International Journal of Social Work Values and Ethics

Volume 19, Number 1 (2022)

ISSN: 2790-6345
DOI: 10.55521/10-019-100
www.jswve.org

Reinvigorating Social Work's Focus on Perinatal Health

DOI: 10.55521/10-019-111

Megan E Deichen Hansen, MSW, PhD
Florida State University College of Medicine
Megan.Deichen@med.fsu.edu

International Journal of Social Work Values and Ethics • Volume 19(1), Copyright 2022 by IFSW

Abstract

Perinatal health in the United States is plagued by persistent and pervasive racial and socioeconomic disparities. Although many researchers and health professionals have committed to eliminating these long-lasting disparities, not all women benefit from research and intervention efforts equally. The social work perspective, which emphasizes diversity, cultural competency, and healthy families, once served as a central force in combating structural inequities and associated perinatal health adversity. This article argues that, despite the fact that contemporary social work no longer places a heavy emphasis on structural barriers to optimal and equitable perinatal health, the profession's core values make social workers particularly well-equipped to champion maternal and infant health disparities. Given this potential, this commentary calls for social work to reinvigorate its focus and discusses the ways in which social workers can draw from their professional knowledge, training, and experience to help promote health equity for new mothers and babies.

Keywords: perinatal health; health inequities; social determinants of health; contemporary social work

Perinatal health, defined as women's and infants' health during pregnancy and the first year postpartum, is considered a critical indicator of a nation's overall wellness (Office of Disease Prevention and Health Promotion [ODPHP], 2020). Women and infants are experiencing a crisis within the United States, however, where the rate of pregnancy-related mortality and associated complications during pregnancy (e.g., cardiovascular conditions, hypertensive disorders, hemorrhage, and infection) is comparable to that of developing nations (Kassebaum et al., 2016). When women experience complications during pregnancy, their risk for additional pregnancy-related mortality and morbidities (e.g., preterm birth, low birth weight, infant mortality, and poor maternal health) is heightened (Goldenberg et al., 2008; Peterson et al., 2019). Rates of maternal morbidity and mortality are particularly dire within the US. For example, in 2018, there were approximately 17.4 deaths per 100,000 (Hoyert et al., 2020). For every maternal death, there are approximately 70 cases of severe morbidity (Fingar et al., 2018). Likewise, US infant mortality continues to remain far too high, ranking below 46 other nations (World Factbook, 2020).

Although all women can experience perinatal health complications, populations traditionally served by social workers are the most likely to be affected. Black and Native American women experience an unacceptable and disproportionate risk for poor perinatal health outcomes (Martin et al., 2018; Peterson et al., 2019). Among racial/ethnic perinatal disparities, the contrast between White and Black women's pregnancy-related mortality is the starkest of all, with Black women dying at three to four times the rate of White women (Howell & Zeitlin, 2017; Peterson et al., 2019). Women who experience socioeconomic stress, mental health and substance use conditions are also at a greater risk of experiencing perinatal health challenges (Blumenshine et al., 2010; Forray & Foster, 2015; Ross & Dennis, 2009). For families who experience multiple co-occurring marginalizations (e.g., an intersection of racial/ethnic minority status, low-income, and mental health and substance use conditions) the risk for experiencing poor health is higher (Chinn et al., 2021; Lopez & Gadsden, 2016). In particular, research indicates that the combined exposure to chronic maternal stress, greater likelihood

of poverty, and the effects of racism and discrimination have a notable influence on the disproportionate rates at which Black and Native American women experience poor perinatal outcomes (Bryant et al., 2010; Kozhimannil, 2020). Since families often experience poor perinatal health across multiple generations (Aizer & Currie, 2014), this pattern of risk places some of the most vulnerable families in a continuous cycle of reproductive health disadvantage.

