

Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities

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Black women in the United States experience unacceptably poor maternal health outcomes, including disproportionately high rates of death related to pregnancy or childbirth. Both societal and health system factors contribute to high rates of poor health outcomes and maternal mortality for Black women, who are more likely to experience barriers to obtaining quality care and often face racial discrimination throughout their lives.

Due to racism, sexism and other systemic barriers that have contributed to income inequality, Black women are typically paid just 63 cents for every dollar paid to white, non-Hispanic men. Median wages for Black women in the United States are \$36,227 per year, which is \$21,698 less than the median wages for white, non-Hispanic men.¹ These lost wages mean Black women and their families have less money to support themselves and their families, and may have to choose between essential resources like housing, childcare, food and health care.

These trade-offs are evident in Black women's health outcomes and use of medical care. Compared to white women, Black women are more likely to be uninsured,² face greater financial barriers to care when they need it³ and are less likely to access prenatal care.⁴ Indeed, Black women experience higher rates of many preventable diseases and chronic health conditions including higher rates of diabetes, hypertension and cardiovascular disease.⁵ When, or if, Black women choose to become pregnant, these health conditions influence both maternal and infant health outcomes.

Black women are three to four times more likely to experience a pregnancy-related death than white women.

To improve Black women's maternal health, we need a multi-faceted approach that addresses Black women's health across the lifespan, improves access to quality care, addresses social determinants of health and provides greater economic security.

Background: Black maternal health disparities

Too many Black women are dying in pregnancy and childbirth. Black women in the United States are more likely to die from pregnancy or childbirth than women in any other race group.⁶

- ▶ Black women are three to four times more likely to experience a pregnancy-related death than white women.⁷
- ▶ Black women are more likely to experience preventable maternal death compared with white women.⁸
- ▶ Black women's heightened risk of pregnancy-related death spans income and education levels.⁹

Black women experience more maternal health complications than white women. Black women are more likely to experience complications throughout the course of their pregnancies than white women.

- ▶ Black women are three times more likely to have fibroids (benign tumors that grow in the uterus and can cause postpartum hemorrhaging) than white women, and the fibroids occur at younger ages and grow more quickly for Black women.¹⁰
- ▶ Black women display signs of preeclampsia earlier in pregnancy than white women. This condition, which involves high blood pressure during pregnancy, can lead to severe complications including death if improperly treated.¹¹
- ▶ Black women experience physical "weathering," meaning their bodies age faster than white women's due to exposure to chronic stress linked to socioeconomic disadvantage and discrimination over the life course, thus making pregnancy riskier at an earlier age.¹²

Black-serving hospitals provide lower quality maternity care. Seventy-five percent of Black women give birth at hospitals that serve predominantly Black populations.¹³

- ▶ Black-serving hospitals have higher rates of maternal complications than other hospitals. They also perform worse on 12 of 15 birth outcomes, including elective deliveries, non-elective cesarean births and maternal mortality.¹⁴

Many Black women have a difficult time accessing the reproductive health care that meets their needs. Access to reproductive health care, which helps women plan their families, improves health outcomes for women and children.

- ▶ Black women experience higher rates of unintended pregnancies than all other racial groups,¹⁵ in part because of disparities in access to quality contraceptive care and counseling.¹⁶
- ▶ Many Black women lack access to quality contraceptive care and counseling.¹⁷ For example, in a recent analysis of California women enrolled in Medicaid, Black women were less likely than white or Latina women to receive postpartum contraception, and when they did receive it, they were less likely to receive a highly effective method.¹⁸
- ▶ Black women's access to abortion is limited,¹⁹ and they may be more likely to experience the ill effects of abortion restrictions – such as delayed care, increased costs or lack of access to care.²⁰

Policymakers, health care professionals and communities can improve Black women's maternal health.

Expand and maintain access to health coverage.

