EXPLAINER

Disparities in Maternal Health

July 2026

California Health Benefits Review Program (CHBRP)
University of California

The Disparities in Health Policy Series

CHBRP's explainer series, Disparities in Health Policy, examines barriers to healthcare access in California and how these barriers affect different populations. Disparities are defined as "a particular type of health difference that is closely linked with economic, social, or environmental disadvantage" (Braveman, 2014). This series aims to illuminate underlying systemic challenges while providing a clearer understanding of potential policy approaches to address them. Consistent with CHBRP's commitment to objective, evidence-based analysis, each explainer is grounded in data and empirical research. Together, these explainers seek to inform policymakers and the public about how health policies can have different impacts across communities.

Births, Maternal Mortality, and Health Disparities

Maternal health disparities specifically refer to differences within maternal health outcomes. This explainer provides an overview of births in California, maternal and pregnancy-related mortality, known health disparities, and efforts in California to mitigate these disparities.

Births in California

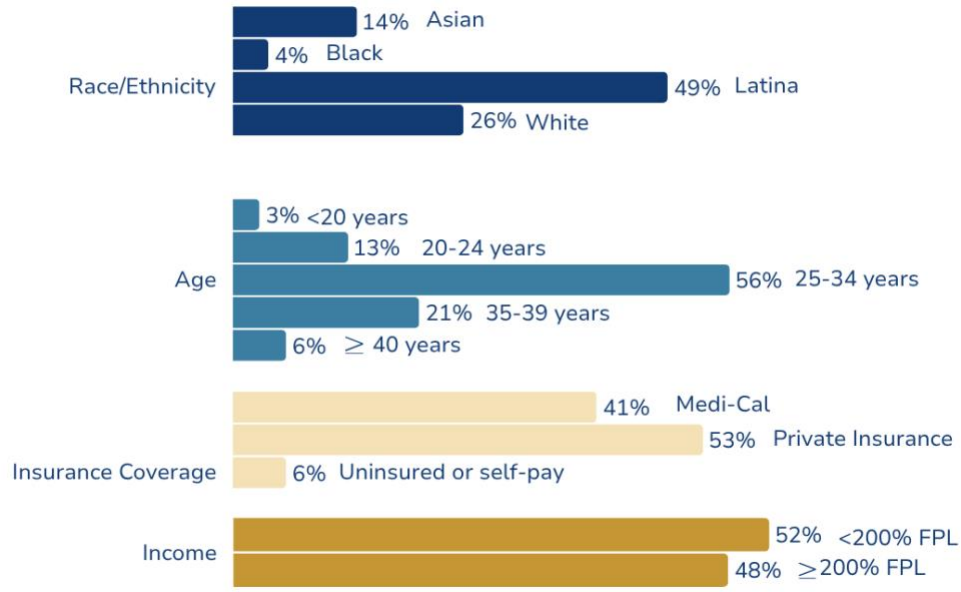
In 2023, there were just over 400,000 births[1] (also referred to as live births) in California, accounting for about 1 in 10 births nationally (CHCF, 2026). There is variation of births by race and ethnicity, age, insurance coverage, and income (Figure 1).

[1] Births are infants born live to California residents (CDPH, 2026a).

Race and Ethnicity: Approximately half (49%) of 2023 California births were among Latinas, one-quarter (26%) of births were among White women[2], 14% of births were among Asian women, and 4% were among Black women (CHCF, 2026).

Age: In 2023, more than half of births were among women ages 25 to 34 years (CHCF, 2026). Compared with 2013, the share of births among women age 29 and younger decreased, while the share of births among women ages 30 and older increased (CHCF, 2026).

Figure 1. Births in California, by Demographics, 2023



Source: CHBRP based on CDPH, 2026b and CHCF, 2026.
Key: FPL = federal poverty level.