It is important that the US health system enhance its capacity to address women's and infants' perinatal health needs. Several national organizations, including the Centers for Disease Control and Prevention (CDC), have prioritized improving perinatal health outcomes (CDC, 2015). Perinatal disparities and the need for reproductive justice have also received increasing attention from national media sources (Belluz, 2017; Frakt, 2020; Villarosa, 2018), sparked by a wave of advocacy led by persons of color (e.g., the JJ Way Model of Maternity Care; Black Mamas Matter Alliance; and the National Birth Equity Collective). In turn, interventions targeting perinatal health disparities have also become more prominent in state policies across the US.

Just as women and infants are not uniformly exposed to risk for poor outcomes, not all women and infants benefit from perinatal public health interventions uniformly (Thomas et al., 2011). This issue is complex. Although there are many interventions targeted toward medically vulnerable or underserved persons, interventions have historically focused too narrowly on the individual, without consideration for the larger system within which the individual exists (Jones et al., 2019). Multiple stressors on minoritized populations, along with medical mistrust, work to sustain existing disparities and make intervention a daunting contemporary health challenge. Broader system-level issues further complicate efforts to reduce perinatal disparities (Purnell et al., 2016). For example, disparities-oriented implementation science indicates that more research is needed to understand how interventions can effectively influence provider biases, enhance existing health resources, and address issues of care access and coordination (Purnell et al., 2016). Stark disparities persist in relation to a wide variety of

perinatal health conditions, including the disproportionate rates of unaddressed maternal mental and physical health conditions, preterm birth, low birth weight, and maternal-infant mortality (CDC, 2019; Goldfarb et al., 2018; Mukherjee et al., 2016; US Department of Health and Human Services Office of Minority Health, 2019). Continued perinatal health disparities, despite public health efforts, suggest the need for additional perspectives in order to close the gaps in perinatal health and wellbeing.

Effectively confronting perinatal health disparities will require increased attention from diverse stakeholders in order to identify gaps in interventions designed to enhance health equity (Purnell et al., 2016). The social work perspective can play a particularly valuable role in championing changes to a health system that has routinely failed some of its most vulnerable subpopulations. This commentary highlights ways that social work knowledge and values can contribute to the imagination of comprehensive intervention strategies that have the potential to erode the entrenched systems that foster disparities as well as roles that social workers can take on to aid in reducing existing disparities. It also presents ways that the social work profession can help to advance current progress within the perinatal health field. Given the profession's emphasis on advocating on behalf of underserved communities, its embrace of the person-in-environment perspective, and its strong support of strengths-based care provision, this article argues that social workers should enhance their purposeful attention to maternal and infant health equity.

Social Work and the Complex Landscape of Perinatal Care

Evidence of perinatal health disparities began garnering attention at the beginning of the 20th century, where Hull House social workers emerged as advocates for reducing high rates of infant morbidity and mortality, particularly among the very poor (Sherraden, 2015). Within their role at the Hull House, social workers such as Jane Addams and Julia Lathrop conceptualized strategies to address infant mortality beyond a need for enhanced medical care. These early social workers situated their concerns with

perinatal health in underlying conditions, including the "economic, social, civic, and family conditions" (Lathrop, 1918, p.1), such as adequate housing, education, food safety, sanitation, and the overarching issue of abject family poverty (Sherraden, 2015).

Today, Hull House efforts would be recognized as work to address social determinants of health (SDH). SDH, the "conditions that shape the ways that people are born, grow, live, and work" (Commission on Social Determinants of Health, 2008, p. 2), dictate how individuals experience social infrastructures that predict health and ill-health. Key contemporary SDH that influence perinatal outcomes echo the touchstones of Hull House workers, including education, employment, income, housing, and access to quality healthcare (ODPHP, n.d.). By continuing to emphasize these factors, contemporary perinatal health scholars and practitioners are able to explain how environmental conditions prime some families for poor health, while protecting others (Larson et al., 2017; Rust et al., 2012).

The risk and protective factors explained through SDH help to conceptualize the most effective strategies for promoting enhanced perinatal care and outcomes. When perinatal health providers integrate an SDH lens into service delivery, they have the potential to improve both direct treatment approaches and their ability to engage in prevention strategies. Unfortunately, while there are numerous social workers helping women address perinatal care needs across the US (National Association of Perinatal Social Workers, n.d.), the majority of social workers align themselves with clinical roles (Abramovitz & Sherraden, 2016) that limit their capacity for stemming structural inequities.

