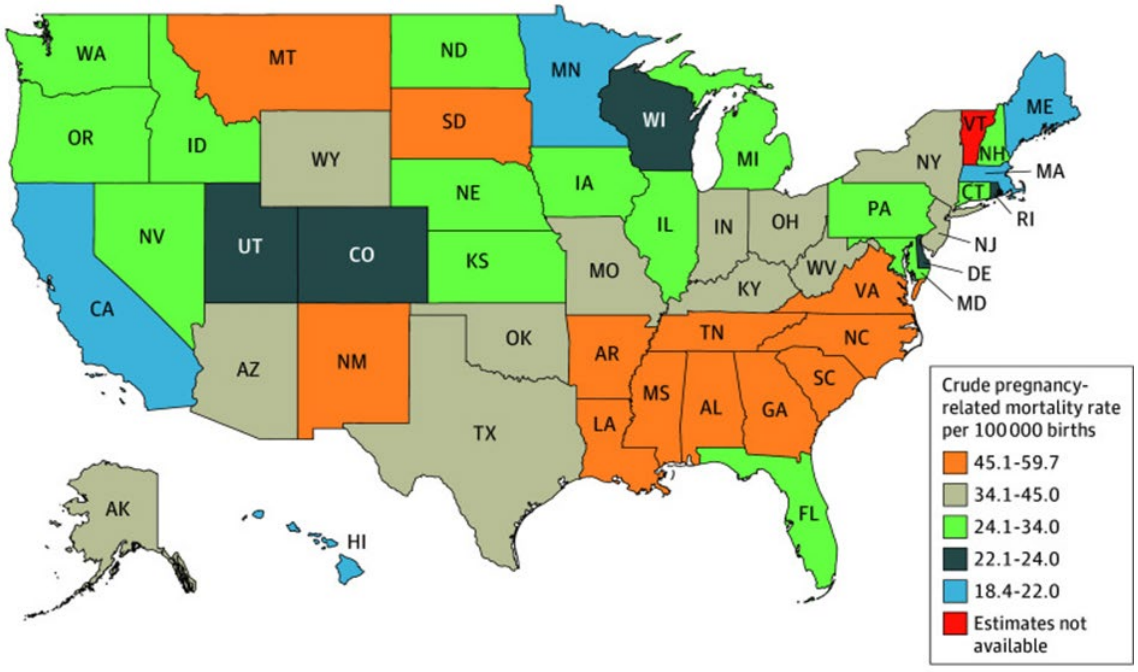
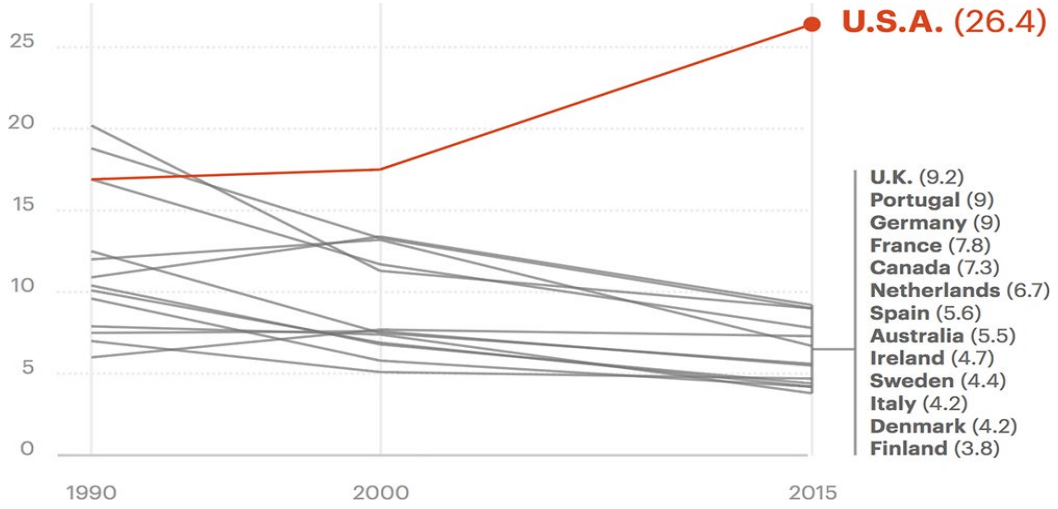


Fig. 2. Aggregated Pregnancy-Related Mortality Rates per 100,000 Live Births, by State, 2018-2022. [5]

[2] O'Connell-Domenech, "Mississippi Ranked Worst State for Women's Health Care."
[3] MSDH, "Mississippi Maternal Mortality Report."
[4] Kolmar, "The 10 Mississippi Cities with the Largest Black Population."
[5] Chen, Y. et al., "Pregnancy-Related Deaths in the U.S."

As of 2015, the United States had a maternal mortality rate of 26.4 per 100,000 live births—the worst performance among the industrialized nations, and the difference was not even close (see fig. 3).[6] A few years later, the U.S. rate declined to 23.8, but women who gave birth in the U.S. were over three times more likely to die than those living in France, Sweden, or Britain, and at least *six times* more likely to die than those in Norway, Germany, or Japan (see fig. 4 below).[7] They also had a chance of dying here that was greater than that for birth mothers in the People's Republic of China, where the rate was 16.3/100,000 as of 2023.[8]



Credit: Rob Weychert/ProPublica

Fig. 3. Maternal Mortality Is Rising in the U.S. As It Declines Elsewhere.

For most of the twentieth century, maternal mortality rates dropped rapidly in the U.S. and much of the world due to the introduction of healthier living conditions, improved maternity services, safer surgical procedures, and antibiotics. During the 1980s and into the 1990s, clinical interventions and public health efforts further reduced maternal mortality. However, the United States has recently experienced a troubling reversal of this trend.[9] Between 2000 and 2009, the U.S. "pregnancy-related mortality ratio increased by 22.8 percent . . . before stabilizing at about 660 deaths a year."[10] While the COVID-19 pandemic increased maternal mortality rates around the world, most high-income nations were able to significantly reverse the trend with the regression of the disease. And yet, the reversal in the U.S. lagged behind many Western countries, leaving it with "the highest rate of maternal deaths of any high-income nation" in 2022.[11]

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[6] Martin and Montagne, "U.S. Has the Worst Rate of Maternal Deaths."
[7] Gunja, Gumas, and Williams, "U.S. Maternal Mortality Crisis Continues to Worsen."
[8] World Health Organization, "China - WHO Data."
[9] Huang and Greenhalgh, "U.S. Maternal Deaths Keep Rising."
[10] Declercq and Zephyrin, *Maternal Mortality in the United States* (data from Centers for Disease Control and Prevention, "Pregnancy Mortality Surveillance System," last updated Nov. 14, 2024).
[11] Gunja et al., *Insights into the U.S. Maternal Mortality Crisis*.

This stems partly from an overemphasis on hospital-based interventions at the expense of community-based care, and a failure to address persistent racial and ethnic disparities. Regarding the former,

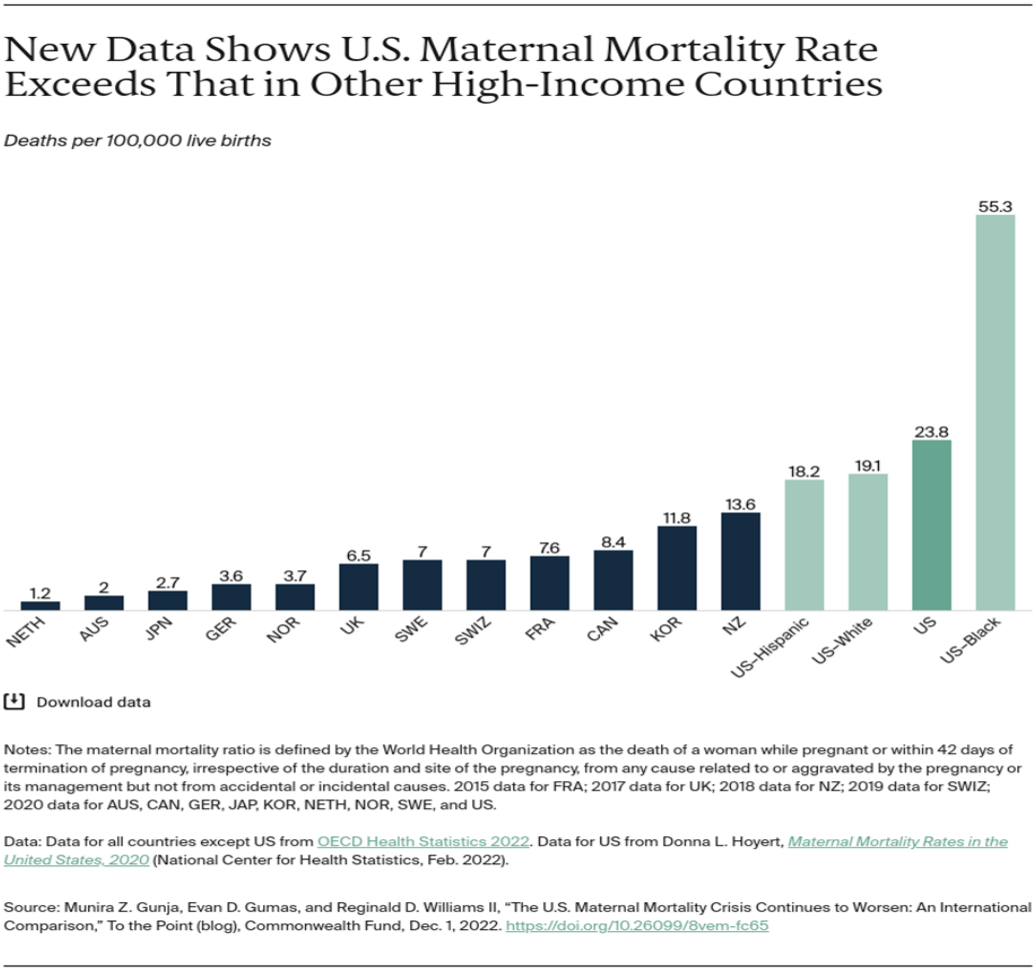

Fig. 4. U.S. Maternal Mortality Exceeds That in Other High-Income Countries.

researchers find that, "midwives are often considered the backbone of the reproductive health system" in countries with much lower maternal mortality rates such as Australia, France, Norway, Sweden, and the United Kingdom, but in the U.S., obstetrician-gynecologists (OB/GYNs) far outnumber midwives.[12] In addition, the U.S. maternity care landscape often excludes doulas, who traditionally help mothers prepare for birth, manage delivery, and adapt to the postpartum environment. In fact, only "ten states [, not including Mississippi,] and Washington, D.C. [are] providing Medicaid coverage for doula services as of February 2023."[13]

[12] Ibid.