Insurance coverage: Approximately 41% of births in California were covered by Medi-Cal and 53% were covered by private insurance sources[3] (CHCF, 2026). However, the share of births covered by Medi-Cal varies significantly by race and ethnicity. Between 2021 and 2023, Medicaid covered 57.1% of births among Hispanic women, 54.4% among American Indian/Alaska Native women, and 51.3% among Black women, compared to 22.1% among White women and 17.4% among Asian/Pacific Islander women (March of Dimes, 2025).

Income: Just over half (52%) of births were among women with household incomes below 200% of the federal poverty level, which was $30,000 for a family of four in 2023 (CHCF, 2026).

Maternal and Pregnancy-Related Mortality

Maternal Morality: Maternal deaths are deaths among women from any cause related to, or aggravated by, the pregnancy or its management that occur either during pregnancy or within the 42 days of its termination, excluding accidental or incidental causes (CDC, 2024b). The maternal mortality rate is calculated by dividing the number of maternal deaths during a period of time by 100,000 live births during the same period of time (WHO, 2025).

Pregnancy-Related Mortality: Deaths that occur among women while pregnant and up to one year after pregnancy are referred to as pregnancy-related deaths, and are also calculated by dividing the number of deaths by 100,000 live births during the same period of time.

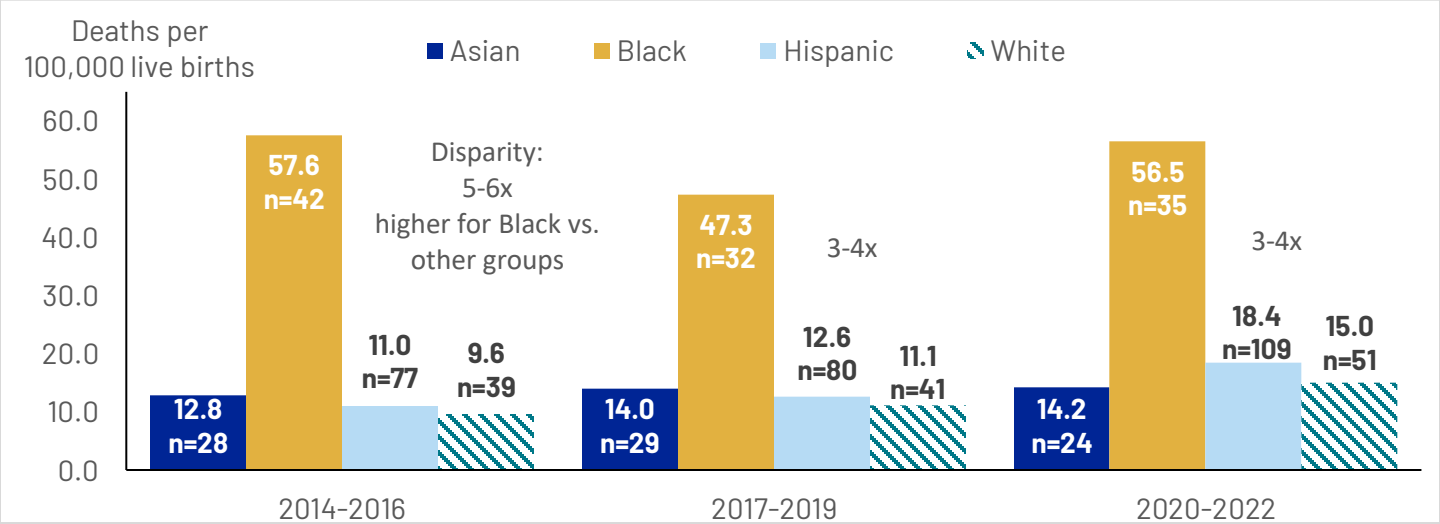
Data at the national and international level are presented as maternal mortality rates, while California-specific data is typically presented as pregnancy-related mortality rates. The 2023 U.S. maternal mortality rate of 18.6 deaths per 100,000 live births (669 women; CDC, 2026) was higher than in peer nations of similar income and economic development, such as Canada (12.0/100,000), Germany (3.6/100,000), Japan (3.1/100,000), and the United Kingdom (8.3/100,000) (WHO,

[2] CHBRP uses the term "women," but recognizes that some birthing people may identify as male or nonbinary and may also have female reproductive organs.
[3] Private insurance includes state-regulated commercial and CalPERS insurance as well as self-insured plans regulated by the Employee Retirement Income Security Act (ERISA).

