The death of a maternal health advocate brings mortality crisis of African American mothers into focus

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In his 1845 work, *The Condition of the Working Class in England*, Friedrich Engels defined a phenomenon that describes with chilling precision the current state of maternal and infant health in the United States: social murder. Engels wrote: “When society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death ... its deed is murder just as surely as the deed of a single individual.”

The preventable death of a mother in the 21st century is not a “tragic accident” or an act of God; it is a calculated result of a social order that subordinates human life to the accumulation of private profit.

The recent death of Dr. Janell Green Smith, a 31-year-old certified nurse-midwife and doctor of nursing practice, casts a grim light on this crisis. Dr. Green Smith had dedicated her life to a solution to maternal mortality, assisting in over 300 births with a particular focus on helping African American women navigate a healthcare system that frequently ignores their pain. Despite her expertise, her credentials did not shield her from the systemic failures of American medicine.

After being admitted with severe preeclampsia, she underwent an emergency C-section and subsequent surgery for a ruptured incision. On January 1, 2026, her heart stopped beating. Her death underscores the barbaric reality that in the United States, black women—regardless of education, income, or professional expertise—face disproportionate risks that are 80 to 90 percent preventable.

Maternal mortality is calculated according to two basic measures: the maternal mortality ratio (MMR) counts the number of maternal deaths per 100,000 live births in a given time and place. This is the indicator most often cited in global reports and allows comparison between countries and over time. The maternal mortality rate (MMRate) is measured by deaths per 100,000 women of reproductive age (usually 15–49 years), capturing risk in the entire population of women who could become pregnant. The two measures are often used interchangeably.

US an outlier in maternal mortality

The United States stands as a staggering outlier in maternal mortality among industrialized nations. While global maternal mortality rates dropped by 40 percent between 2000 and 2023, the rate in the US has spent decades climbing. Each year, 18.6 mothers die for every 100,000 live births, a figure nearly double the average for other high-income countries. In Norway, the maternal mortality rate is a mere 1.9 per 100,000 births; in Canada it is 9.4 per 100,000. If the US performed at the level of California—the state with the nation’s lowest rate—nearly 2,700 deaths could have been avoided in a recent four-year window under study.

The conditions are even more stark for black mothers, with the mortality rate for black women in the standing at 3.5 to 4 times higher than that of white mothers. In 2023, this rate reached a staggering 50.3 deaths per 100,000 live births. While African American women make up only 14 percent of the female population, they account for approximately 40 percent of all maternal deaths. This is not a matter of “lifestyle choices” or genetics; it is the result of systemic factors, including implicit bias and the dismissal of symptoms by a medical establishment that views the marginalized with indifference. It is also a reflection of higher mortality rates among poor women. In the US, 30 to 35 percent of black women are in the lowest economic quintile, according to US Census Bureau estimates, compared to 20 percent of the overall US population.

This crisis extends to those who have not yet had the chance to live. In the US, black infants are twice as likely to die as white infants. The infant mortality rate (IMR) in the US is calculated as the number of deaths of infants under one year of age per 1,000 live births in a given year or cohort. The IMR for black children stands at 10.9 per 1,000 births, compared to the national average of 5.6. In Mississippi, the overall infant mortality rate recently hit 9.7, the highest in over a decade. This death of the innocent exposes a society that cannot even guarantee the most basic requirement of any civilization: the survival of its children past one year of age.

Beyond the headlines of death lies a “silent burden” of maternal morbidity—debilitating conditions such as preeclampsia, gestational diabetes and postpartum depression that erode the quality of life for decades. In 2025 alone, these conditions are projected to result in the loss of 350,000 healthy life years for black women. On average, a woman who gives birth in 2025 will spend 10 days every year for the rest of her life dealing with a

disability connected to pregnancy.

This physiological toll is driven by "weathering," a process where the chronic stress of economic inequity, racism and marginalization causes premature biological aging. This emotional and environmental stress triggers a cascade of unhealthy responses, leading to avoidance of health problems, substance abuse or other behaviors, which in turn create a higher risk of life-threatening complications.