[13] Chen and Rohde, "Doula Medicaid Training and Certification Requirements."

When we dig into the U.S. data, it becomes apparent that the most distinctive element in our high overall maternal mortality rate is racial disparity. Currently, Black mothers face mortality rates almost three times higher than those for non-Hispanic White women. The data in figure 3 shows a mortality rate of 55.3 deaths per 100,000 births for Black women compared to just 19.1 for White women.[14]

Many people first became aware of the nation's Black maternal mortality crisis when they read about the nearly fatal experience of tennis superstar Serena Williams after giving birth to her first daughter in 2017. Writing for *Elle*, she relates that the problems began hours after her successful surgery for caesarean section ("C-section") delivery:

So much of what happened after that is still a blur. I may have passed out a few times. In my haze, I wondered if I should ask someone about my drip. In 2010, I learned I had blood clots in my lungs—clots that, had they not been caught in time, could have killed me. Ever since then, I've lived in fear of them returning. It wasn't a one-off; I'm at high risk for blood clots. I asked a nurse, "When do I start my heparin drip? Shouldn't I be on that now?"

The response was, "Well, we don't really know if that's what you need to be on right now." No one was really listening to what I was saying. The logic for not starting the blood thinners was that it could cause my C-section wound to bleed, which is true. Still, I felt it was important and kept pressing.

I began to cough. The nurses warned me that coughing might burst my stitches, but I couldn't help it. The coughs became racking, full-body ordeals.

I couldn't breathe. I was coughing because I just couldn't get enough air. I grabbed a towel, rolled it up, and put it over my incision. Sure enough, I was hacking so hard that my stitches burst. I went into my first surgery after the C-section to get re-stitched.

Little did I realize that this would be the first of many surgeries. I wasn't coughing for nothing; I was coughing because I had an embolism, a clot in one of my arteries. The doctors would also discover a hematoma, a collection of blood outside the blood vessels, in my abdomen, then even more clots that had to be kept from traveling to my lungs.

I spoke to the nurse. I told her: "I need to have a CAT scan of my lungs bilaterally, and then I need to be on my heparin drip." She said, "I think all this medicine is making you talk crazy." I said, "No, I'm telling you what I need: I need the scan immediately. And I need it to be done with dye." I guess I said the name of the dye wrong, and she told me I just needed to rest. But I persisted: "I'm telling you, this is what I need." Finally, the nurse called my doctor, and she listened to me and insisted we check. I fought hard, and I ended up getting the CAT scan. I'm so grateful to her. Lo and behold, I had a blood clot in my lungs, and they needed to insert a filter into my veins to break up the clot before it reached my heart.

[14] Gunja, Gumas, and Williams, "U.S. Maternal Mortality Crisis Continues to Worsen."

In the U.S., Black women are nearly three times more likely to die during or after childbirth than their White counterparts. Being heard and appropriately treated was the difference between life or death for me; I know those statistics would be different if the medical establishment listened to every Black woman's experience.[15]

The plight of Serena Williams alerted millions to the crisis, but relatively few know that the racial disparity in maternal health not only persisted but worsened over the past century. In 1915, the maternal mortality rate for Black mothers in the U.S. was 1.8 times that of White mothers. After World War II, White maternal mortality declined rapidly, but the opposite happened to Black mothers, with their mortality rates rising to at least four times that of White mothers in the 1950s and again in the 1990s (see fig. 5 below). Between 1999 and 2019, median state maternal mortality ratios for Black women doubled, increasing from 26.7 to 55.4 deaths per 100,000 live births.[16] This return to historic, segregation-era levels of inequality is a troubling indicator of national systemic failures.

Yet Mississippi's maternal health metrics are catastrophic even when compared to national figures. Recent data shows that, contrary to the national decrease from 22.3 to 18.6 from 2022 to 2023, the state's maternal mortality rates have not only remained higher but *increased* from 23.1 in 2022 to 23.2 the following year.[17]

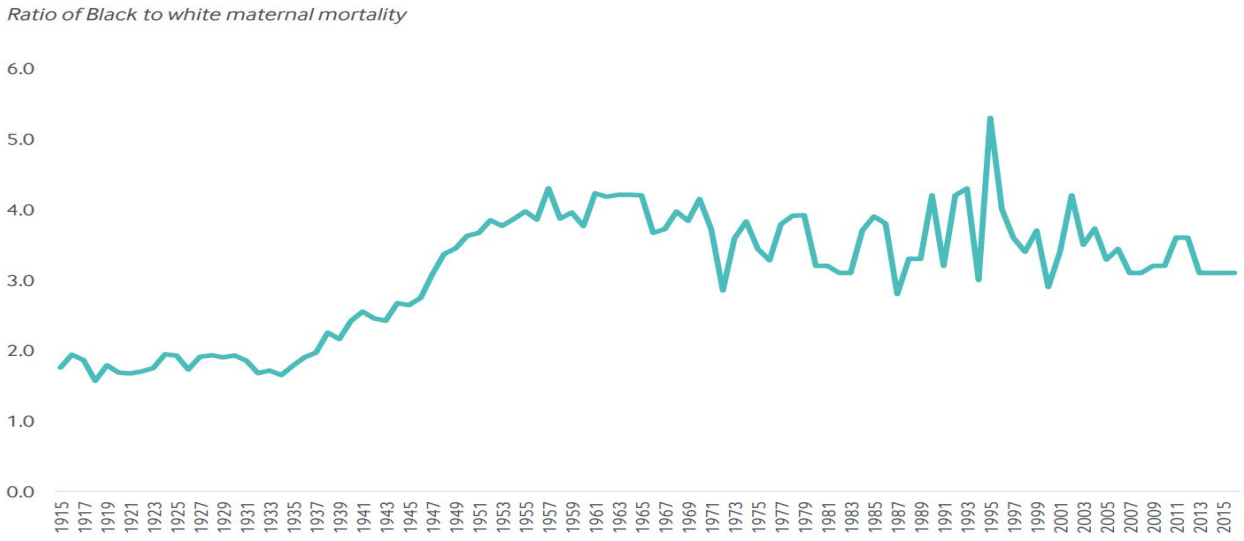

Fig. 5. Ratio of Black to White Maternal Mortality, 1915-2015.[18]

Data: National Center for Health Statistics (NCHS), "Maternal Mortality and Related Concepts," *Vital and Health Statistics*, series 33, no. 3 (Feb. 2007); and NCHS annual data reports. Data for 1915–60 from NCHS, *Vital Statistics Rates in the United States 1940–1960*. Data for 2007–16 based on two-year estimates of the pregnancy-related mortality rate, from Emily E. Petersen et al., "Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016," *Morbidity and Mortality Weekly Report* 68, no. 35 (Sept. 6, 2019): 762–65.

[15] Williams, "How Serena Williams Saved Her Own Life."
[16] Fleszar et al., "Trends in State-Level Maternal Mortality."
[17] MSDH, "Mississippi Maternal Mortality Report" (data on p.15).
[18] Declercq and Zephyrin, *Maternal Mortality: A Primer*.

As mentioned in the Executive Summary, when it comes to Black women in the state, the situation is dire, with their pregnancy-related deaths from 2017 through 2021 accounting for 77.9 percent of the total—or close to five times the rate for White, non-Hispanic women (see table 1 below). This persistent and accelerating disparity reveals more than a statistical anomaly—it exposes a profound systemic failure. If one considers the fact that, during segregation, Black mothers gave birth either with the help of midwives or at under-resourced Black hospitals, it seems implausible that their mortality rates compared to White mothers would recede back to that era's levels when both the hospitals they visit

Table 1. Pregnancy-Related Deaths by Race/Ethnicity in Mississippi, 2017-2021.[19]

Race/Ethnicity	Count (n = 77)	Percentage of Total
Black, non-Hispanic	60	77.9%
White, non-Hispanic	13	16.9%
Other or Unknown, non-Hispanic	1	1.3%
Hispanic, all races	3	3.9%

Source: MSDH Office of Vital Records, death certificates (2017-2021).

and medical technology have improved. The continued worsening of maternal health outcomes for Black women in Mississippi indicates that a lethal combination of systemic racism, inadequate healthcare infrastructure, and a breakdown of comprehensive communal and medical support is at work.