2025). In California, the 2023 pregnancy-related mortality rate was 12.0, compared with the national rate of 18.7 (CDPH, 2026c). California has one of the lowest maternal and pregnancy-related mortality rates in the U.S. (NCHS, 2026).

However, significant racial disparities exist within maternal mortality across the U.S. and in California. Black women are 3-4 times more likely to experience severe pregnancy complications or die during labor, compared to White women (Digitale, 2024). Even while accounting for factors like lower socioeconomic status and poorer pre-pregnancy health, Black women experience twice as many pregnancy complications, including deaths (Digitale, 2024). Disparities also exist between White women and Asian and Latina women. There was an increase in mortality rates for Hispanic and Asian/Pacific Islander Communities between 2016 and 2019 (OSG, 2024). Figure 2 shows racial and ethnic disparities within pregnancy-related mortality in California. Black women experienced the greatest number of pregnancy-related deaths per 100,000 live births in all three studied time periods spanning from 2014 to 2022, while rates are more similar between White, Asian, and Latina women (CDPH, 2025).

Figure 2. Pregnancy-Related Mortality Ratio by Race/Ethnicity California 2014-2022 (N=617)



Source: CDPH, 2025.

In addition to disparities by race and ethnicity, disparities also exist by several other characteristics as of 2023:

- **Weight**: Pregnancy-related mortality was more than seven times higher for women with body mass index (BMI) 40 and over as compared with women with BMIs under 25 (CDPH, 2026c).
- **Age**: Mortality rates among women ages 40 years and older were five times higher than among women ages 20 to 24 years and three times higher than women ages 20 to 34 (CDPH, 2026c).
- **Education**: Mortality rates were higher among women who did not complete high school (45.9/100,000) as compared with women who graduated college (8.8/100,000) (CDPH, 2026c).
- **Social Drivers of Health**: Mortality rates were almost four times higher among women living in the least healthy communities (as defined by the Healthy Places Index; 33.6/100,000) as compared with women living in the healthiest communities (8.6/100,000) (CDPH, 2026c).
- **Insurance Coverage**: Pregnancy-related mortality rates were three times higher for women in Medi-Cal (28.9/100,000) as compared with women in private insurance (9.4/100,000) (CDPH, 2026c).

Causes of Pregnancy-Related Mortality and Obstetric Complications

Between 2020 and 2022, 232 women in California died during pregnancy or within the first year after the pregnancy ended (CDPH, 2026c). There are various causes of pregnancy-related mortality, including complications during and after pregnancy, and chronic conditions that may exist prior to, or are exacerbated by, pregnancy. The leading causes of pregnancy-related death in California from 2020 to 2022 included COVID-19, hemorrhage, cardiovascular disease, thrombotic pulmonary embolism, other infections/sepsis, amniotic fluid embolism, and hypertensive disorders of pregnancy (CDPH, 2026c). Deaths from COVID-19 accounted for approximately one-quarter of pregnancy-related deaths (CDPH, 2026c). Approximately 60% of these deaths occurred after delivery (CDPH, 2026c). This is a shift in timing of deaths that occurred between 2017 and 2019, when the highest share of deaths occurred on the day of delivery. This shift coincides with a reduction in death due to complications from delivery, such as hemorrhage, and an increase in infection-related causes, including COVID-19 and sepsis. In 2020-2022, 22.4% of deaths occurred on the day of delivery, 19.8% occurred on days 1 to 6 postpartum, 27.6% occurred 7 to 42 days postpartum, and 12.1% occurred 43 to 365 days postpartum (CDPH, 2026c). A federal report examining pregnancy-related deaths before the COVID-19 pandemic found approximately 60% of deaths were preventable and did not vary significantly by race or ethnicity or timing of death (Petersen et al., 2019).

