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Pepperdine University

Graduate School of Education and Psychology

BLACK MIDWIVES FOR BLACK MOTHERS: AMELIORATING RACIAL DISPARITIES IN THE QUALITY OF MATERNAL HEALTHCARE

A dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Philosophy in Global Leadership & Change

by

Kimberly Navarro

July, 2023

Kfir Mordechay, Ph.D. – Dissertation Chairperson

This dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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DEDICATION

I am thankful to my merciful God for allowing me to achieve this tremendous accomplishment. With this PhD, I honor my family, friends, and the community I come from in Passaic, New Jersey, and Villa Altagracia, Dominican Republic, who bless me with a rich and beautiful culture and global mindset. I dedicate my dissertation to my precious daughter, Soledad Rosalia, who shows me how wonderful life is now that she's in my world; to my brother Isaiah for being love and light to everyone around him; to my siblings, Glowigr, Gloribeth, and Genesis for their love and support, to my nieces and nephews, Ezra, Ayla, Zoe, Theo, and Avy for giving me purpose and joy; to my parents Gloria and Wigberto Navarro for their unending sacrifices and commitment to our family; to the Navarro Dynasty who give me a bloodline of great thinkers, creators, and leaders and who always encourage me to reach greater heights; and to my Rodriguez-Paniagua family, consistent of midwives, nurses, and healers, who give me the birthright of a midwife. I stand on the shoulders of giants.

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VITA

OBJECTIVE:

I am a healer and a social scientist, trained as a certified nurse midwife and women's health nurse practitioner, leading with love, a global mindset, and committed to ending maternal health racial inequities by providing of high-quality, culturally reverent healthcare and education.

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- Experienced in Global Maternal healthcare and global health missions
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-Joseph Munoz Urgent Care	Anaheim, CA. July 2019-March 2020
-Occidental College student health center	Los Angeles, CA. Sept. 2018-May 2019
-Dusk to Dawn Urgent Care	Los Angeles, CA. Sept. 2018-March 2020
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- Awarded Grant Funding for Research on: Black midwives for Black mothers
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ABSTRACT

In the United States, maternal mortality represents a dire health crisis with a stark racial imbalance. Black women are two and a half to three times more likely to die from pregnancy and birth-related complications than their White counterparts. Racial disparities in maternal health can be explained by variations in the quality of maternal healthcare services that women tend to receive. Racial and ethnic minority women are more likely to receive inferior quality prenatal care (PNC), which brings to question the care model of traditional PNC and its adequacy in serving the healthcare needs of Black women. Since Black women disproportionately experience lower quality PNC, the overall improvement in the quality of PNC is likely to yield high benefits for Black women. This study sought to identify and give perspective to the unique challenges that Black women experience in the maternal healthcare system. Findings show that Black mothers who had home births with a race-concordant midwife experienced excellent quality of care. For Black home-birthing mothers in this study, PNC and childbirth were normalized at home, PNC was accessible, mother led, consistent, encouraging, and supportive, good quality, emotionally fulfilling and peaceful, personalized, race-concordant, and with family involvement, which made mother feel well prepared for birth. Findings from this study highlight the importance of race-concordant midwifery care for Black mothers to experience high quality care. Black midwives in this study demonstrated the provision of high-quality midwifery care to Black mothers. These findings may help inform clinical practice for the maternal care of Black women. Advocating for Black women to receive high-quality PNC, promoting race-concordant midwifery care and diversity in midwifery are essential to ameliorate racial disparities in maternal health. Policies that support further research into maternal healthcare for Black women, promote midwifery care and diversity in midwifery, like the Black Maternal Health

Momnibus, are instrumental to improve maternal health outcomes for Black women.

Keywords: prenatal care, Black maternal health, midwifery care, race-concordant care, quality of care

Chapter 1: Introduction

Background

Childbirth is a female biological phenomenon that frames the dichotomy of harvesting new life and the risk of fatal health implications. Worldwide, an unprecedented number of women die from complications related to pregnancy and childbirth, an incident known as maternal mortality (World Health Organization [WHO], 2019). In 2017, about 295,000 women around the world died as a result of pregnancy and childbirth. In 2020, the global maternal mortality rate (MMR) was 152 deaths per 100,000 live births, increasing from 151 deaths per 100,000 live births in 2019 (Bill and Melinda Gates Foundation, 2021). Excessive bleeding and infection are the leading causes of maternal deaths globally (UNICEF, 2019; WHO, 2019). Complications leading to maternal death can occur without warning at any time during pregnancy and childbirth and most can be prevented. Healthcare solutions to prevent maternal mortality include high-quality pregnancy and childbirth care by skilled healthcare professionals such as midwives (WHO, 2019). Yet, maternal mortality remains a global health problem that takes the lives of about 800 women daily (WHO, 2019).

In the United States, maternal mortality represents a dire health crisis with a stark racial imbalance. Women in the United States are dying before, during, and after pregnancy at a higher rate than in any other developed country (Harris, 2021). In 2020, 861 women died of complications related to pregnancy and birth in the United States (MMR of 23.8 deaths per 100,000 live births), compared with 754 maternal deaths in 2019 (MMR of 20.1 deaths per 100,000 live births; Hoyert, 2020). Maternal death accounts for the lives of over 700 women yearly in the United States, while disproportionately affecting Black women (Centers for Disease Control and Prevention [CDC], 2019a). Black women are two and a half to three times more

likely to die from pregnancy and birth-related complications than their White counterparts. Black women older than 30 are four to five times more likely than their White counterparts to die as a result of pregnancy and birth (CDC, 2020b). Education and socio-economic status do not serve as protective factors for Black women's maternal health outcomes. A study of two million births in California found that the wealthiest Black mothers are twice as likely to die as a result of pregnancy and birth as the wealthiest White mothers (Kliff et. al., 2023). Five times more Black mothers with a college education die from pregnancy and birth complications than White mothers with a college education (Declercq & Zephyrin, 2020). Senator Padilla (2021) claims, "Black women are dying at alarming rates due to disparities in our healthcare systems, and this has only been exacerbated by the COVID-19 pandemic" (para. 3). According to The Wall Street Journal (Toy, 2023), the U.S maternal mortality rate has catapulted in 2021 to the highest level since 1965 as COVID-19 exacerbated long standing problems such as access to healthcare.