Though social workers have largely been replaced by other allied health professionals as the leading champions of community-centered practices that can promote perinatal health research and practice, the profession's role in addressing SDH offers an opportunity for new perspectives on persistent perinatal health challenges (Coren et al., 2011; Keefe et al., 2016; Rine, 2016). Social workers, whose professional role is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are

vulnerable, oppressed, and living in poverty" (National Association of Social Workers, 2017, p 1), undergo explicit training to provide services that address individuals' social needs (National Academies of Science, Engineering, and Medicine, 2019). Through this training, social workers are poised to address clients' challenges and concerns from a person-in-environment, bio-psycho-social-based perspective, which allows the profession to frame individual or community experiences as expressions of social inequity, and to work towards social justice using a broad approach to solution-building.

Given their professional training and knowledge, social workers should strive to balance individualized medical care with community-based interventions (Abramovitz & Sherraden, 2016). Through this strategic balance, social workers can contribute in a variety of ways to developing interventions designed to address perinatal health care quality and accessibility while simultaneously addressing upstream factors that influence health outcomes. In particular, social workers can act as a critical source of support for enhancing communities' access to perinatal care. For example, social workers can 1) engage communities of women in conversations related to desired approaches to perinatal health care; 2) advocate for insurance options that enhance women's ability to access quality perinatal care; or 3) pilot health navigation strategies that allow perinatal care workers to actively help women to address barriers to care (Dominguez, 2011; Natale-Pereira et al., 2011; National Academies of Science, Engineering, and Medicine, 2019).

Social Workers' Role in Establishing Social Justice and Perinatal Health Equity

Perinatal health equity cannot be fully achieved without acknowledging the underlying predictors of inequity (Jones, 2018). Perinatal health workers invested in mitigating disparities must remain cognizant of the history of racism, discrimination, and bias, which shape differential access to key determinants of health. The disparities that characterize contemporary perinatal health are shaped by women's exposure to chronic racism and

discrimination, which have impacted African and Native American families' social experiences for generations (Prather et al., 2018).

Race-based discrimination pervades US health care settings, further sustaining and reinforcing existing health disparities (Forson-Dare et al., 2021). Social workers must approach perinatal health with an understanding of the values that permeate health care provision in the US, including the "myth of meritocracy" (Jones, 2018). The myth of meritocracy, first defined by Dr. Camara Jones, is the idea that "if you work hard, you will make it," despite the fact that working harder does not always equate to equitable outcomes (Crear-Perry et al. 2021). With respect to health, the myth of meritocracy fails to acknowledge the structural inequities that undergird disparate outcomes, and, as such, invalidates the experiences of persons who are exposed to health adversity. This myth can be further extrapolated to justify health as a privilege that can be earned or lost, rather than as a basic human right, thus shaping the ideals of which individuals are worthy of care and which individuals can be disregarded.

Meritocratic ideologies consistently disadvantage marginalized populations (Kwate & Meyer, 2010). By reinforcing a belief system that perpetuates the systemic and structural factors that underlie ill-health, these ideologies shift blame from public policies that negatively and disproportionately affect low-income communities and communities of color onto individuals who experience ill-health as a result of their systemic and structural constraints (Crear-Perry et al., 2021; Kwate & Meyer, 2010). Regarding perinatal health, women have experienced stigma related to their experiences of mental health conditions (Alderice & Kelly, 2019; McCauley et al., 2011), substance use behaviors (Terplan et al., 2015), and reproductive health practices (Cook & Dickens, 2014), which in turn shape the quality of the care that they receive. As a result, meritocratic ideologies have the capacity to reinforce negative stereotypes and can allow health workers to rationalize variable healthcare strategies based on demographic characteristics.