Severe maternal morbidity, which includes unexpected outcomes and complications from labor and delivery that can result in significant health consequences[4], has increased by almost 50% in California between 2016 and 2023 (CHCF, 2026). The rate in California (111.6 per 10,000 delivery hospitalizations in 2023) is also higher than the national rate (94.7 per 10,000 in 2022) (CHCF, 2026). Rates of severe maternal morbidity are highest among Black and Native Hawaiian and Pacific Islander women, and lowest for Latina and White women (CHCF, 2026). Increases in severe maternal mortality are likely due to changes in the health status of birthing people in California (CHCF, 2026).

As rates of chronic conditions increase among Californians, the rates are similarly increasing among pregnant women. Chronic conditions are associated with complications and poor birth outcomes, including preeclampsia, preterm birth, and low birthweight births (CHCF, 2026). In 2023, 18% of women had hypertension at the time of delivery, 13% had diabetes, and 6% had asthma (CHCF, 2026). Rates varied by race and ethnicity, although Black and Native Hawaiian and Pacific Islander (NHPI) women had the highest rates of hypertension, Asian and NHPI women had the highest rates of diabetes, and Black and Multiracial women had the highest rates of asthma.

Access to and Experiences With Health Care

There are many reasons why disparities in maternal health exist, including those stemming from access to care, health care delivery, systemic factors, and racism.

Access to Reproductive and Maternity Health Services

Maternity care deserts are defined as “areas with limited or no access to an obstetric provider like certified nurse/midwives (CNMs/CMs) or obstetrician/gynecologists (OBs)” (JHU, 2023). Over 35% of counties in the US are labeled maternity care deserts (March of Dimes, 2024). In California, 56 hospitals (16% of general acute care hospitals) closed their labor and delivery units between 2012 and February 2025 (CHCF, 2026; Hwang et al., 2024). The median travel time to the nearest hospital with maternity services was more than 30 minutes in 14 counties in 2024 (CHCF, 2026). The number of practicing obstetricians/gynecologists per 1,000 live births was greater in the greater Bay Area, Orange County, Los Angeles County, and Sacramento County as compared with the San Diego area, Central Coast, Inland Empire, San Joaquin Valley, and Northern and Sierra regions (CHCF, 2026). It is projected there will be a shortage of almost 2,000 obstetricians/gynecologists in California by 2032 as the supply of these clinicians continues to decrease (CHCF, 2026). Reasons for the gap in supply of clinicians include limited numbers of residency training spots, clinicians leaving the

[4] Complications include hemorrhage, infection, and cardiac events. Resulting significant health consequences can include short or long-term health consequences, including cardiovascular disease, severe nuerological issues, and hysterectomy.

workforce, and decline in work-life balance (Medicus Healthcare Solutions, 2025). A report by the Government Accountability Office concluded that the two most important factors that affect the availability of obstetric care in rural areas were Medicaid reimbursement rates and the challenge of recruiting and retaining clinicians (Adashi et al., 2024). Nurse-midwives and licensed midwives also provide care to birthing women in California, although the numbers have remained relatively stable in California between 2017 and 2023 (approximately 1,600 practitioners total) (CHCF, 2026).

The availability of clinicians can impact a pregnant person's ability to access health services, including prenatal care. In 2023, three-quarters (74.5%) of pregnant women received adequate prenatal care[5], although this varied by race and ethnicity (CHCF, 2026). A higher share of White (78%), Asian (76%), Latina (73.1%) and Multiracial (72.9%) women received adequate prenatal care as compared with Black (67.1%), American Indian and Alaska Native (65.2%), and Native Hawaiian and Pacific Islander (60.4%) women. Among 800 Black and Latina women surveyed in California, 26% of women reported having difficulty accessing obstetric and gynecological care and 32% of respondents reported challenges finding a clinician for routine care (Byerly et al., 2025).