Several factors contribute to Black mothers' disproportionate and unusually high overall maternal mortality rate in Mississippi. While some challenges mirror national trends, it appears Mississippi's unique historical and contemporary circumstances have contributed to racial health disparities. The historical determinants of Black maternal health in Mississippi include factors such as slavery, structural racism, and discriminatory institutional policies and practices. Among the latter are Jim Crow laws, inequitable implementation of the G.I. Bill (the Servicemen's Readjustment Act of 1944), redlining, and the abuse of the penal clause of the Thirteenth Amendment.[20] The lasting impact of these historical forces has been particularly powerful in Mississippi, where we find some of the nation's most severe maternal health disparities. The graph in figure 6 (below) depicts how maternal mortality rates for Black Mississippi women far exceeded those for White women

[19] MSDH, "Mississippi Maternal Mortality Report" (data on p.27).
[20] Njoku et al., "Listen to the Whispers before They Become Screams."

at the state level from 2013 through 2019, and at the national level from 2016 through 2018.

There is a direct link from the historical legacies of slavery and segregation to contemporary Black maternal and infant health outcomes. From the earliest days of American slavery, Black women's bodies were exploited for their reproductive capacity, and their fertility was valued as an economic asset for maintaining adequate numbers in

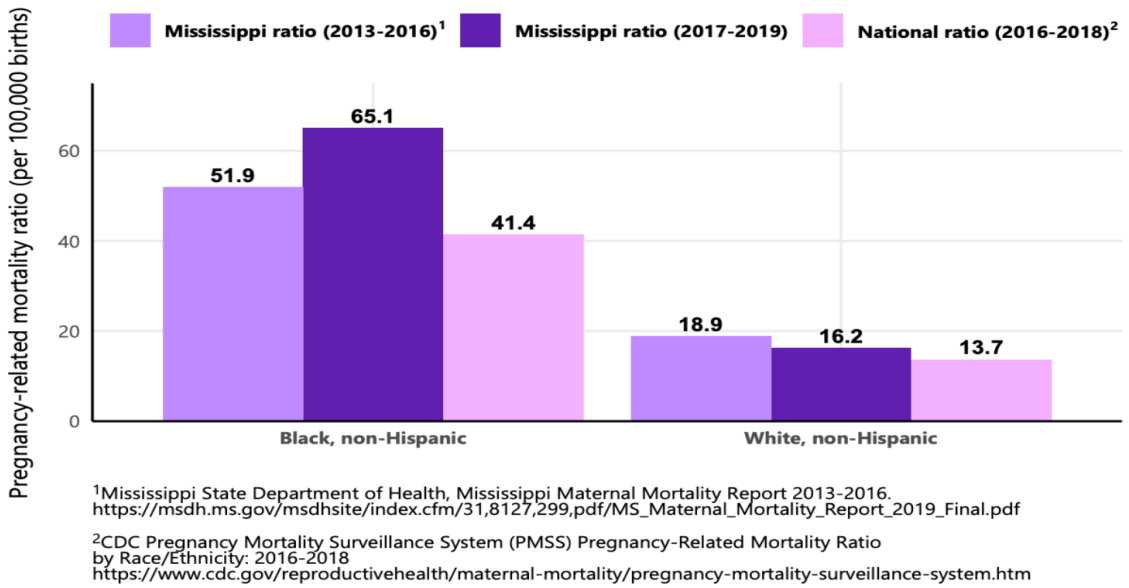

Fig. 6. Pregnancy-Related Mortality by Race/Ethnicity, Comparison of Mississippi and National Ratios.[21]

the slave labor force. Today, the effects of slavery and racism are observable at physiological levels, including persistent maternal and infant death disparities. For example, conditions such as hypertension have been associated with the stress of inhabiting a racist society, and can further exacerbate disparities in pregnancy-related complications such as preeclampsia. Dr. Monique Rainford, an OB/GYN and assistant professor at Yale School of Medicine, wrote in her book *Pregnant while Black* about how the "toxic stress" of systems such as slavery and segregation, "based on a completely avariciously designed human notion that Black people are lesser human beings, can affect a developing baby in the womb."[22] She explained, "Epigenetic effects may not only affect the birthweight of the baby but lead to increased risk of conditions," and if, for example, the child is a low-birthweight girl, these will "include hypertension, coronary artery disease, and type 2 diabetes," which, taken together, will also be risk factors for her to miscarry and/or suffer life-threatening preeclampsia during pregnancy.[23]

[21] Ganucheau and Royals, "Mississippi's Already Troubling Maternal Mortality."
[22] Rainford, *Pregnant while Black*, p.17.
[23] Ibid., pp.17, 31, 71-2.

For Black women in Mississippi, these effects are extremely pertinent. In the 2017-2021 period (excluding COVID-19), "cardiovascular-related conditions continue to be the top primary cause of pregnancy-related deaths in Mississippi," and "preeclampsia and postpartum/peripartum cardiomyopathy impacted pregnancy-related deaths in Black, Non-Hispanic women" as the next two greatest causes.[24]

The historical trauma of slavery continued through the Jim Crow era, when legal oppression and extralegal acts of violence were the rule. Jim Crow laws legalized segregation in the southern U.S. states for a century after the Civil War, until federal interventions in the mid-1960s. Mississippi originated some of the nation's strictest segregation laws or "Black Codes," which states from South Carolina to Texas often copied into their legislation.[25] These laws exposed Black persons to noxious social, economic, and physical conditions that precluded access to care. To put it plainly, the descendants of Black people whom Whites had devalued during slavery became second-class citizens in the eyes of all state institutions in Mississippi for decades after Emancipation. Years after the passage of the Thirteenth Amendment ended the institution of slavery, some states used its penal clause allowing "involuntary servitude as a punishment for crime whereof the party shall have been duly convicted" to justify creating huge, plantation-sized prison farms mostly to house Black prisoners. "

By the early 1900s, the great bulk of Mississippi's convicted felons had been delivered to Parchman Farm,"[26] one of the region's most notorious penal institutions. In 1917, Blacks "comprised about 90 percent of the prison population," with women making up less than 5 percent of this total, and some of the male convicts being boys "as young as twelve and thirteen." Parchman had fifteen field camps, mostly for growing cotton, and, in a recapitulation of slavery, not only were public whippings a form of punishment, but the farm was so profitable it "poured almost a million dollars into the state treasury through the sale of cotton and cotton seed" in 1917.[27]

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[24] MSDH, "Mississippi Maternal Mortality Report," pp.35-36.
[25] Oshinsky,*"Worse Than Slavery": Parchman Farm*, pp.20-21.
[26] Ibid., p.137.
[27] Ibid., pp.137-38, 149, 155, 169.

In terms of extralegal racist acts, lynching "had evolved into the region's most popular form of vigilante justice" by the turn of the twentieth century, and Mississippi led the nation in this form of killing.[28] No doubt, lynching and mass incarceration at prisons like Parchman also contributed to the breakup of Black families. And just as Black parents feared separation from their loved ones due to sale as chattel in antebellum times, the violent workings of Jim Crow justice brought on renewed fear and "toxic stress" around the forced removal of Black fathers and sons. In the U.S. from 1880 to 1940, "13 to 14% of Black children between the ages of 0 and 14 were living with their mothers, compared to only 5 to 6% of White children," and, as segregation was being drawn to a close (1960), the number had risen to 18.2% for Black children compared to 5.9% for White ones.[29]

The G.I. Bill of Rights of 1944 promised equal benefits to all World War II veterans, but southern Black veterans faced systematic exclusion at state and local levels. Banks routinely denied their home loan applications through redlining practices, while segregation policies prevented them from accessing many educational institutions. As a result, while White veterans in Mississippi used these benefits to purchase homes, attend college, find skilled employment, and start businesses—creating wealth that benefited future generations—Black veterans were largely denied these same opportunities for economic advancement.[30] Systematic exclusion from G.I. Bill benefits contributed significantly to the nation's racial wealth gap that continues to negatively affect Black families today, including their ability to attain better housing and access healthcare.

When birthright enslavement was legal under U.S. law, it provided that children inherited their mother's slave status. During Mississippi's early years, growing the slave population was an economic necessity, and that meant exploiting and preserving Black women's bodies. This commodification of enslaved women attracted White medical practitioners who helped slave owners maximize Black women's labor and reproductive capacity. In fact, the man often referred to as the "father of modern gynecology," J. Marion Sims, owed much of his knowledge and surgical proficiency to abusive experiments he performed on enslaved women and girls in Alabama.31 Being enslaved, each of these girls and women underwent surgeries without their consent, and Dr. Sims did not provide anesthesia for any of them.[32]

Mississippi's former status as one of the most rigidly segregated states in the Jim Crow era had direct implications for its healthcare system. In 1946, Mississippi had the nation's greatest racial disparities in hospital access: the amount of hospital beds available to Black residents was only 43 percent of those available to White residents, the largest such inequity in any segregated state.[33]

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[28] Ibid., p.100.
[29] Rainford, *Pregnant while Black*, p.101.
[30] Katznelson, *When Affirmative Action Was White*, pp.114-15, 122, 127-29, 137-39.
[31] Marsh and White, "'Racialized Myths,' Medical Exploitation."
[32] Ibid.
[33] Dent, "Hospital Services and Facilities Available to Negroes."