Only 87 percent of Black women of reproductive age have health insurance, and many more experience gaps in coverage during their lives. To improve Black women's health outcomes, policies should focus on expanding and maintaining access to care and coverage.

Women need health coverage throughout their lifespan including access to preventive health care, such as birth control, to maintain their health and to choose when and whether to become a parent. For women who choose to become a parent or expand their families, good prenatal and maternity care are critically important for healthy pregnancies and healthy children. Pregnant women who lack insurance coverage often delay or forgo prenatal care in the first trimester,²¹ and inadequate prenatal care is associated with higher rates of maternal mortality.²²

Black women are more likely to live in the South, where women generally experience poorer health outcomes and where many states have chosen not to expand Medicaid coverage,²³ which leaves many Black women in the “coverage gap.” Women fall into the coverage gap because they earn too much to qualify for traditional Medicaid, but not enough to purchase insurance on the Affordable Care Act (ACA) marketplace; as a result, they lack access to health coverage. Expanding Medicaid coverage would improve maternal outcomes for Black women by providing better access to care and reducing financial instability.

Provide patient-centered care that is responsive to the needs of Black women.

Black women should receive health care that is respectful, culturally competent, safe and of the highest quality. Unfortunately, research shows that Black women receive a lower quality of care than white women.²⁴ Much too often, Black women are subject to discrimination in the health care field – 22 percent report discrimination when going to the doctor or clinic.²⁵

Public policies and medical practice should incentivize providing patient-centered care that focuses on Black women's individualized needs, including non-clinical, social needs. Moreover, policies should endeavor to eradicate cultural biases and discrimination in medical practice and medical education, increase provider diversity in maternity care and hold individual providers and hospital systems accountable if they fail to provide unbiased, high-quality, evidence-based care.

Address the social determinants of health.

Social determinants of health are the conditions under which people live, work and play. Social determinants have consequential and varying effects on health outcomes across race and ethnicities. For Black women who are affected by structural inequality and discrimination, the chronic stress of poverty and racism has been shown to have a deleterious effect on health outcomes and is linked to their persistent maternal health disparities.²⁶

To improve Black maternal health outcomes, social determinants of health must be addressed through policies that raise incomes and build wealth; provide access to clean, safe and affordable housing; improve the quality of education; prioritize reliable public transportation and transport for medical appointments; and increase the availability of healthy, affordable food.

Expand paid family and medical leave.

Black women need paid leave to take care of their own health needs and to have time to care for their children. More than one in four Black workers report that there was a time in the last two years that they needed or wanted to take time away from work for parental, family or medical reasons but could not.²⁷ Only 30 percent of Black mothers are both eligible for and able to afford to take unpaid leave under the federal Family and Medical Leave Act.²⁸

Only 15 percent of all workers have access to paid family leave through their employers. Paid family and medical leave allows workers to earn a portion of their pay while taking time off from work to care for themselves or their families. But current inadequate leave policies mean that Black mothers are more likely to quit and/or be fired from their jobs after giving birth than white women,²⁹ or return to work before they are healthy enough to do so. Lawmakers should pursue robust, comprehensive paid leave policies that are accessible and affordable for all working people.

Expand access to quality, patient-centered and comprehensive reproductive health care.

Quality, patient-centered reproductive health care is critical to improving maternal health and addressing the reproductive health disparities that Black women face including higher rates of unintended pregnancies and restricted access to abortion. Researchers attribute these disparities to a number of factors, including disparities in access to high-quality health care generally, and family planning services specifically.³⁰ Indeed, women with unintended pregnancies are at increased risk for maternal mortality and morbidity, maternal depression, experiencing physical violence during pregnancy,³¹ infant mortality, birth defects, low birth weight and preterm birth.³²

Black women also live with a legacy of reproductive oppression, and continue to experience reproductive coercion, sometimes leading to a distrust of the health care system that further exacerbates disparities. For instance, Black women are more likely to report having been pressured by a clinician to use a contraceptive method.³³ Moreover, some Black women may be forced to continue pregnancies because onerous restrictions and a lack of insurance coverage have pushed abortion out of reach.