Adverse Treatment When Accessing Reproductive Health Services

Among 800 Black and Latina women surveyed in California, more than half (57%) of women report experiencing adverse or unfair treatment during pregnancy or a birthing experience (Byerly et al., 2025). In an annual, statewide-representative survey of California residents with a recent live birth [6], 19% of Black women reported that they rarely or never felt heard or listened to by providers during delivery, compared to 12% of Latina women, 8.5% of White women, and 5.4% of Asian women (CHCF, 2026).

Beyond the person-level experiences of birthing Black and Latina women, research has shown that structural racism is driving health disparities (Pillai et al., 2026; Marchi et al., 2023) and contributes to the increased risk of adverse maternal health outcomes (Hailu et al., 2022; Montalmant and Ettinger, 2024; Njoku et al., 2023; Pillai et al., 2026). As described in the Centering Black Mothers in California report (Marchi et al., 2023), structural racism shapes maternal health outcomes at the societal, neighborhood, family, and individual levels through several pathways:

- Discriminatory policies at the societal level that influence current neighborhood conditions;
- Chronic stress created by racism and racist policies; and,
- Lack of access to high quality, respectful healthcare.

Efforts to Reduce Maternal Health Disparities

Efforts to reduce and eliminate these disparities are occurring at the national, state, and local level. Below, CHBRP describes policy approaches in California that aim to address maternal health.

California Legislation and Initiatives

In response to maternal mortality and disparities in maternal health and mortality, California has implemented several laws and initiatives:

- **California Dignity in Pregnancy and Childbirth Act:** Initially established through Senate Bill (SB) 464 in 2019 and amended by Assembly Bill (AB) 2319 in 2024, this Act requires implicit bias training for all health care professionals involved in perinatal care provided in hospitals, birth centers, and primary care clinics. This Act also legally recognizes all birthing people, including nonbinary and transgender individuals.

[5] Adequacy of prenatal care utilization is based on the month prenatal care began and the number of visits, adjusted for gestational age.
[6] The Maternal and Infant Health Assessment is an annual, statewide-representative survey of California residents with a recent live birth. Approximately 12,000 Californians answered the question about delivery experiences in 2021-2022.

- **Department of Health Care Services' The Bold Goals:** This initiative was launched in 2022 to improve the quality and equity of care in three areas outlined in DHCS' Comprehensive Quality Report, one of which is maternity care. Specifically, one major goal is to close maternity care disparities for Black and Native American persons by 50% by the end of the 2025 measurement year. To meet this and other goals, DHCS outlines specific clinical quality measures for Medi-Cal managed care plans, a health equity framework, and systemwide initiatives to strengthen care delivery and community engagement. Available data show the rate of prenatal and postpartum care for Black and Native American persons has increased between 2021 and 2024 and rates in 2024 exceeded the 2025 goals (DHCS, 2026).

- **The California Maternal Health Blueprint:** The 2024 Blueprint, developed by the Office of the California Surgeon General, highlights existing work being done as well as next steps for reducing maternal mortality and inequities in care (OSG, 2024). The two overarching goals included in the report are to assist reproductive-age individuals with understanding the possible health risks they may encounter in future pregnancies, and decreasing maternal deaths in California by 50% by December 2026. The report describes two initiatives in progress:

    - The development of a pregnancy medical risk questionnaire to enable individuals to understand their risk of pregnancy complications and engage in an informed discussion with healthcare providers.

    - Building partnerships and engaging with stakeholders to develop culturally appropriate resources in order to improve communication and provide health information to allow for shared decision-making in healthcare.

- **The California Momnibus Act:** In 2021, the California Legislature passed SB 65, which requires the State to take several actions related to maternal health, including:

    - Establish the Midwifery Workforce Training Act, which would provide funding to increase the number of students being trained as certified nurse-midwives or licensed midwives. However, it is unclear if funding has been appropriated by the Legislature.

    - Establish the California Pregnancy-Associated Review Committee to identify and review all pregnancy-related deaths and severe maternal mortality.