Such access denials were particularly severe in terms of maternal care. While 87 percent of White babies and 45 percent of Black babies were born in hospitals in the U.S. in 1946, in the state of Mississippi only 10 percent of Black babies were born in hospitals, compared to 69 percent of White babies.[34] This forced Black communities to develop alternative systems of care, primarily relying on lay midwives and home births. However, the legacy of the Jim Crow hospital system helps explain why Mississippi has such severe disparities in maternal care access today—as of 2024, 51.2 percent of Mississippi counties are classified as "maternity care deserts," compared to 32.6 percent nationally.[35]

The state's history of reproductive exploitation was also particularly severe. During the Eugenics Movement (1907-1978), Mississippi became notorious for the forced sterilization of Black women, a practice so common it gained the grimly ironic nickname "Mississippi appendectomy."[36] The Eugenics Board of Mississippi, established in 1928, disproportionately targeted poor Black women for unnecessary hysterectomies. Civil Rights icon Fannie Lou Hamer “underwent surgery for removal of a fibroid and instead was given a hysterectomy without her knowledge or consent. Hamer found that 3/5 (60%) of all Black women from her community in Sunflower County, Mississippi, underwent unwanted sterilization.”[37]

These historical forces continue to shape maternal health consequences through both direct and indirect mechanisms. The chronic stress of living in communities shaped by historical trauma contributes to higher rates of conditions like hypertension, which can complicate pregnancy. Limited access to quality healthcare in historically underserved areas reinforces legacies of medical neglect and reduces preventive care opportunities. Persistent distrust of medical institutions, born from generations of documented abuse, can delay care-seeking behavior among pregnant Black women—even when complications arise. In 2024, Kaiser Family Foundation (KFF) released results from a study that found “Black adults are more likely than their White peers to say they were treated unfairly or with disrespect by a health care provider due to their race and ethnicity.”[38]

[34] Ibid.
[35] March of Dimes, “2024 March of Dimes Report Card.”
[36] Villarosa, “The Long Shadow of Eugenics.”
[37] Wyrsch, “Black History Month, Week 2.”
[38] Artiga, Hill, and Presiado, “How Present-Day Health Disparities.”

Whether this perception of discriminatory practices is completely accurate or not, it speaks to the persistence of cultural divisions, differing sensitivities, and bias, even in a medical setting where care providers are the authority figures African American adults come to when in need of understanding as well as treatment.

In the KFF study mentioned above, they also found Black adults were more likely than their White counterparts "to report certain negative experiences, including being refused pain medication they thought they needed or having a request or question ignored."[39]

According to a study on racial bias involving medical students and residents, "false beliefs about biological differences between" the races, "beliefs dating back to slavery . . . are associated with the perception that Black people feel less pain than do White people, and with inadequate treatment recommendations for Black patients' pain."[40] One can see how medical professionals holding similar biases could make serious errors when treating Black women who experience pain during pregnancy, and how misdiagnoses, inadequate care, and downplaying symptoms could lead to maternal morbidity and mortality. A misdiagnosis may have had lethal consequences for Whitney Hunter-Batteast, an African American mother whose experience was recounted in the *Mississippi Free Press* in 2024:

Late in her pregnancy, she went to the hospital because she was having contractions five minutes apart. The doctors told her she had Braxton-Hicks contractions, also known as false labor, and observed her for a while in the hospital before sending her home.

After telling her grandmother about her diagnosis, she spent the next eight hours alone in her home suffering excruciating pain.

"I was in so much pain that I couldn't fathom to call anyone," Hunter-Batteast said on Sept. 20 during a conference in Vicksburg, Miss.

By the time she returned to the hospital, she was almost nine centimeters dilated, "Just enough time to get the IV in, change my clothes, and push." A crowd of students, doctors, and nurses helped and observed Hunter-Batteast give birth at a teaching hospital.

"The next day, the nurse came to help me to the bathroom and she said, 'Be careful of your stitches.' I said, 'What stitches? Why do I have stitches?'" Hunter-Batteast recalled.

The nurse told her she had an episiotomy, which is a surgical incision made in the tissue between the vagina and the anus that widens the vaginal opening during childbirth.

"I'm 22, 135 pounds, great elasticity. I'm pretty sure I would've been fine," Hunter-Batteast said. "And that was my first experience of realizing that that was something I should've been asked for my consent. That shouldn't have been done without me knowing and I didn't know why it had to happen." [41]

[39] Ibid.
[40] Hoffman et al., "Racial Bias in Pain Assessment."
[41] Harrison, "Mississippi Health Leaders Collaborate."

Ms. Hunter-Batteast's challenges around the birth of her daughter inspired her to found an organization in Jackson, MS, called Pickles & Popsicles that supports other moms during and after pregnancy. Like Serena Williams, who communicated her plight along with a wake-up call on the Black maternal mortality crisis, she took constructive action. Implicit bias may also connect these women, and some researchers have now deemed it to be a "contributing factor" to the crisis.

Implicit bias may be defined "as thoughts and feelings that exist outside of conscious awareness and subsequently can affect human understanding, actions, and decisions unknowingly" and without our control.[42] Such bias is not the same as conscious bigotry or racism, but the words and actions resulting from it can have the same effects. Moreover, the "potential influence of implicit bias is especially relevant in settings that are prone to overload or high stress. These environments include emergency departments or labor and delivery settings, where relying on automatic or unconscious processes to execute medical decision making quickly becomes essential."[43] Implicit bias may explain why Black women are ten times more likely than White women to report experiencing discrimination from maternity care providers.[44] This bias manifests in various ways, from dismissal of symptoms to misdiagnoses to delayed interventions, creating a pattern of substandard care that directly affects maternal health. Indeed, while it seems to be a truism that "early access to prenatal care is associated with reduced risk of maternal death," one study assessing that relation found the opposite to be true for Black women. Could it be that real and/or perceived implicit bias from mostly White OB/GYN's contributed to Black women having "four times the risk of maternal death even when presenting for prenatal care in all trimesters compared to Whites"[45] in this study? Whether implicit or subconscious, intentional or unintentional, provider bias and discrimination are real, and they can compromise the quality of available healthcare in medical institutions. Truly, the culturally sensitive intervention the National Black Church Initiative proposes below could be what is needed to mitigate, if not end, the Black maternal mortality crisis in Mississippi.

[42] Saluja and Bryant, "How Implicit Bias Contributes to Racial Disparities."
[43] Ibid.
[44] National Partnership for Women & Families, "Listening to Black Mothers."
[45] Lister et al., "Black Maternal Mortality-The Elephant in the Room."

Project Overview

The NBCI Wraparound Interdisciplinary Service Structure and the Black Beautiful Babies Campaign

To solve Mississippi's Black maternal health crisis, we are proposing an unprecedented community-powered intervention called The Black Beautiful Babies Campaign. This program will create a comprehensive support system for Black mothers utilizing our network of 10,000 churches across Mississippi and deploying 20,000 trained volunteers to serve 2,000 pregnant women across the state. Each mother in our program receives dedicated support from 10 volunteers who form an unbreakable network of continuous care around her throughout her pregnancy and into early motherhood. We will recruit 2 to 6 pediatricians (depending on the budget) who will train the volunteers and oversee their medicine-related activities and public campaign. This project will collaborate with the American Clinical Health Disparities Commission (ACHDC) to offer overall guidance along with the physicians recruited. The program combines volunteer-based support networks with professional medical oversight from African American pediatricians, and a powerful public health education campaign that transforms how communities understand and support maternal health.

Behind this initiative lies a powerful philosophy captured in the ancient African proverb: "It takes a village to raise a child." For too long, many Black mothers in Mississippi have faced their pregnancy journeys alone, virtually isolated by a healthcare system that has failed them. The Black Beautiful Babies Campaign shatters this isolation. Drawing on the wisdom of this proverb, our program will celebrate motherhood and reestablish the traditional values of communal caregiving in a modern healthcare setting. We are not just building a support network—we are reviving the village.

And, to quote Nise-Akosua Oduyefo, a doula active in Guyana, “If there’s one person going through something, the whole village is going through it,” so, when it comes to pregnancy, “everyone wants to make sure that [a mother’s] child is happy, healthy, and comes out with a destination and a purpose in life.”[46] Like the traditional African village, the Black Beautiful Babies Campaign ensures that no mother will walk alone. No mother will suffer in silence. And no mother will face the critical moments of pregnancy and childbirth without a community standing ready to support her. By surrounding each mother with a dedicated support network, we directly address the isolation and lack of resources that help drive maternal mortality rates, and solve part of the problem right there.

[46] Rahim, “The Role of the Doula.”

The NBCI Wraparound Interdisciplinary Service Structure seeks to demonstrate "It takes a village to raise a child" in the context of modern-day life in Mississippi. We aim to solve the state's Black maternal health crisis by creating "The Baby Circle" wherein the mother is followed from the moment she enters the program in early pregnancy and until her child is two—up to 33 months of support. Extended support is critical because, when it comes to the timing of maternal deaths, "about 19% [are] in the first six days after delivery, 21% between seven and forty-two days, and 12% from forty-three days to a year after birth," meaning that the majority (52%) occur during the first post-parturition year.[47] Thus, the Baby Circle provides mothers with full coverage during pregnancy, through the postpartum period (usually up to one year), and until the child has received all the recommended vaccines and is likely walking and talking at 24 months old. The Baby Circle is designed to be a labor-intensive initiative, especially helpful to single moms. In fact, each mom will have a dedicated team of 10 volunteers, drawn from the nearest church, who agree to help her in any way they can.

The Baby Circle, as a service structure in every community, will:

(1) have from 5,000 to 10,000 churches committed to support it;

(2) identify *every* pregnant African American woman within the zip code of the grant;

(3) provide comprehensive education;

(4) provide outreach;

(5) provide material support in terms of mental health counseling, food, clothing, rental assistance, and transportation;

(6) train a "Pregnant Woman's Circle" of 10 volunteers on how to support a woman during her pregnancy, and then give every mom in the program those 10 volunteers—5 regulars and 5 alternates—from a church community who will be "on call" for continuity of care during and after pregnancy;

(7) give every mom constant education on what to expect from 3 obstetricians who will provide Baby Circle lectures on YouTube; and

(8) offer a Referral Service to mothers who did not make the cutoff obligated under the contract, so they can find help with another program.