This experience falls short of the level of high-quality, patient-centered care that all women should be able to expect. Policymakers must work to ensure that Black women are able to plan their families in the way that feels best for them, which includes access to counseling on the contraception method of their choice, access to abortion care without restrictions and access to prenatal and maternity care from providers they trust.

Expand and protect access to trusted community providers.

Community health care providers play an essential role in providing Black women with basic, reproductive and maternal health care services. Without these vital resources, many Black women would not have information about or access to birth control, annual exams, Pap tests and other essential preventive care.³⁴ Policymakers should expand funding for trusted, community-based providers including Planned Parenthood. Community-based providers can help Black women get and stay healthy throughout their lifespan, including when, or if, they choose to become a parent.

Expand protections for pregnant workers.

Women report pregnancy discrimination across races and ethnicities, but Black women are disproportionately affected. Nearly three in 10 charges of pregnancy discrimination (28.6 percent)

were filed by Black women from 2011-2015, yet Black women comprise only 14 percent of women ages 16 to 54 in the workforce.³⁵ Pregnancy discrimination has serious consequences for women and their families. Women who are demoted, not promoted or discharged because they are, or might become, pregnant can lose critical income.³⁶ If they are discharged or have their hours cut, they may lose their health insurance and other workplace supports at a time when their families' budgets are already stretched. Because Black women are also at a higher risk for pregnancy-related complications like preterm labor, preeclampsia and hypertensive disorders,³⁷ the loss of wages and health insurance due to pregnancy discrimination is especially challenging.

Stronger protections for pregnant workers, including federal and state laws that ensure that employers provide reasonable accommodations to pregnant women, robust enforcement of the Pregnancy Discrimination Act and continued education about existing legal rights are critical to combatting and, ultimately, eliminating pregnancy discrimination in this country.

Invest in health care safety and quality improvement initiatives.

Maternal mortality is three to four times higher for Black women than it is for white women, and Black women are more likely to experience complications during pregnancy and childbirth. There are existing, proven safety and quality improvement initiatives that need greater uptake to meaningfully improve health care outcomes for Black women.

Maternal mortality review committees increase understanding of the underlying and contributing causes of pregnancy-related deaths and the reasons maternal mortality affects Black women at such a high rate. A structured death review process can provide powerful data and information to facilitate change that improves the health of women before, during and after pregnancy.³⁸ Review committees should include medical professionals, community stakeholders, health advocates, patients and family members. Together, they should work to identify factors that lead to complications and corresponding strategies to avoid preventable complications as well as provide recommendations aimed at reducing pregnancy-related deaths.

Hospitals and medical practices should be encouraged and supported in participating in quality improvement efforts that are known to improve maternal health. For example, the Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiative based on proven implementation approaches to improving maternal safety and outcomes in the United States.³⁹

Similarly, the California Maternal Quality Care Collaborative provides a multifaceted, solutions-based approach to quality improvement including toolkits on how to address the leading causes of preventable death and complications for mothers and infants.⁴⁰ State-level perinatal quality collaboratives have begun to address severe maternal morbidity and related quality and safety issues and should be encouraged to expand this critical work as they can scale implementation of the AIM resources and toolkits across states.⁴¹

Many structural and societal issues affect Black women's health. There is extensive research and evidence that point the way to strategies to improve our health care system and ensure that it delivers safe, effective and evidence-based maternal health care to everyone.

Conclusion

Black women deserve to have safe and healthy pregnancies and childbirth. To meaningfully improve Black maternal health outcomes, we need systemic change that starts with the health care system, improves access to care and makes the places Black women live and work healthier, more fair and more responsive to their needs. Only when we do that will Black women be able to achieve their optimal health and well-being throughout their lifespan, including if they choose to become parents.