Work that addresses the perinatal health ramifications of racism and simultaneously critiques the existing myth of health meritocracy is greatly needed. Social work, which has prioritized issues such as healthy child

development, equitable health outcomes, cultural and linguistic care, and the amelioration of racially-driven barriers to equal opportunity and justice (Sherraden, 2015; Uehara et al, 2015), is well-suited to join forces with existing leaders in the reproductive justice movement to respond to this need. Social workers can apply their professional skills and foundational tenets to begin to mitigate racially driven inequities and existing ideologies related to health meritocracy. Social workers are called to engage in active listening with clients to understand how their clients' lived experiences relate to their overall health and wellbeing. Through active listening, social workers can identify, articulate, and protest mechanisms which prevent clients from obtaining optimal health.

Similarly, social workers are trained to identify client strengths and support their pursuit of resources in an effort to ensure clients' right to self-determination and sustained ability to experience optimal health. For example, social workers' strengths-based approach to solution-building can be a valuable skill in identifying examples of *positive deviance*, which highlights unique examples of alternative approaches to positive health outcomes. Within the perinatal health field, positive deviance, typically generated by individuals within affected communities, has emerged as a strategy for developing novel, potentially generalizable approaches to care (Rust et al., 2012). Social work's professional skills and tenets may offer an ideal constellation of knowledge regarding power and oppression as well as multisystemic strategies for perinatal health promotion.

Skills and Key Roles for Social Workers in Perinatal Health

Given social work's theoretical knowledge and foundations, the profession can challenge systemic and structural factors contributing to perinatal health disparities across the micro, mezzo, and macro systems. First, social workers can intervene at the micro level by assisting individual clients with addressing social, physical, and mental health concerns during the perinatal period. Examples of such support include facilitating communication between clients and their health providers, addressing symptoms of perinatal

depression and anxiety, establishing brief interventions to help mothers engage in health promoting behaviors, supporting mothers in their desired approaches to delivery, and problem solving around infant feeding during the postpartum period.

At the mezzo level, social workers provide support within communities and perinatal health practices to enhance perinatal health outcomes. Here, social workers play a primary role in patient-centered medical homes (PCMHs) and health navigation (National Academies of Science, Engineering, and Medicine, 2019). Social work knowledge, for example, is valuable within PCMH settings, which promote evidence-based strategies for implementing screenings and processes for utilizing community resources, including timely access to and coordination of care and overseeing electronic care management mechanisms (Institute for Healthcare Improvement, 2016; Stange et al., 2010). Health navigation shifts the burden of finding and coordinating specialty care from the hands of the client to professionals in the healthcare system (Valaitis et al., 2017). Social workers can use health navigation to help establish linkages across women's physical, emotional, and social care needs. Women's perinatal care needs may vary based on their personal and cultural preferences (Coast et al., 2016), and social workers, who are trained in person-centered, culturally-competent care practices, can use their professional knowledge to establish acceptable healthcare plans for patients while helping to educate nurses, physicians, and other allied health providers on best practices for patient-centered care. Through perinatal health provider education, social workers can broaden the likelihood that women receive care that aligns with their health needs and desires.

At the macro level, social workers can act as key players in social and health policy advocacy across several domains including (1) enhancing equity related to underlying SDH; (2) promoting access to *quality* health services, such as the Council on Patient Safety in Women's Health Care's patient safety bundle on reducing peripartum racial/ethnic disparities (2016); and (3) naming and calling for the dissolution of policies that promote health environments characterized by stigma and discrimination. In order

to promote equity across SDH, social workers can advocate in support of progressive social policies that promote quality education for all, reliable transportation, and access to affordable nutrition, housing, and childcare. As professionals who embrace the fit between individual and environment across a lifespan (Hutchinson, 2008), social workers are oriented to advocating for equity across numerous SDH domains.