The proposed Black Beautiful Babies Campaign will have three core components:

1) An Infrastructure of Care
2) The Faith Safety Net
3) A Public Relations Promotional Campaign.

[47] Rainford, *Pregnant while Black*, pp.151-52, citing Tikkanen et al., *Maternal Mortality and Maternity Care in the U.S.*

An Infrastructure of Care: Strategic Network of Support

The Black Beautiful Babies Campaign establishes a robust, multi-tiered infrastructure designed to deliver comprehensive maternal support across Mississippi. At the heart of this network is our headquarters in Jackson, which serves as the command center for all program operations. This headquarters houses a two-member executive leadership team, two to six pediatricians, and a data management center. As a command center, it coordinates all program activities, manages relationships with healthcare partners, and ensures consistent implementation of our support protocols across the state. Supporting our headquarters are eight strategically placed satellite offices, each serving a major Black population center in Mississippi. These offices function as regional coordination centers, each staffed with four paid, full-time professionals who oversee local program implementation.

The foundation of our infrastructure lies in our network of 10,000 participating churches, which serve as community hubs across Mississippi's major African American population centers. Carefully selected and equipped to serve as a one-stop resource center, each church hub provides space for health education sessions, support group meetings, and direct-service delivery. We will position all hubs strategically to ensure that every major zip code with a significant African American population has direct access to program resources.

The Black Beautiful Babies Campaign will focus on both rural communities and the following ten majority-Black cities in Mississippi[48] (in alphabetical order): Byram, Canton, Clarksdale, Greenville, Indianola, Jackson, McComb, Moss Point, Vicksburg, and Yazoo City. NBCI will work with all the delivering hospitals and major care providers in the state currently serving African Americans.

Our volunteer network, 20,000 strong, operates through the church hubs, with each location coordinating 20 to 40 trained volunteers. These volunteers will undergo a rigorous, six-week training program covering maternal health basics, emergency response protocols, cultural competency, and support service coordination. This training ensures that every volunteer is fully prepared to serve as part of the 10-person support team assigned to each pregnant woman in our program. Each team will have 5 regulars and 5 alternates from the beginning, in order to assure each mother that known volunteers will walk beside her throughout her pregnancy and postpartum journey, no matter what.

[48] Kolmar, "The 10 Mississippi Cities with the Largest Black Population."

All mothers will be visited weekly by regular team members during pregnancy, assisted during childbirth, and visited biweekly or as needed postpartum.

The regulars and alternates will include at least 2 experienced doulas in both groups who can provide additional training, as needed. The team will rely on doulas to visit with mothers during their pregnancies, to support them through their labor and delivery, and to visit with them postpartum. Research has "demonstrated that doula-assisted mothers are four times less likely to have a low-birthweight baby," and "doula support showed promise in decreasing birth complications involving the mother or baby."[49] Indeed, doulas can work side-by-side with mothers to ensure clinicians are hearing them, faith leaders inspire them, and their practical needs are being met on a daily basis. Each assigned doula provides hands-on, continuous emotional, physical, and informational support, serving as a bridge between home, community, and clinical care.

To maintain quality and consistency, we implement a hierarchical supervisory structure. A trained coordinator oversees each group of volunteers at their church hub, and reports to the satellite office in their region. The satellite offices maintain daily communication with headquarters, ensuring smooth information flow and rapid response to any emerging needs. This layered approach to program management ensures that, while we operate on a massive scale—supporting 2,000 pregnant women simultaneously—each mother receives carefully coordinated, personalized care.

The Faith Safety Net: Comprehensive Maternal Support

The Faith Safety Net represents the heart of our program's direct-service delivery, providing immediate, comprehensive support to every enrolled mother. The moment a woman enters our program, she receives three immediate resources: (1) a team of 10 dedicated volunteers, (2) a comprehensive handbook containing both physical and online guidelines for pregnancy and postpartum care, and (3) access to a 24/7 toll-free support line for emergencies and general inquiries. This last resource emphasizes the Baby Circle's overall role as a system that is "on call," or available at all times, for each mother in the program.

A mother's enrollment process begins with a thorough assessment using a detailed questionnaire that evaluates:

- Current health condition and medical history
- Family health background
- Financial circumstances
- Existing medication regimens and health support
- Health insurance status
- Comprehensive needs assessment.

[49] Rainford, *Pregnant while Black*, p. 105.

The staff at our data management center immediately digitizes all of this information and integrates it into our secure database before sharing it with our network of satellite offices and headquarters to create a comprehensive record for access by authorized healthcare providers and state health offices. Such systematic data collection ensures coordinated care delivery while enabling real-time monitoring of maternal health trends across the state. With this foundation in place, our volunteer teams provide coordinated support across several critical areas.

Comprehensive Healthcare Navigation Plan

The financial barriers to maternal healthcare are particularly stark in states like Mississippi that have not expanded Medicaid coverage under the Affordable Care Act. As of 2019, Medicaid paid "for more than 40 percent of U.S. births and 65 percent of births to Black mothers," but some 25,000 Black women of reproductive age were excluded from this benefit in Mississippi due to the state's "Medicaid coverage gap."[50] When you consider that nearly two-thirds of reproductive-age women caught in the gap are women of color (29% of them Black, as of 2019),[51] it is hard not to conclude that this denial of healthcare is rooted in structural racism. While Black women in gap states are eligible for Medicaid "if they become pregnant . . . they have no pathway to coverage until they know they are pregnant and apply for and enroll in Medicaid. This leaves them without access to care that could identify and address their health risks before pregnancy."[52] In other words, delayed access to Medicaid coverage limits or denies prenatal services for Black mothers in the gap, creating dangerous barriers to early diagnosis of mortality risk factors such as hypertension and diabetes, as well as preventive care and early interventions, thus increasing the possibility of adverse pregnancy outcomes.[53]

Because of these healthcare access challenges, the first step in our support system is the development of a personalized maternal care roadmap for each mother that includes health insurance coverage. Our trained volunteers will work with each mother to create a plan that maps out every stage of her maternal health journey, from pregnancy through delivery and postpartum care. This customized plan integrates all aspects of maternal well-being—from health screenings to establishing financial preparedness and accessing social services—to ensure, as much as possible, that every mother knows exactly what she needs, when she needs it, and where to find it. This living document evolves with the mother's health journey, incorporating regular updates based on changing health assessments, personal circumstances, and needs. Most importantly, it serves as a practical handbook for both the mother and her volunteer support team, guiding coordinated, holistic care throughout her pregnancy.

[50] Solomon, "Closing the Coverage Gap."
[51] Ibid.
[52] Ibid.
[53] Ibid.

24/7 Comprehensive Assistance

Our program provides daily, round-the-clock support through a dedicated, 24/7 toll-free hotline for any need: medical, personal, or emergency. Trained volunteers are available to assist in any medical appointments: taking detailed notes, helping with paperwork completion, ensuring all questions are addressed, and facilitating clear communication with healthcare providers. After each appointment, volunteers help schedule follow-up visits, send appointment reminders, and maintain detailed records of all medical recommendations.

Earlier, we discussed how Serena Williams and Mississippian Whitney Hunter-Batteast suffered needless ordeals around their pregnancies due to apparent implicit bias. NBCI's volunteers will be trained to counteract such clinician bias with faith-based interventions that elevate mothers, newborns, and the best medical intentions at the same time.

The absence of advocates can affect the quality of care received, leaving women vulnerable to having their concerns dismissed or overlooked instead of being addressed. A 2023 National Public Radio report illustrated this problem in the case of a Black mother whose clinicians were less than responsive both before and after her pregnancy:

SCOTT DETROW, HOST:

Ana Rodney is 38 years old and lives in Baltimore (Maryland) with her sons. She says she always imagined the birth of her first child would be beautiful, what she considered a very natural thing. During her pregnancy, Rodney had life-threatening blood clots in her left leg. She says she repeatedly told doctors about her symptoms and was repeatedly ignored. That didn't change until a friend who was a nurse went with her to the hospital and demanded that Rodney be admitted. After she delivered her son by C-section, internal bleeding led to an emergency surgery. Weeks later, her incision site became infected. Rodney says that even though the pain was so intense that she could barely walk, a doctor checked the scar and said she was fine. The next day, she went back to the ER and was admitted with an aggressive infection. And while all of this was happening to her, her son Aiden was also struggling for his life.

RODNEY: He was born at 28 weeks.

DETROW: Her son was 1 pound, 5 ounces when he was born.

RODNEY: He spent about six months in the NICU.

DETROW: Rodney spoke to NPR producer Brianna Scott. She says she hoped when she gave birth that it would be a partnership between her and the medical staff. But that wasn't the case.

RODNEY: I was also navigating institutionalized racism . . . and all types of different biases and felt the need to qualify myself.

Every time I had a question or a pushback or a concern about my son's care, I felt that I needed to recite my resume or somehow prove that I was worth listening to, as if him being inside me for the last couple of months did not make me enough of an expert on my child.

DETROW: So she had to advocate for herself and her son over and over and over again.[54]

In the Black Beautiful Babies program, a mother in Ms. Rodney's situation could lean on the members of her 10-person volunteer team to advocate for her every step of the way.