Endnotes

¹ National Partnership for Women & Families. (2017, September). *Quantifying America's Gender Wage Gap by Race*. Retrieved 4 April 2018, from <http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/quantifying-americas-gender-wage-gap.pdf>

² National Partnership for Women & Families. (2017, October). *Women's Health Coverage: Sources and Rates of Insurance*. Retrieved 4 April 2018, from <http://www.nationalpartnership.org/research-library/health-care/womens-health-coverage-sources-and-rates-of-insurance.pdf>

³ The Commonwealth Fund. (2017, February). *Biennial Health Insurance Survey, 2003-2016*. Retrieved 4 April 2018, from <http://www.commonwealthfund.org/interactives-and-data/surveys/biennial-health-insurance-surveys/2017/biennial-explorer>

⁴ Agency for Healthcare Research and Quality. (2012, October). *Disparities in Health Care Quality Among Minority Women Selected Findings From the 2011 National Healthcare Quality and Disparities Reports*. U.S. Department of Health and Human Services. Retrieved 4 April 2018, from <https://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr11/minority-women.html#maternal>

⁵ Office of Minority Health. (2017, May). *Profile: Black/African Americans*. Retrieved on October 30, 2017, from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19>

⁶ Tucker, M. J., Berg, C. J., Callaghan, W. M., & Hsia, J. (2007). The Black–White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates. *American Journal of Public Health*, 97(2), 247-251. Retrieved 4 April 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/?term=Tucker+MJ%2C+Berg+CJ%2C+Callaghan+WM%2C+Hsia+J>

⁷ Creanga, A.A., Syverson, C., Seek, K., & Callaghan, W.M. (2017). Pregnancy-Related Mortality in the United States, 2011-2013. *Obstetrics & Gynecology*, 130(2), 366-373. Retrieved 4 April 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/28697109>

⁸ Louis, J. M., Menard, M. K., & Gee, R. E. (2015). Racial and ethnic disparities in maternal morbidity and mortality. *Obstetrics & Gynecology*, 125(3), 690-694.

⁹ Black Mamas Matter Alliance & Center for Reproductive Rights. (2016). *Research Overview of Maternal Mortality and Morbidity in the United States*. Retrieved 2 April 2018, from https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf

¹⁰ Eltoukhi, H. M., Modi, M. N., Weston, M., Armstrong, A. Y., & Stewart, E. A. (2014). The health disparities of uterine fibroid tumors for African American women: a public health issue. *American Journal of Obstetrics & Gynecology*, 210(3), 194-199. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3874080/>

¹¹ Shahul, S., Tung, A., Minhaj, M., Nizamuddin, J., Wenger, J., Mahmood, E., & Talmor, D. (2015). Racial disparities in comorbidities, complications, and maternal and fetal outcomes in women with preeclampsia/eclampsia. *Hypertension in Pregnancy*, 34(4), 506-515. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4782921/>

¹² Gerominus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethnicity & Disease*, 2(3), 207-221.

¹³ Howell, E. A., Egorova, N., Balbierz, A., Zeitlin, J., & Hebert, P. L. (2016). Black-white differences in severe maternal morbidity and site of care. *American Journal of Obstetrics & Gynecology*, 214(1), 122-e1. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/26283457>

¹⁴ Creanga, A. A., Bateman, B. T., Mhyre, J. M., Kuklina, E., Shikrul, A., & Callaghan, W. M. (2014). Performance of racial and ethnic minority-serving hospitals on delivery-related indicators. *American Journal of Obstetrics & Gynecology*, 211(6), 647-e1. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/24909341>

¹⁵ Finer, L. B. & Zolna, M. R. (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006 (p. 480). *Contraception*, 84, 478-485.

¹⁶ See, e.g., Dehlendorf, C., Park, S. Y., Emeremni, C. A., Comer, D., Vincett, K., & Borrero, S. (2014). Racial/ethnic disparities in contraceptive use: Variation by age and women's reproductive experiences (p. 526.e1). *American Journal of Obstetrics & Gynecology*, 210(6), 526.e1-526.e9.