Collaboratives

The California Maternal Quality Care Collaborative, housed within the Stanford School of Medicine and co-founded by the State of California, is a multi-stakeholder organization that utilizes a quality-improvement approach to develop effective strategies to reduce rates of maternal complications and mortality (Digitale, 2024). These efforts include producing toolkits for hospitals on how to mitigate obstetric issues such as hypertension, sepsis, and hemorrhage, and developing more consistent, standardized solutions (Digitale, 2024). This group also develops birth equity initiatives and is working to identify implicit bias and systemic racism within obstetrics (Digitale, 2024). In its 2025 Impact Report, the Collaborative highlights their partnerships with several state agencies, including the California Department of Public Health, the Department of Health Care Services, and the Office of the California Surgeon General (CPQCC, 2025). The Impact Report also discusses partnerships with hospitals and health care providers, as well as community and patient engagement efforts. One project the report highlights is a statewide Maternal Health Taskforce that aims to reduce maternal mortality and severe maternal morbidity. Midway through the five-year initiative, which began in October 2023, the Taskforce supported efforts to expand access to community-based doula services for Medi-Cal members and led and launched two critical quality improvement initiatives.

Expanding the Maternity Care Workforce

Several reports have highlighted ways to increase access to maternity care through expanding the location, number, and type of clinicians providing the care. Additionally, there are several federal and state funding mechanisms available to directly support and diversify the maternity care workforce. These funding opportunities include providing scholarships, loan forgiveness, and graduate medical education funding for rural hospital obstetrical residency programs (Sonnenburg, 2023). Another strategy, given the projected gap in the supply of obstetrician/gynecologists, is the promotion of family physicians and midwives to help fill this gap is growing (Adashi et al., 2024; Stringer and Williams, 2025). Family physicians and midwives are more likely to practice in underserved and rural areas. However, these clinicians may face challenges including low reimbursement rates and challenges obtaining hospital privileges.

As part of California's Fiscal Year 2021-2022 budget, the Department of Health Care Services added doula services as a covered benefit under the Medi-Cal program effective January 1, 2023 (DHCS, 2025). Doulas are health care professionals who provide various types of support during pregnancy, labor and delivery, miscarriage, and abortion, and for up to one year postpartum. Research has shown that doula support may influence engagement in health care and improve maternal health outcomes, including reduced rates of cesarean sections and increased prenatal care (DHCS, 2025).

Conclusion

Maternal health disparities exist by race/ethnicity, weight, age, income, education, and insurance status. In particular, rates of pregnancy-related mortality and morbidity are substantially higher among Black and Latina women as compared with White and Asian women. Obstetric complications, adverse treatment when accessing maternity services, systemic and implicit racism, maternal health status, and barriers to accessing maternity services all contribute to the existence of these disparities. Reproductive health risks are disproportionate for women of color and go beyond individual-level risks to expand to structural and social factors, including reduced neighborhood health services and insurance coverage, racial bias and stereotyping, and less educational access (Sutton et al, 2021).

In California, there are several efforts to reduce maternal mortality overall, with an emphasis on reducing disparities. These efforts include legislation, funding initiatives to increase the maternity care workforce, and collaboratives to drive changes throughout health care delivery systems in California. Addressing maternal health inequities requires continued attention to the policies that structure access to care. CHBRP's work contributes to this effort by examining the potential impacts of legislation related to maternal health services, coverage requirements, and related health benefits. In line with CHBRP's mission to provide evidence-based analysis, CHBRP considers how proposed health policies affect both overall maternal health outcomes and the disparities that persist among different populations.

References

Adashi EY, O'Mahony DP, Cohen IG. Maternity Care Deserts: Key Drivers of the National Maternal Health Crisis. J Am Board Fam Med. 2025 May 12;38(1):165-167. doi: 10.3122/jabfm.2024.240198R1. PMID: 40268316; PMCID: PMC12096371.