Harris County, Texas, serves as a case study in this systemic failure. Home to the nation's highest maternal mortality rate for black women between 2016 and 2020—a shocking 83.4 per 100,000 live births—the county is an outlier even within a state known for its regressive health policies. It was here that Moriah Ballard, then 22, experienced a nightmare facilitated by medical negligence. Diagnosed with preeclampsia, she was told the only cure was "delivery or death." Ballard recounted the excruciating pain of feeling her pleas were ignored: "I remember telling God that I know you're going to take me, but save my baby," she told capitalbnews.org. Her son, Denim, was delivered stillborn by C-section. Ballard later discovered that an epidural needle had been left in her back for two days following the procedure. Now 28, she struggles with the trauma: "When I'm in pain, it takes so much for me to go to the hospital because I do not trust anything at all."

Medicaid cuts and maternity deserts

The policy response from the ruling class is not to expand care, but to dismantle what little remains of the safety net. Medicaid, the program for the poor jointly administered and financed by the federal government and the states, is the cornerstone of maternal care in the US, financing 41 percent of all births and 64 percent of births to black women, yet it is currently under a massive legislative assault. H.R. 1 (also known as Trump's One Big Beautiful Bill), signed into law on July 4, 2025, calls for systematic funding withdrawals from public safety net programs, including over $900 billion to $1 trillion in Medicaid cuts over the next decade.

Under the guise of "fiscal responsibility," the law institutes onerous 80-hour monthly work reporting requirements. While pregnant mothers are technically exempt, they are caught in a web of frequent and complex recertification hurdles that will inevitably lead to a loss of coverage for millions. Simultaneously, the law bans Medicaid funding for community hubs like Planned Parenthood for one year. This is a counter-intuitive strike against primary care; two out of three Planned Parenthood patients consider the clinic their regular doctor, and 60 percent of these centers are located in underserved or rural areas.

These cuts will exacerbate the growth of maternity care deserts, which already affect 36 percent of US counties. Rural hospitals are closing their obstetric units at an accelerating rate because low Medicaid reimbursement rates make the service "unprofitable." Furthermore, critical policy levers that could save lives—such as doula reimbursement, the removal of prior authorization for maternal mental health treatments, and home-visit programs—are being systematically defunded. In Indiana, the state recently cut $225 million from local health departments, disrupting home-visit initiatives that were successfully preventing preeclampsia.

The ruling class has even attempted to obscure the scale of the carnage. While the full implementation of the "pregnancy checkbox" on death certificates in 2018 led to better counting, it also revealed a horrifying trend: age-standardized pregnancy-related death rates climbed by 28 percent between 2018 and 2022. This is not just a statistical adjustment; it is a real-world surge in death.

A significant portion of this loss occurs after the hospital discharge. A third of maternal deaths—so-called "late maternal deaths"—take place between 42 days and one year after the pregnancy ends. This highlights the six-week "cliff" in the American healthcare system for mothers, where insurance coverage and clinical attention vanish just as life-threatening complications like postpartum depression or cardiovascular issues often peak.

The refusal of the government to fund basic maternal healthcare, while funneling billions into war and state violence, reveals a ruling class policy that does not value human life. As federal paramilitary forces occupy cities like Minneapolis and the administration slanders victims of state violence, the same logic of class rule is applied to the delivery room. The state is "committed" to health and life only insofar as they do not interfere with the requirements of the financial oligarchy.

The maternal health crisis is the inevitable result of a social system that treats medical care as a commodity and the lives of working class mothers as an expendable overhead cost. Ruthlessly, the assault on life begins in the womb. For far too many women, what should be a joyous time becomes a nightmare, and their deaths leave their children motherless.

The struggle for the right to a safe pregnancy and a healthy child is, at its core, a struggle against the capitalist system. Only by reorganizing society on a socialist basis—where healthcare is a fundamental human right and the vast resources of society are directed toward the preservation of life—can this "social murder" of mothers and their babies be brought to an end.