¹⁷ Ibid.

¹⁸ deBocanegra, H. T., Braughton, M., Bradsberry, M., Howell, M., Logan, J., & Shwarz, E.B. (2017). Racial and ethnic disparities in postpartum care and contraception in California's Medicaid program (pp. e3-e4). *American Journal of Obstetrics & Gynecology*, 217(47), e1-e7.

¹⁹ See note 15; see, e.g., Dehlendorf, C., Harris, L. H., & Weitz, T. A. (2013). Disparities in abortion rates: A public health approach. *American Journal of Public Health*, 103(10), 1772-1779.

²⁰ See, e.g., Dehlendorf, C., Harris, L. H., & Weitz, T. A. (2013). Disparities in abortion rates: A public health approach (p. 1776). *American Journal of Public Health*, 103(10), 1772–1779 (describing that “studies have found that restricted access to abortion services can limit women’s ability to abort a pregnancy when they wish to do so, and that these effects may be particularly pronounced for Black women and women with lower educational attainment”); Henshaw, S. K., Joyce, T. J., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *Restrictions on Medicaid funding for abortions: A literature review*. Guttmacher Institute. Retrieved 27 March 2018, from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.295.8439&rep=rep1&type=pdf>

²¹ Egerter, S., Braverman, P., & Marchi, K. (2002). Timing of insurance coverage and use of prenatal care among low-income women. *American Journal of Public Health*, 92(3), 423-427. Retrieved 27 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447093/>

²² U.S. Centers for Disease Control and Prevention. *Prenatal Care*. Retrieved 4 April 2018, from <https://www.cdc.gov/healthcommunication/tooltemplates/entertainmented/tips/PregnancyPrenatalCare.html>

²³ America’s Health Rankings. (2018). *2018 Health of Women and Children Report*. Retrieved 4 April 2018, from <https://www.americashealthrankings.org/explore/2018-health-of-women-and-children-report>

²⁴ See note 9.

²⁵ Robert Wood Johnson Foundation. (2017, December). *Discrimination in America: Experiences and Views of American Women*. Retrieved 4 April 2018, from https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf441994

²⁶ Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries IV, W. L. (2016). The impact of racism on the sexual and reproductive health of African American women. *Journal of Women’s Health*, 25(7), 664–671. Retrieved 4 April 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939479/>

²⁷ Horowitz, J.M., Parker, K., Graf, N., & Livingston, G. (2017, March 23). *Americans Widely Support Paid Family and Medical Leave, but Differ Over Specific Policies*. Pew Research Center. Retrieved 18 March 2018, from <http://www.pewsocialtrends.org/2017/03/23/americans-widely-support-paid-family-and-medical-leave-but-differ-over-specific-policies/>

²⁸ diversitydatakids.org. (2015). *Policy Rankings: The Family and Medical Leave Act*. Brandeis University, The Heller School, Institute for Child, Youth and Family Policy Publication. Retrieved 18 March 2018, from <http://www.diversitydatakids.org/data/ranking>

²⁹ Laughlin, L. (2011, October). *Maternity Leave and Employment Patterns of First-Time Mothers: 1961–2008*. U.S. Census Bureau Publication. Retrieved 28 March 2018, from <http://www.census.gov/prod/2011pubs/p70-128.pdf>