Social workers should also advocate for increased access to healthcare services. Evidence suggests that Medicaid Expansion, which promotes access to affordable preconceptive care, has positive implications for women and infants during the perinatal period (Brown et al., 2019; Searing & Cohen Ross, 2019). It is equally imperative that families receive quality perinatal health services. Research, however, indicates that health resources remain racially and economically segregated (Chandra et al., 2017; Janevic et al., 2020; Yearby, 2018), with quality health services remaining more accessible to wealthier, White patient populations (Chandra et al., 2017). Social workers can help to ensure perinatal health equity by advocating in support of policies and funding mechanisms that ensure quality and allocate cutting-edge resources to perinatal providers and health institutions that serve low-income and racially-diverse communities.

Lastly, social workers are called to ensure that patients have access to perinatal health care that doesn't subject them to stigmatization and discrimination. As such, consideration of strategies to curb racially-driven criminal justice practices is necessary. During the perinatal period this may be particularly important, as the racial disparities in drug charges and sentencing may discourage pregnant and postpartum mothers with risky substance use practices from engaging in care (Lester et al, 2004; Stone, 2015). Although stringent perinatal substance use policies are designed to benefit children, studies show that children whose mothers engage in risky substance use practices receive suboptimal or delayed care due to mothers' fear of stigma and engagement in the child welfare system (Stone, 2015). Therefore, policies intended to improve health are further perpetuating the cycle of inadequate healthcare provision and enhancing the likelihood of poor intergenerational health outcomes.

Although social work is no longer a leader in promoting perinatal health equity, social work values affirming human worth regardless of racial identification, economic wellbeing, or behavioral health status make them ideal health professionals to address a wide array of women's perinatal health needs. Several models of health and social care have been inspired by social work's original values (Abramovitz & Sherraden, 2016), and social workers are already peppered throughout practices and programs in some states. Their critical skills and knowledge, however, demand that the profession reinvigorate its emphasis on community-based care and its attention to perinatal health.

Conclusions

Racial and socioeconomic disparities in perinatal health adversities are persistent and pervasive and are attributable to a host of negative repercussions for affected individuals, families, and communities. Although many health professionals are focused on closing the health gaps that occur during the perinatal period, stark inequities remain. In order to address the complex underlying factors associated with contemporary inequities, the perinatal health field is in need of a multi-systemic approach to solution-building. Social workers offer skills, perspectives, and a mastery of social care that lay a foundation for positively impacting the existing perinatal health crisis. Likewise, social workers place prominent value on curtailing racism, discrimination, and the inequities that emerge from socially unjust institutional structures, further driving the importance of social work's contributions to dismantling perinatal health disparities. Given the important role that social workers play in addressing health inequities during the perinatal period, it is essential that the social work profession reinvigorate its focus on perinatal health.

References

Abramovitz, M., & Sherraden, M. S. (2016). Case to cause: Back to the future. *Journal of Social Work Education, 52*(sup1), S89-S98.

Academies of Science Engineering Medicine. (2019). Addressing patients' social needs within health care delivery is key to improving health outcomes and reducing health disparities, new report says. http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=25467

Aizer, A., & Currie, J. (2014). The intergenerational transmission of inequality: Maternal disadvantage and health at birth. *Science, 344*, 856-861.

Alderdice, F., & Kelly, L. (2019). Stigma and maternity care. *Journal of Reproductive and Infant Psychology, 37*(2), 105-107.

Belluz, J. (2017). Black moms die in childbirth 3 times as often as white moms. Except in North Carolina. *Vox Magazine*. https://www.vox.com/health-care/2017/7/3/15886892/black-white-moms-die-childbirth-north-carolina-less

Black Mamas Matter Alliance. (n.d.). Black mamas matter alliance. https://blackmamasmatter.org/

Blumenshine, P., Egerter, S., Barclay, C. J., Cubbin, C., & Braveman, P. A. (2010). Socioeconomic disparities in adverse birth outcomes: A systematic review. *American Journal of Preventive Medicine, 39*, 263-272.

Brown, C. C., Moore, J. E., Felix, H. C., Stewart, M. K., Bird, T. M., Lowery, C. L., & Tilford, J. M. (2019). Association of state Medicaid expansion status with low birth weight and preterm birth. *JAMA, 321*, 1598-1609.