While limited health literacy may prevent some women from recognizing warning signs or advocating for appropriate care during their pregnancies, even highly educated Black women face inordinate barriers due to deeply embedded racial biases in healthcare delivery. The persistence of these barriers across economic, social, and education levels reveals how individual factors cannot be separated from broader systemic inequities.[55]

In *Pregnant while Black*, Dr. Rainford tells the story of a woman she calls "Sally Ward" (for privacy reasons) whose dealings with clinicians postpartum were nearly catastrophic even though she is a doctor herself. Dr. Ward had no hypertension during her pregnancy, needed a C-section to deliver her baby, and was able to leave the hospital three days after surgery. In two days, her feet began to swell, a symptom her family doctor was unconcerned about. Fortunately, Sally Ward's husband, also a physician, checked her blood pressure and rushed her to the hospital. An Advanced Practice Practitioner (APP) on duty failed to do blood and urine tests, "which are part of standard care when a recently postpartum woman [presents with] new onset high blood pressure," but did send her home with prescriptions and an appointment to see her OB/GYN.[56]

Two days later, after she told her husband she had a headache and felt fatigued, he found her blood pressure was elevated again and took her back to the hospital. The same APP noted her blood pressure was high at 171/100 and, minutes later, at 169/104, but he started no antihypertensive therapy because he wanted to wait for her OB/GYN's instructions. Sally Ward's husband demanded she get treatment right away. The APP conceded, and she received magnesium sulfate for seizure prevention as well; however, Dr. Sally Ward had to be hospitalized, and it took three more days for her blood pressure to lower to an acceptable level. Still, as a Black woman, "she wonders: what if her physician husband had not taken her blood pressure? What if he had not advocated for her treatment to be started? What if she did not have a nanny to leave her baby with?"[57] If our program encountered a mother in Dr. Ward's situation, but one who had no significant other with a medical degree and no nanny at home to leave her baby with, she would still be in good hands in the Faith Safety Net. Our volunteers would do the advocating, and provide timely transportation and childcare for her newborn.

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[54] Detrow, Scott, and Woods, "U.S. Maternal Deaths . . . Black Women Are Most at Risk."
[55] Taylor, "Structural Racism and Maternal Health."
[56] Rainford, *Pregnant while Black*, pp.155-56.
[57] Ibid., pp. 156-57.

Churches as One-Stop Resource Centers

Our church network reimagines traditional houses of worship as dynamic maternal support hubs that are true one-stop centers where mothers can access every resource they need right in their own neighborhoods. Whether a mother needs immediate guidance on maternal health or childcare options, or access to community resources, or essentials like infant clothing and feeding supplies, our church resource centers provide both the information and practical help to meet these needs efficiently and compassionately.

Maternity Care Access and Mobility Support

Studies show that where a woman lives—including her neighborhood, access to resources, and community infrastructure—significantly impacts both her pregnancy and overall maternal health.[58] A shortage of needed medical personnel—including obstetricians, nurse midwives, and women's health nurses—directly impacts pregnancy outcomes. This staffing crisis is especially severe in Mississippi's rural and predominantly Black communities, where pregnant women must often travel significant distances to receive basic prenatal care (see figs. 7 and 8 below). Hospital closures and provider shortages help create what researchers term "maternity care deserts." Mississippi exemplifies these access challenges in striking terms:

- 51.2% of Mississippi counties qualify as maternity care deserts, compared to 32.6% of those nationally.[59]
- In at least 16 counties, pregnant women must travel up to 51.8 miles (averaging 56 minutes) to reach the nearest birthing hospital.[60]
- These extended travel requirements correlate with increased risks of maternal morbidity and adverse infant health outcomes, including higher rates of unplanned, out-of-hospital deliveries and neonatal intensive care unit (NICU) admissions.[61]
- The burden of travel creates additional financial strain and increases prenatal stress and anxiety.

[58] Mayne, “Racial Residential Segregation and Hypertensive Disorder.”
[59] March of Dimes, “2024 March of Dimes Report Card.”
[60] Ibid.
[61] Grzybowski, Stoll, and Kornelsen, “Distance Matters: A Population-Based Study.”

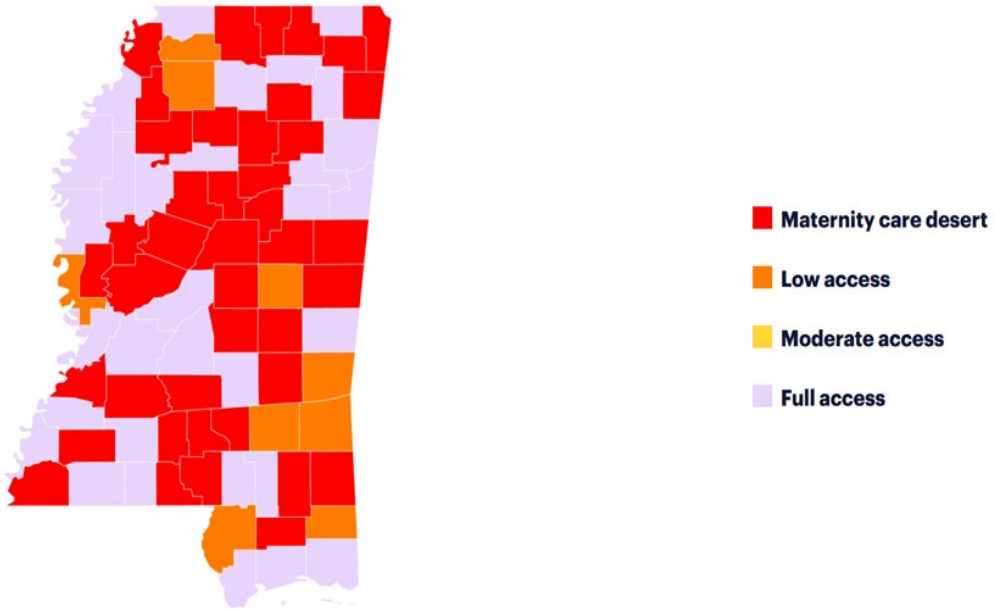

Fig. 7. Maternity Care Access in Mississippi.[62]

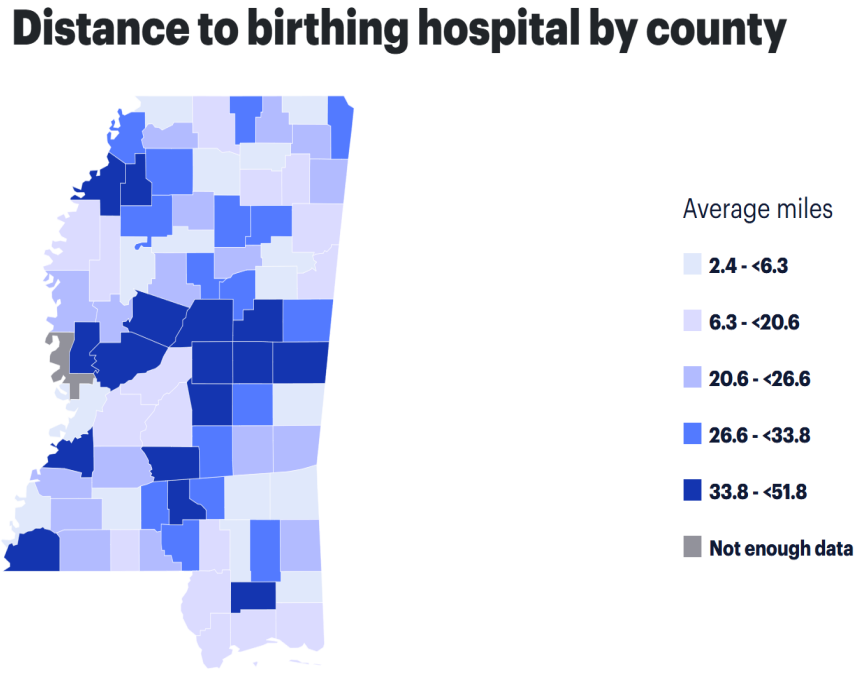

Fig. 8. Distance to Birthing Hospitals by County in Mississippi.[63]

[62] March of Dimes, "2024 March of Dimes Report Card."
[63] Ibid.

With 11 percent of pregnancy-associated deaths in Mississippi related to motor vehicle incidents,[64] reliable transportation and accompaniment services are essential for maternal safety. Our program addresses this through a reliable transportation network powered by trained volunteers in the Faith Safety Net. We will provide safe transportation to all medical appointments, pharmacy visits, and lab tests—and to handle emergencies. Our systematically organized network ensures that geographic distance never prevents a mother from accessing essential care, whether for routine visits or emergent situations.

Educational Support and Health Literacy

Our program empowers mothers through structured health education that combines one-on-one sessions with group learning opportunities. The curriculum covers essential topics, including: pregnancy milestones, warning signs, nutrition, exercise, medication management, childbirth preparation, and postpartum care. Delivered through culturally appropriate methods and supported by digital tools, such education enables mothers to make informed decisions about their health. Regular interactions with trained volunteers reinforce this learning and provide ongoing opportunities for questions and clarification, so that each mother becomes a confident advocate for her own well-being.

Food and Nutritional Support

Our program takes a proactive approach to maternal nutrition by providing both direct food assistance and comprehensive nutritional guidance. For mothers facing food insecurity, we deliver healthy, pregnancy-appropriate meals and fresh groceries through our volunteer network. Our nutritional support system includes personalized meal planning based on medical needs and dietary restrictions, and connections to resources like WIC, SNAP, and local food-assistance programs. It is critical for our volunteers to also be aware of: the mother's alcohol intake, current or past smoking history, nutritional status (e.g., chronic energy deficiency vs. good nutrition), and whether she is working or not, since all of these factors have been shown to affect a woman's risk for maternal morbidity and mortality. Mississippi residents face an increased risk of pregnancy complications because of high rates of chronic conditions such as diabetes and high blood pressure.

[64] MSDH, "Mississippi Maternal Mortality Report" (data covers 2017-2021).