³⁰ See note 15; see note 20, Henshaw; see, e.g., Dehlendorf, C., Park, S. Y., Emeremni, C. A., Comer, D., Vincett, K., & Borrero, S. (2014). Racial/ethnic disparities in contraceptive use: Variation by age and women’s reproductive experiences (pp. 526.e7). *American Journal of Obstetrics & Gynecology*, 210(6), 526.e1–526.e9 (citations omitted). A number of studies have demonstrated that there is not a significant disparity in knowledge about contraception between Black women and white women. See, e.g., Craig, A. D., Dehlendorf, C., Borrero, S., Harper, C. C., & Rocca, C. H. (2014). Exploring young adults’ contraceptive knowledge and attitudes: Disparities by race/ethnicity and age. *Women’s Health Issues*, 24(3), e281–e289; Rocca, C. H. & Harper, C. C. (2012). Do racial and ethnic differences in contraceptive attitudes and knowledge explain disparities in method use? Perspectives on Sexual and Reproductive Health, 44(3), 150–158. See also, e.g., Dehlendorf, C., Harris, L. H., & Weitz, T. A. (2013). Disparities in abortion rates: A public health approach (p. 1776). *American Journal of Public Health*, 103(10), 1772–1779.

³¹ See, e.g., generally Tsui, A. O., McDonald-Mosley, R., & Burke, A. E. (2010). Family planning and the burden of unintended pregnancies. *Epidemiologic Reviews*, 32, 152–174.

³² See, e.g., generally Conde-Aguedelo, A., Rosas-Bermúdez, A., & Kafury-Goeta, A. C. (2006). Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *JAMA*, 295(15), 1809–1823.

³³ Becker, D. & Tsui, A. O. (2008). Reproductive health service preferences and perceptions of quality among low-income women: Racial, ethnic and language group differences (p. 208). *Perspectives on Sexual and Reproductive Health*, 40(4), 202–211.

³⁴ See, e.g., Stevenson, A. J., Flores-Vazquez, I. M., Allgeyer, R. L., Schenckan, P., & Potter, J. E. (2016). Effect of removal of Planned Parenthood from the Texas Women’s Health Program. *New England Journal of Medicine*, 374, 853–860 (describing the negative impact of cuts to family-planning services on women’s access to contraception). Recent studies have also shown that, in Texas, deep funding cuts to family planning services correlated with dramatic increases in the maternal mortality rate. See generally MacDorman, M. F., Declercq, E., & Thoma, M. E. (2018). Trends in Texas maternal mortality by maternal age, race/ethnicity, and cause of death, 2006–2015. *Birth*, 1–9; MacDorman, M. F., Declercq, E., Cabral, H., & Morton, C. (2016). Is the United States maternal mortality rate increasing? Disentangling trends from measurement issues. *Obstetrics & Gynecology*, 128(3), 447–455 (describing how the reported maternal mortality rate in Texas doubled within a two-year period); see also Bassett, L. (2016, August 18). Pregnancy-Related Deaths Nearly Doubled in Texas After Cuts to Women’s Health. *Huffington Post*. Retrieved 27 March 2018, from https://www.huffingtonpost.com/entry/womens-health-texas_us_57b5d949e4b034dc73260bf3

³⁵ National Partnership for Women & Families. (October 2016). *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace*. Retrieved 6 April 2018 from <http://www.nationalpartnership.org/research-library/workplace-fairness/pregnancy-discrimination/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf>

³⁶ Ibid.

³⁷ See note 14.

³⁸ Association of Maternal & Child Health Programs. (n.d.). *MMR Resource Portal for States: Building Capacity for Maternal Mortality Review*. Retrieved 4 April 2018, from <http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/MMR/Pages/default.aspx>

³⁹ Council on Patient Safety in Women's Health Care. (n.d.). *Alliance for Innovation on Maternal Health*. Retrieved 5 April 5 2018, from <http://safehealthcareforeverywoman.org/aim-program/>

⁴⁰ California Maternal Quality Care Collaborative. (n.d.). *QI Initiatives*. Retrieved 4 April 2018, from <https://www.cmqcc.org/qi-initiatives>

⁴¹ U.S. Centers for Disease Control and Prevention. (2018, January 25). *Perinatal Quality Collaborative*. Retrieved 4 April 2018, from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm#success>

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at NationalPartnership.org.

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