Braveman, P. What Are Health Disparities and Health Equity? We Need to Be Clear. Sage Journals 29(1). 2014. Accessed March 9, 2026. Available at: https://journals.sagepub.com/doi/10.1177/00333549141291S203

Byerly et al. California Equity in Maternal Health Report. 2025. Accessed April 9, 2026. Available at: https://www.latinas.org/wp-content/uploads/California-Equity-in-Maternal-Health-Report.pdf

California Department of Health Care Services (DHCS). Bold Goals. Last modified 2026. Available at: https://calaim.dhcs.ca.gov/pages/bold_goals. Accessed June 22, 2026.

California Department of Health Care Services (DHCS). *Doula Benefit Implementation Report*. 2025. Available at: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/Doula-Benefit-Report.pdf. Accessed June 22, 2026.

California Department of Public Health (CDPH). *About the Data – Births*. Center for Family Health, Maternal, Child and Adolescent Health Division. Last modified February 2026a. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/CDPH%20Document%20Library/Data-Dashboards/About-the-Data-Births.pdf. Accessed June 22, 2026.

California Department of Public Health (CDPH). Births. Last modified April 2026b. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx. Accessed June 22, 2026.

California Department of Public Health (CDPH). Pregnancy-Related Mortality. Last modified April 2026c. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Pregnancy-Related-Mortality.aspx. Accessed June 22, 2026.

California Department of Public Health (CDPH). Pregnancy-Related Mortality in California, 2009-2022. 2025. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/CA-PMSS.aspx. Accessed July 7, 2026.

California Health Care Foundation (CHCF). Maternity Care in California Almanac — 2026 Edition. Published March 31, 2026. Available at: https://www.chcf.org/resource/maternity-care-almanac/. Accessed June 17, 2026.

California Perinatal Quality Care Collaborative (CPQCC), California Maternal Quality Care Collaborative (CMQCC). *2025 Impact Report*. Published 2025. Available at: https://www.cmqcc.org/files/CPQCC-CMQCC_2025_Impact_Report_FINAL3.pdf. Accessed June 23, 2026.

Centers for Disease Control (CDC). Severe Maternal Morbidity. 2024a. Accessed May 12, 2025. Available at: https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/index.html

Centers for Disease Control and Prevention (CDC). National Center for Health Statistics. Frequently Asked Questions. Last reviewed: April 2024b. Available at: https://www.cdc.gov/nchs/maternal-mortality/faq.htm. Accessed June 17, 2026.

Digitale, E. How California is taking on inequity for Black patients during pregnancy, childbirth. Stanford Medicine News Center. 2024. Accessed March 9, 2026. Available at: https://med.stanford.edu/news/insights/2024/01/california-inequity-black-patients-pregnancy-childbirth.html

Hailu EM, Maddali SR, Snowden JM, Carmichael SL, Mujahid MS. Structural racism and adverse maternal health outcomes: A systematic review. Health Place. 2022 Nov;78:102923. doi: 10.1016/j.healthplace.2022.102923. Epub 2022 Nov 16. PMID:

Hoyert DL. Maternal mortality rates in the United States, 2024. NCHS Health E-Stats. March 2026;(113):1-7. Available at: https://www.cdc.gov/nchs/data/hestat/hestat113.htm#table. Accessed June 17, 2026.

Hwang K, Yee E, Ibarra AB. California's maternity care crisis is worsening as Newsom decides on bills to slow closures. *CalMatters*. Published September 16, 2024. Available at: https://calmatters.org/health/2024/09/new-maternity-care-closures/. Accessed June 22, 2026.

Johns Hopkins University (JHU). Confronting the Issue of Maternity Care Deserts. 2023. Accessed May 7, 2026. Available at: https://nursing.jhu.edu/magazine/articles/2023/08/confronting-the-issue-of-maternity-care-deserts/

March of Dimes. Health Insurance/Income. 2025. Accessed March 9, 2026. Available at: https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=653&lev=1&slev=4&obj=1&sreg=06

March of Dimes. Nowhere to Go: Maternity Care Deserts Across the US. 2024. Accessed May 7, 2026. Available at: https://www.marchofdimes.org/maternity-care-deserts-report

Marchi K, Rinki C, Asiodu I, et al. *Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants*. California Department of Public Health (CDPH), Maternal, Child and Adolescent Health Division; Center for Health Equity at the University of California San Francisco (UCSF). Published 2023. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Centering-Black-Mothers/Centering-Black-Mothers-Report-2023.pdf. Accessed June 23, 2026.