Bryant, A. S., Worjoloh, A., Caughey, A. B., & Washington, A. E. (2010). Racial/ethnic disparities in obstetric outcomes and care: prevalence and determinants. *American Journal of Obstetrics and Gynecology, 202*, 335-343.

Centers for Disease Control and Prevention. (2015). Topic areas at a glance. https://www-cdc-gov.proxy.lib.fsu.edu/nchs/healthy_people/hp2020/hp2020_topic_areas.htm

Centers for Disease Control and Prevention. (2019). *Racial and ethnic disparities continue in pregnancy-related deaths.* US Department of Health and Human Services. https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html

Chandra, A., Frakes, M., & Malani, A. (2017). Challenges to reducing discrimination and health inequity through existing civil rights laws. *Health Affairs (Project Hope)*, *36*, 1041-1047.

Chinn, J. J., Martin, I. K., & Redmond, N. (2021). Health equity among Black women in the United States. *Journal of Women's Health*, *30*, 212-219.

Coast, E., Jones, E., Lattof, S. R., & Portela, A. (2016). Effectiveness of interventions to provide culturally appropriate maternity care in increasing uptake of skilled maternity care: A systematic review. *Health Policy and Planning*, *31*, 1479-1491.

Commission on Social Determinants of Health. (2008). *Commission on social determinants of health - final report*. https://apps-who-int.proxy.lib.fsu.edu/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=1F5AD3E3D53C0B3F20881C49C0C7D9F7?sequence=1

Cook, R. J., & Dickens, B. M. (2014). Reducing stigma in reproductive health. *International Journal of Gynecology and Obstetrics*, *125*(1), 89-92.

Coren, E., Iredale, W., Rutter, D., & Bywaters, P. (2011). The contribution of social work and social interventions across the life course to the reduction of health inequalities: A new agenda for social work education? *Social Work Education: Health and Well-Being*, *30*, 594-609.

Council on Patient Safety in Women's Health Care, Alliance for Innovation on Maternal Health. (2016). *Safe Health Care for Every Woman, Reduction of Peripartum Racial/Ethnic Disparities*.

Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health, 30*, 230-235.

Dominguez, T. P. (2011). Adverse birth outcomes in African American women: The social context of persistent reproductive disadvantage. *Social Work in Public Health, 26*(1), 3-16.

Fingar, K. R., Hambrick, M. M., Heslin, K. C., & Moore, J. E. (2018). Trends and disparities in delivery hospitalizations involving severe maternal morbidity, 2006–2015: statistical brief# 243. *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs*. https://europepmc.org/article/MED/30371995/NBK52651#free-full-text

Forray, A., & Foster, D. (2015). Substance use in the perinatal period. *Current Psychiatry Reports, 17*(11), 1-11.

Forson-Dare, Z., Harris, L. M., & Gallagher, P. G. (2021). Disparities in perinatal health: what can we do? *Journal of Perinatology, 41*, 363-364.

Frakt, A. (2020). What's missing in the effort to stop maternal deaths. *New York Times Magazine* https://www.nytimes.com/2020/07/13/upshot/maternal-deaths-policy-neglect.html?auth=login-email&login=email

Goldenberg, R.L., Culhane, J.F., Iams, J.D. & Romero, R. (2008). Preterm birth 1: Epidemiology and causes of preterm birth. *The Lancet, 371*, 75.

Goldfarb, S. S., Houser, K., Wells, B. A., Brown Speights, J. S., Beitsch, L., & Rust, G. (2018). Pockets of progress amidst persistent racial disparities in low birthweight rates. *PloS One, 13*(7), e0201658.

Howell, E. A., & Zeitlin, J. (2017). Improving hospital quality to reduce disparities in severe maternal morbidity and mortality. *Seminars in Perinatology, 41*, 266-272.

Hoyert, D. L., & Miniño, A. M. (2020). Maternal mortality in the United States: changes in coding, publication, and data release, *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, *69*, 1-18.

Hutchinson, E. D. (2008). A life course perspective. *Dimensions of human behavior: The changing life course* (pp. 1-38) Sage Publications.