The state has the highest prevalence of both conditions among all U.S. states.[65] Providing nutritional support and aiding medical intervention can lower morbidity for these conditions, particularly if the mother's current diet or healthcare access is a concern.

Mental Health and Church-Based Counseling for Spiritual Support

Mental health challenges touched 36.3 percent of pregnancy-related deaths in Mississippi during the 2017-2021 period.[66] However, by the state's own admission, as of 2020, "There is a shortage of mental health service providers across the state," and their support "may be unavailable to those who are uninsured, underinsured, or are covered by Medicaid."[67] This leaves little hope for Black mothers with Medicaid or insurance issues who need mental health support during pregnancy and postpartum. But we're changing that. Our network of 10,000 churches serve as more than just program hubs—they provide essential spiritual and emotional support throughout the pregnancy journey. Each participating church offers a sacred space where mothers can receive faith-based counseling, join prayer circles, and connect with other mothers and communities of shared experience. We also provide access to postpartum doulas trained in mental health and church-based peer mentors. Of course, pastoral counseling will be available to provide spiritual guidance for all mothers in the program during this transformative life stage.

The impact of chronic stress represents another critical factor affecting Black maternal health. Studies demonstrate that the intersection of racial and gender discrimination creates what researchers call "double pressure" on Black women, leading to adverse health outcomes.[68] As discussed earlier, this chronic stress manifests physically, contributing to higher rates of premature births and low-birthweight babies among African American women.[69] Our volunteers will function as a relief system for stress and pressure by literally taking part of the mental load of pregnancy off the shoulders of women in our program. And, in recognition of the fact that Perinatal Mood and Anxiety Disorders (PMADs), especially "perinatal depression and anxiety are common, with prevalence rates for major and minor depression up to almost 20% during pregnancy and the first 3 months postpartum,"[70] the Faith Safety Net will encourage routine mental health screenings for all mothers during and after pregnancy. Recommended screenings will include those for PMADs during pregnancy "using an evidence-based tool such as the Edinburgh Postnatal Depression Screen (EPDS)" or the more culturally and trauma-informed version, the EPDS-US. Benefits of an EPDS include that it is "self-administered, easy to complete," and "a reliable and valid measure of mood in fathers," too.[71] Such screenings also prove valuable if either the mother or father experience any of the issues discussed in the next two sections.

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[65] Muthler, "Addressing Mississippi's Maternal Health-Care."
[66] Ibid.
[67] MSDH, "Title V Maternal and Child Health 2020 Needs Assessment, Data Brief 2."
[68] Coussons-Read, "Effects of Prenatal Stress on Pregnancy."
[69] Jackson et al., "Anticipated Negative Police-Youth Encounters."
[70] O'Hara and Wisner, "Perinatal Mental Illness."
[71] PSI, "Screening Recommendations."

Substance Use Prevention and Support

According to the "Mississippi Maternal Mortality Report," during the five-year period 2017-2021, substance use disorder (SUD) contributed to 22 out of 77 total pregnancy-related deaths.[72] That is why our program takes bold, decisive action on this critical issue. Building on NBCI's proven track record through our successful Tobacco and Alcohol Cessation Program and Opioid Response Initiative and directly aligning with the Mississippi Maternal Mortality Review Committee's recommendations, this program will provide early screening and intervention services that prioritize privacy and cultural sensitivity. Our approach combines family support systems, recovery monitoring, and relapse prevention while addressing underlying social stressors.

Interpersonal Violence (IPV) Prevention and Support

Mississippi faces a profound challenge with pregnancy-associated IPV. Between 2017 and 2021, the state recorded 27 pregnancy-associated deaths (occurring either during the pregnancy or within one year of its end) that were the result of IPV-related homicides. This figure means that 56 percent of the IPV cases where expectant or new mothers died were intimate partner homicides.[73] In addition, Mississippi has owned the distinction of having "the highest firearm mortality rate in the United States," with a five-year (2018-2022) average rate of 27.84 deaths per 100,000 people, which is close to double the national average rate of 14.7 in this period.[74] These statistics highlight how relationship safety directly affects maternal survival. Our response to this challenge will be swift and comprehensive. Working through our church network, this program will provide both spiritual counseling and practical support for domestic and interpersonal violence prevention. Our trained volunteers conduct regular, confidential screenings and maintain direct connections to local shelters and emergency services. For mothers in danger, we offer instant access to safe housing and support services. Beyond emergency response, we will conduct church-based counseling to mitigate domestic conflict, and we offer community education to prevent future violence.

A Public Relations Promotional Campaign

Women with limited family and community support face increased health risks, particularly when navigating complex healthcare systems. Awareness of support and accurate information are lifelines to maternal health for Black women facing systemic disparities. Preventing maternal mortality is a critical imperative for NBCI that resonates with profound urgency. Our proposed Black Beautiful Babies program will launch an extensive, penetrating public engagement strategy, leveraging 2 to 6 pediatricians (depending on the project budget) and a formidable force of 20,000 volunteers to create an unprecedented promotional campaign—unrivaled in its methodological innovation and expansive scale.

[72] MSDH, "Mississippi Maternal Mortality Report."
[73] Ibid.
[74] Action on Armed Violence, "Mississippi Has Highest Firearm Death Rate."

Our campaign will produce six meticulously crafted video series that will walk expectant mothers through the transformative journey of pregnancy and postpartum care:

1. Months 1-3 of pregnancy: Foundational health and early detection
2. Months 3-6 of pregnancy: Navigating physical and emotional transitions
3. Months 6-9 of pregnancy: Preparing for birth and addressing potential complications
4. 24 months postpartum, providing care and oversight for potential medical issues: Critical recovery and maternal insights
5. Infant and toddler care: Comprehensive maternal and child wellness
6. Holistic mental and physical health for mothers: Integrated well-being strategies.

These videos will provide culturally competent and practical guidance that speaks directly to Black women's experiences.

Our social media strategy will amplify these messages, creating short, shareable content that reaches beyond traditional healthcare communication. Flyers, graphics, and succinct video clips will spread across digital platforms, ensuring that critical maternal health information reaches Black women of reproductive age where they are likely to engage.

Our volunteers will not just distribute information, but actively fundraise, collect resources like clothing and food, and create a visible, tangible support network for expectant and new mothers.

The pediatricians will train and oversee volunteers' engagement and run a Train the Trainer (ToT) program to produce a pool of trained volunteers who will work as health ambassadors. Through public discussion, interactive workshops, and community engagement initiatives, they will deconstruct cultural barriers and challenge medical misconceptions surrounding maternal health challenges. By making maternal health a community-driven conversation, we will raise the level of awareness and transform words into action.

The Rationale of Our Model

The core of the tragedy of Mississippi's Black maternal mortality crisis is the fact that the deaths were largely *preventable*. According to the Mississippi Maternal Mortality Review Committee (MMRC), 83.1 percent of pregnancy-related deaths between 2017 and 2021 could have been avoided through reasonable changes to patient care, family support, provider practices, facility protocols, and/or community resources. Even more alarming is the stark racial disparity in preventable deaths.

As noted in the Executive Summary, the racial breakdown for preventable, pregnancy-related deaths during this period was:

- 78.1% were Black women
- 18.8% were White women
- 3.1% were women of other races.[75]

These statistics reveal not just a healthcare crisis but a systemic failure disproportionately affecting Black mothers and costing them their lives. Each of these deaths represents a family devastated by the loss of a mother. According to medical experts who compiled and analyzed the data, too many of these tragedies happened because of a lack of proper interventions. That over *three-quarters* of preventable maternal deaths occurred among Black women, despite the fact that, in 2019 for example, live births among Black women represented *less than half* of Mississippi's total (15,706 out of 36,636),[76] underscores the urgent need for both targeted interventions and systemic change.

Despite numerous initiatives to address maternal mortality, the persistent racial disparities demonstrate that current approaches mean well but are insufficient. While providing important services, Mississippi's state programs reveal significant limitations. The Healthy Moms, Healthy Babies program, though operating in all 82 Mississippi counties, restricts eligibility to women under 19 with specific health risks, leaving many vulnerable mothers without support. Similarly, the recently launched Mississippi Access to Maternal Assistance (MAMA) program offers digital resources to "quickly access health care services, infant essentials, clothing, food, shelter, financial assistance, child care, jobs, education, legal aid, adoption services, and more,"[77] but it lacks a crucial human connection and does not guarantee the cultural sensitivity necessary for effective intervention with Black mothers.

In reality, hardly any state programs have been able to reduce the disproportional mortality of Black mothers in the United States. In California, where it was widely celebrated that the overall "maternal death rate fell from an average of 13.1 per 100,000 live births from 2005 to 2009 to 7.0 between 2011 and 2013," the rates for Black women remained "three to four times higher" than for their White counterparts.[78] And even now, as the state's surgeon general, Dr. Diana Ramos, plans to reduce pregnancy-related deaths by 50 percent by the end of 2026, California's "Black mothers are three to four times more likely than other racial or ethnic groups to die from pregnancy-related complications."[79] This persistent disparity, even in states with the most progressive maternal health initiatives, tells us a fundamental truth: technical solutions alone cannot address a crisis rooted in cultural, historical, and systemic challenges.

[75] MSDH, "Mississippi Maternal Mortality Report" (data on p.38).
[76] Martin et al., "Births: Final Data for 2019" (data on p.21).
[77] AG Lynn Fitch, "Mississippi Access to Maternal Assistance."
[78] Reichel, "Maternal Death Rate Lowered in California."
[79] Associated Press, "Most Maternal Deaths Can Be Prevented."