Medicus Healthcare Solutions. Insights into the OB/GYN Shortage: Understanding the Supply and Demand Gap. Published August 21, 2025. Available at: https://medicushcs.com/resources/insights-into-the-ob/gyn-shortage-understanding-the-supply-and-demand-gap. Accessed June 22, 2026.

Montalmant KE, Ettinger AK. The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature. J Racial Ethn Health Disparities. 2024 Dec;11(6):3658-3677. doi: 10.1007/s40615-023-01816-x. Epub 2023 Nov 13. PMID: 37957536.

National Center for Health Statistics (NCHS). Maternal Mortality Rates by State: 2018–2022. Centers for Disease Control and Prevention (CDC). Available at: https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2022-state-data.pdf. Accessed June 17, 2026.

Njoku A, Evans M, Nimo-Sefah L, Bailey J. Listen to the Whispers before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States. Healthcare (Basel). 2023 Feb 3;11(3):438. doi: 10.3390/healthcare11030438. PMID: 36767014; PMCID: PMC9914526.

Office of the California Surgeon General (OSG). California's Maternal Health Blueprint 2024. 2024. Accessed March 9, 2026. Available at: https://osg.ca.gov/wp-content/uploads/sites/266/2024/09/CAMaternalHealthBlueprint_web.pdf

Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017. *MMWR Morb Mortal Wkly Rep*. Published May 10, 2019;68(18):423–429. Available at: https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm. Accessed June 22, 2026.

Pillai A, Latoya H, Artiga S. Recent Research on How Experiencing Racial Discrimination Impacts Health. Kaiser Family Foundation (KFF). January 30, 2026. Available at: https://www.kff.org/racial-equity-and-health-policy/recent-research-on-how-experiencing-racial-discrimination-impacts-health/. Accessed July 2, 2026.

Sonnenberg, et al. Maternity Care Deserts in the US. JAMA Health Forum, 4(1). 2023. Accessed March 9, 2025. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2800629

Stringer H, Williams C. Midwives help fill maternity care gaps as California faces OB-GYN shortage. *California Health Care Foundation (CHCF)*. Published October 31, 2025. Available at: https://www.chcf.org/resource/midwives-help-fill-maternity-care-gaps-california-faces-ob-gyn-shortage/. Accessed June 18, 2026.

Sutton, M et al. Racial and Ethnic Disparities in Reproductive Health Services and Outcomes. 2020. Obstetrics and Gynecology. Accessed May 7, 2026. Available at: https://journals.lww.com/greenjournal/fulltext/2021/02000/racial_and_ethnic_disparities_in_reproductive.5.aspx

World Health Organization (WHO). Maternal Mortality Ratio (per 100,000 live births). 2025. Accessed March 9, 2026. Available at: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26

About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

To read any of the 200+ bill analyses CHBRP has completed, see the Completed Analysis page on CHBRP's website. In addition to analysis of introduced legislation, CHBRP produces other publications including several annually updated resources, as well as issue briefs and explainers.

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH, Principal Policy Analyst
Karen Shore, PhD, Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor working with CHBRP to support analyses and other projects.

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org
(510) 664-5306

CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research.

Acknowledgements

This issue brief was prepared by Adara Citron, MPH, of CHBRP staff, and Srinidhi Nagarajan during her time as a student intern at CHBRP, with support from Penny Reynolds during her time as a student assistant at CHBRP. Drafts were reviewed by An-Chi Tsou, PhD, and Anna Pickrell, MPH, of CHBRP staff.

CHBRP assumes full responsibility for the issue brief and the accuracy of its contents.

Suggested Citation

California Health Benefits Review Program (CHBRP). (2026). Explainer: Disparities in Maternal Health. Berkeley, CA