Institute for Healthcare Improvement. (2016). The maternity medical home: The chassis for a more holistic model of pregnancy care?. http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=222

Janevic, T., Zeitlin, J., Egorova, N., Hebert, P. L., Balbierz, A., & Howell, E. A. (2020). Neighborhood racial and economic polarization, hospital of delivery, and severe maternal morbidity. *Health Affairs*, *39*, 768-776.

JJ Way. (n.d.). The JJ way- A patient-centered model of care. https://commonsensechildbirth.org/jjway/

Johnson, A. K. (2004). Social work is standing on the legacy of Jane Addams: But are we sitting on the sidelines? *Social Work*, *49*, 319-322.

Jones, C. P. (2018). Toward the science and practice of anti-racism: Launching a national campaign against racism. *Ethnicity & Disease*, *28*(Suppl 1), 231-234.

Jones, C. P., Holden, K. B., & Belton, A. (2019). Strategies for achieving health equity: concern about the whole plus concern about the hole. Ethnicity & disease, 29(Suppl 2), 345.

Kassebaum, N. J., Barber, R. M., Bhutta, Z. A., Dandona, R., Dandona, L., Gething, P. W., Hay, S.I., Kinfu, Y., Larson, H.J., Liang, X., Lim, S.S., Lopez, A.D., Lozano, R., Mensah, G.A., Mokdad, A.H., Naghavi, M., Pinho, C., Salomon, J.A., Steiner, C. ... Murray, C.J.L. (2016). Global, regional, and national levels of maternal mortality, 1990–2015: A

systematic analysis for the global burden of disease study 2015. *The Lancet, 388*, 1775-1812.

Keefe, R. H., Brownstein-Evans, C., & Rouland Polmanteer, R. S. (2016). Addressing access barriers to services for mothers at risk for perinatal mood disorders: A social work perspective. *Social Work in Health Care, 55*(1), 1-11.

Kozhimannil, K. B. (2020). Indigenous Maternal Health—A Crisis Demanding Attention. *JAMA Health Forum, 1*, e200517-e200517.

Kwate, N. O. A., & Meyer, I. H. (2010). The myth of meritocracy and African American health. *American Journal of Public Health, 100*, 1831-1834.

Larson, K., Russ, S. A., Kahn, R. S., Flores, G., Goodman, E., Cheng, T. L., & Halfon, N. (2017). Health disparities: A life course health development perspective and future research directions. In N. Halfon, C. B. Forrest, R. M. Lerner & E. M. Faustman (Eds.), *Handbook of life course health development* (pp. 499-520). Springer.

Lathrop, J. (1918). Income and infant mortality. *American Journal of Public Health, 9*, 271-274.

Lester, B. M., Andreozzi, L., & Appiah, L. (2004). Substance use during pregnancy: Time for policy to catch up with research. *Harm Reduction Journal, 1*(1), 5.

López, N., & Gadsden, V. L. (2016). Health inequities, social determinants, and intersectionality. *NAM Perspectives*.

Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. (2018). Births: Final data for 2016. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, 67*, 1.

McCauley, K., Elsom, S., Muir-Cochrane, E., & Lyneham, J. (2011). Midwives and assessment of perinatal mental health. *Journal of Psychiatric and Mental Health Nursing, 18*, 786-795.

Mukherjee, S., Trepka, M., Pierre-Victor, D., Bahelah, R., & Avent, T. (2016). Racial/ethnic disparities in antenatal depression in the United

States: A systematic review. *Maternal and Child Health Journal, 20*, 1780-1797.

Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The role of patient navigators in eliminating health disparities. *Cancer, 117*(S15), 3541-3550.

National Academies of Sciences, Engineering, and Medicine, Division, H. a. M., Services, Board on Health Care, & Health, Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's. (2019). *Integrating social care into the delivery of health care*. National Academies Press.