The National Black Church Initiative (NBCI) offers a targeted and comprehensive solution that addresses these critical gaps. With 30 years of experience serving Black communities, NBCI brings an unmatched understanding of the cultural, spiritual, clinical, and practical needs of Black mothers. Our approach combines:

- Clinical expertise through partnerships with healthcare providers who understand Black maternal health
- Extensive community outreach through our network of 150,000 churches
- Culturally competent education and counseling services
- Comprehensive patient support and advocacy
- Practical assistance with transportation and access to care
- Continuous monitoring and support through pregnancy, childbirth, and postpartum
- Most critically, the trust of the Black community built over three decades of service.

This interdisciplinary framework integrates clinical excellence with deep community engagement—a combination that existing state programs have failed to achieve. Our approach recognizes that reducing Black maternal mortality requires more than just medical intervention, it demands a holistic strategy that addresses both healthcare delivery and the broader social determinants of health.

Where other programs offer pieces of the solution, NBCI provides a comprehensive, culturally rooted approach that can finally begin to close the devastating racial gap in maternal survival. Our track record of success in health initiatives, combined with our unique position within the Black community, makes NBCI duly qualified to lead this critical intervention.

Research strongly supports our community-based and clinical approach to the maternal health crisis, including group support modalities. Studies show that group prenatal care models, particularly those culturally tailored to Black communities, can significantly improve maternal health outcomes.[80] The effectiveness of group prenatal care is well-documented—studies show up to a 41 percent reduction in preterm births, along with decreased NICU admissions, reduced emergency department use, and increased breastfeeding rates.[81] Beyond improved health consequences, this approach proves to be a cost-effective one. A state-level, community-based, group parental care program in South Carolina demonstrated $2.3 million in savings for the state through the prevention of premature births, while also achieving higher satisfaction rates among patients and providers.[82]

This model's success is particularly pronounced in serving Black mothers, as group support naturally addresses many barriers to care. Building on this evidence, our program addresses the unique needs of Mississippi's Black mothers through an integrated support system.

[80] ACOG, "Group Prenatal Care"; Carter et al., "Group Prenatal Care Compared with Traditional"; and Rainford, *Pregnant while Black*, pp.91, 96-7.
[81] Zephyrin et al., "Community-Based Models to Improve Maternal Health."
[82] Ibid.

By creating supportive communities, this approach reduces isolation, builds networks of mutual support, and enhances health knowledge through peer relationships. When delivered through trusted community institutions like churches, the model effectively removes traditional barriers while addressing systemic inequities that often prevent Black women from receiving adequate maternal support.

In fact, our program finds resonance with the latest Clinical Consensus Committee document from the American College of Obstetricians and Gynecologists (ACOG), *Tailored Prenatal Care Delivery for Pregnant Individuals*. This document recommends a change to the traditional "12 to 14 in-person visits" and promotes an approach that offers "pregnant patients and their . . . maternity care clinicians the ability to develop prenatal care plans based on medical, structural, and *social determinants of health* and patient preferences" (emphasis added).[83] The new ACOG recommendations proactively advise "that clinicians screen for social drivers of health, including race, ethnicity, gender identity, education, and employment, and help address them through two key approaches: assistance, which entails providing resources; and adjustment, which entails modifying care delivery to be more accessible."[84]

NBCI's church-based, community-clinical approach will be particularly powerful in Mississippi where spirituality remains deeply interwoven into the fabric of life there. One Gallup poll found Mississippi to be the most religious state in the nation, with 85 percent rating it as "an important part" of their daily lives.[85] And according to Pew Research data, an overwhelming 97 percent of African Americans "say they believe in God or a higher power," and "most, when asked about the nature of the divinity they believe in, say it is 'God as described in the Bible.'"[86] These statistics underscore why a church-based, clinical approach offers unique advantages: not only does it provide exceptional access to nearly the entire Black population, including pregnant mothers and their families, it also leverages the church's role as an anchoring pillar within the Black community. The church remains a trusted sanctuary people consistently rely on for guidance, support, and solace in times of need.

NBCI's community-based, clinical approach takes this proven model further by leveraging our extensive church networks for program delivery. By providing culturally competent training and care through Black healthcare providers and others, the program combines professional medical oversight with sustained community support, creating a holistic system specifically designed to reduce racial disparities in maternal health.

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[83] ACOG, "New ACOG Guidance Recommends Transformation."
[84] Ibid.
[85] Newport, "State of the States: Importance of Religion."
[86] Mohamed, et al., "Faith among Black Americans."

This evidence-based strategy directly addresses the maternal health crisis in Mississippi, where, as stated earlier, over 50 percent of counties qualify as maternity care deserts, forcing many Black women to face disproportionate risks during pregnancy. Through trusted community institutions, our model delivers proven interventions while creating sustainable support systems that extend well beyond the immediate pregnancy period to ensure long-term positive outcomes for mothers and their children.

Core Program Evaluation Components

1. Health Outcome Monitoring

The program will track maternal health outcomes through comprehensive data collection, focusing on key indicators such as pregnancy complications, hospital admissions, and postpartum health status. This data will be compared with local and national statistics for Black maternal health to measure program effectiveness. By maintaining detailed health records of participants through pregnancy and the two-year follow-up period, the program can measure intervention effectiveness and identify areas needing improvement.

2. Volunteer Program Assessment (Biannual Review)

Every six months, the program will evaluate volunteer effectiveness through multiple lenses: training completion and competency, frequency and number of interventions, retention rates, and service quality. This includes assessing whether volunteers demonstrate adequate knowledge of warning signs, cultural competency, and support capabilities. Volunteer assessments will consist of both quantitative metrics (number of support hours, response times) and qualitative evaluation (participant feedback, crisis management effectiveness).

3. Participant Experience and Support System Review

Regular evaluation of participant experiences will assess the program's impact on their maternal health journey. This includes measuring satisfaction with support services, accessibility of resources, and the effectiveness of the volunteer network. Key areas to consider are whether participants feel more empowered in their healthcare decisions and better supported throughout their pregnancy and postpartum period.

4. Community Impact and Resource Utilization

The program will assess its broader community impact by evaluating church engagement levels, utilization of community resources, and the development of sustainable support networks. This includes measuring the effectiveness of transportation services, food-support programs, counseling services, and other practical assistance provided through the church network.

5. Quality Improvement Process

A continuous quality improvement system will be implemented to address identified gaps and enhance program effectiveness. This includes regular reviews of evaluation findings, rapid implementation of necessary changes, and ongoing refinement of support services. The process will incorporate feedback from all stakeholders—participants, volunteers, healthcare providers, and church leaders—to ensure positive program development.

6. Key Performance Indicators

Our most vital performance indicators are:

- Maternal health outcomes
- Participant engagement rates
- Volunteer retention and effectiveness
- Support service utilization
- Program satisfaction metrics

Each evaluation component includes data collection through surveys, interviews, health records, and observational assessments. Analysis occurs quarterly with volunteer and major program reviews conducted every six months. This structured yet flexible evaluation framework allows for both consistent monitoring and responsive program adaptation to meet all participants' needs effectively.

Timeline and Implementation Strategy

❖ Phase 1: Program Setup (Months 1-3)

- Volunteer recruitment and training

- Healthcare provider partnerships

- Church coordinator selection and training

- Participant enrollment process establishment

❖ Phase 2: Program Launch (Months 4-6)

- Initial participant enrollment

- Volunteer team assignments

- Medical oversight implementation

- Support service activation

❖ Phase 3: Ongoing Operations (Months 7-24)

- Continuous participant enrollment
- Regular volunteer training cycles
- Ongoing support service delivery
- Program monitoring and adjustment.

Budget and Resource Requirements

All such requirements will be customized based on the specific city and/or county where the program is active, and that location's needs and scale. With the inclusion of thousands of trained volunteers, NBCI has a strategy that is a cost-effective solution to a problem that vexes health officials and breaks the hearts of far too many families.

Expected Outcomes and Conclusion

The Black Beautiful Babies Campaign intends to serve 2,000 pregnant women across Mississippi, with a focus on improving their quality of life and reducing preventable maternal deaths. As we have seen, in 2019, live births for Black women numbered 15,706, representing less than half of the state's total, yet they had the highest number of preventable deaths (see fig. 1 above). Achievable goals for our program bear these facts in mind. The five goals are:

1. To reduce preventable, pregnancy-related deaths among participants by 40% within three years.
2. To assist 90% of participants in having weekly Baby Circle visits and greater than the traditional 12 to 14 in-person medical visits during pregnancy.
3. To ensure that 90% of participants begin prenatal care before 12 weeks of pregnancy.
4. To ensure that 90% of participants receive mental health screenings and regular postpartum check-ins.
5. To help 80% of participants improve their nutritional status by program's end.

In the new recommendations included in *Tailored Prenatal Care Delivery for Pregnant Individuals*, ACOG highlights maternity care assistance that includes "referrals, partnerships with community organizations, and resource lists."[87]

[87] ACOG, "New ACOG Guidance Recommends Transformation."

We believe the state of Mississippi should take advantage of this advisory and ensure its mothers have access to NBCI's Black Beautiful Babies Campaign. Support for Black Beautiful Babies means partnering with a practical, relationship-based system committed to the ideal that mothers do not have to navigate the pregnancy, birth, or postpartum journey alone. NBCI asks you to work with us on the motivating principle that when maternal care is consistent, coordinated, and culturally aligned, outcomes will improve. Recent history tells us that without new, direct intervention, Black mothers in Mississippi will continue to die at higher rates than all other women in the state both during and after pregnancy. Mississippi's Black maternal health crisis is costly in economic and human terms, yet it is also preventable. Let's work on the solution together.

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