National Association of Social Workers. (2017). The code of ethics. https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english

National Birth Equity Collaborative. (n.d.). National birth equity collaborative. https://birthequity.org/

Office of Disease Prevention and Health Promotion. (2020). Maternal, infant, and child health. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health

Office of Disease Prevention and Health Promotion. (n.d.). What are social determinants of health. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Peterson, E. E., Davis, N. L., Goodman, D., Cox, S., Syverson, C., Seed, K., Shapiro-Mendoza, C., Callaghan, W.M., & Barfield, W. (2019). Racial/ethnic disparities in pregnancy-related deaths. *MMWR Morbidity and Mortality Weekly Report, 68*, 762–765.

Purnell, T. S., Calhoun, E. A., Golden, S. H., Halladay, J. R., Krok-Schoen, J. L., Appelhans, B. M., & Cooper, L. A. (2016). Achieving health equity: closing the gaps in health care disparities, interventions, and research. *Health Affairs, 35*, 1410-1415.

Prather, C., Fuller, T. R., Jeffries IV, W. L., Marshall, K. J., Howell, A. V., Belyue-Umole, A., & King, W. (2018). Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. *Health equity*, *2*, 249-259.

Rine, C. M. (2016). Social determinants of health: Grand challenges in social work's future. *Health & Social Work*, *41*, 143-145.

Ross, L. E., & Dennis, C. (2009). The prevalence of postpartum depression among women with substance use, an abuse history, or chronic illness: A systematic review. *Journal of Women's Health*, *18*, 475-486.

Rust, G., Levine, R. S., Fry-Johnson, Y., Baltrus, P., Ye, J., & Mack, D. (2012). Paths to success: Optimal and equitable health outcomes for all. *Journal of Health Care for the Poor and Underserved*, *23*(2A), 7-19.

Searing, A., & Cohen Ross, D. (2019). *Medicaid expansion fills gaps in maternal health coverage leading to healthier mothers and babies.* Georgetown University. https://ccf-georgetown-edu.proxy.lib.fsu.edu/wp-content/uploads/2019/05/Maternal-Health_FINAL-1.pdf

Sherraden, M. (2015). *Grand accomplishments in social work.* American Academy of Social Work & Social Welfare. https://aaswsw.org/wp-content/uploads/2015/12/WP2-with-cover.pdf

Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice*, *3*(2), 1-15.

Stange, K. C., Nutting, P. A., Miller, W. L., Jaén, C. R., Crabtree, B. F., Flocke, S. A., & Gill, J. M. (2010). Defining and measuring the patient-centered medical home. *Journal of General Internal Medicine*, *25*, 601-612.

Terplan, M., Kennedy-Hendricks, A., & Chisolm, M.S. (2015). Prenatal substance use: Exploring assumptions of maternal unfitness. *Substance Abuse: Research and Treatment*, *2015*(S2), 1-4.

Thomas, S. B., Crouse Quinn, S., Butler, J., Fryer, C. S., & Garza, M. A. (2011). Toward a fourth generation of disparities research to achieve health equity. *Annual Review of Public Health, 32*, 399-416.

Uehara, E. S., Barth, R. P., Catalano, R. F., Hawkins, J. D., Kemp, S. P., Nurius, P. S., Padgett, D.K., & Sherraden, M. (2015). Identifying and tackling grand challenges for social work. https://grandchallengesforsocialwork.org/wp-content/uploads/2015/12/WP3-with-cover.pdf

US Department of Health and Human Services of Office of Minority Health. (2019). Infant mortality and African Americans. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23

Valaitis, R. K., Carter, N., Lam, A., Nicholl, J., Feather, J., & Cleghorn, L. (2017). Implementation and maintenance of patient navigation programs linking primary care with community-based health and social services: a scoping literature review. *BMC health services research*, *17*(1), 1-14.

Villarosa, L. (2018). Why America's Black mothers and babies are in a life-or-death crisis. *New York Times Magazine* https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html

World Factbook. (2020). *Country comparison: Infant mortality rate.* Central Intelligence Agency. https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html

Yearby, R. (2018). Racial disparities in health status and access to healthcare: The continuation of inequality in the United States due to structural racism. *American Journal of Economics and Sociology*, *77*, 1113-1152.