The rate of women dying of preventable causes as a result of pregnancy and childbirth in the United States is a worsening problem. Maternal mortality rates have been trending upward over the past two decades in the United States (Troy, 2023). Maternal mortality is a matter of immense importance and an urgent public health crisis that deserves the attention of the government and society. For that reason, on December 7, 2021, Vice President, Kamala Harris, hosted the nation's first White House Day of Action on Maternal Health. The White House Day of Action on Maternal Health was a nationwide Call to Action to address the intricate national problem of maternal mortality and propose a solution to support safe pregnancies and childbirth (Harris, 2021). Consistent with the nation's sense of urgency to bring attention to the importance of maternal health, TIME recognized a Black midwife, Jennie Joseph, in Women of the Year, for her contributions to ameliorating the Black maternal mortality crisis (Abrams, 2022).

Maternal Mortality

The United States has the highest MMR among developed countries globally (WHO, 2019). In 2018, the United States had 17 pregnancy-related deaths per 100,000 live births, which is more than quadruple the MMR in the Netherlands, Norway, and New Zealand, where there were three pregnancy-related deaths per 100,000 live births (Tikkanen et al., 2020). In the same year, France and Canada had the second-highest MMR among developed countries, with each country having about eight pregnancy-related deaths per 100,000 live births (WHO, 2018).

The United States is the only developed country where the MMR has increased and more than doubled in 30 years (Delbanco et al., 2019). Between the years 1987 and 2014, the MMR in the United States catapulted from 7.2 to 18 pregnancy-related deaths per 100,000 live births (CDC, 2020c). In California, though the current MMR has decreased from previous years, the rate remains unchanged for Black women. Black women in California are affected by maternal mortality four times more than White women (California Department of Public Health [CDPH], 2018).

Poor maternal health outcomes for Black women cannot be solely attributed to poverty, educational level, or access to healthcare (Taylor, 2020). Regardless of income level and education level, Black women are more likely to die from pregnancy and childbirth, a healthcare disparity created primarily by systemic inequities (Harris, 2021). The racial disproportion of maternal mortality brings to question the possibility of implicit biases and racial injustice within the U.S. healthcare system. Research has correlated racial inequality in maternal health outcomes with structural racism within U.S. health institutions (CDC, 2020b; Feagin & Bennefield, 2014; Goode, 2014; Johnson & Hellman, 2021; Prather et al., 2018; Wren Serbin & Donnelly, 2016). Structural racism is a powerful social condition rooted in centuries of oppression and devaluing

of Black people, with a significant impact on the health and well-being of the targeted people (Taylor, 2020). According to the Aspen Institute (2016), structural racism is defined as a system where public policies, institutional practices, and cultural representation work to reinforce and perpetuate racial inequality. Black families continue to be put at risk by U.S. institutions that perpetuate racial inequalities across various domains (Mordechay, 2018; Mordechay & Orfield, 2017). These risks constitute pregnancy-related death, a current maternal health crisis for Black women in the United States.

The Impact of Maternal Mortality. The impact of maternal death is widespread. Maternal death is not only a problem for women; it impacts families, communities, and the global economy (Every Woman Every Child [EWEC], 2015). Maternal mortality is a global health problem with consequences for the economy, health, psychology of families, communities, and society (H. E. Reed et al., 2000). In addition, maternal death directly impacts the health outcomes of children (Finlay et al., 2015). The negative impact of maternal mortality on children's health outcomes is extensive, expanding from infancy to childhood. Maternal mortality is correlated with infant malnutrition, increased risk of infection, poor health, death, child labor, and disruption to the nuclear family (Finlay et al., 2015). The indirect consequences of maternal mortality include household economic insecurity and poverty, making families susceptible to malnutrition, infectious diseases, and lack of education (H. E. Reed et al., 2000).

Improving maternal health and reducing child mortality are interdependent global health goals (WHO, 2020). Efforts to end preventable pregnancy-related deaths by investing in maternal healthcare can help keep women alive and healthy, reduces poverty, stimulates economic growth, and creates jobs (EWEC, 2015). While efforts to end maternal mortality can harvest many benefits to the global society, neglecting this problem can be severely detrimental

to the national and international community. Maternal mortality is an important problem that requires attention to end preventable deaths and produce a positive spillover effect on children, families, and the global society (Finlay et al., 2015).

Black women have a long history of poor maternal health outcomes, but there is a severe gap in the literature about racial disparities in maternal health (Canty, 2020). The maternal health crisis cannot be properly addressed without understanding the influence of racism in the health care system. Racism, not race itself, is a driving force behind the high rates of maternal deaths among Black women (Taylor et al., 2019). Knowledge about healthcare provider-patient relationships, race, and the lived experience of Black women during pregnancy and childbirth is fundamental to understanding racial maternal health and is fundamental to understanding racial health disparities in the United States (Canty, 2020; Oparah et al., 2017).

Maternal Health Racial Disparity in the United States. In the United States, Black women are disproportionately affected by maternal death. Simply being Black in the United States is a risk factor in pregnancy outcomes regardless of education level and socioeconomic status (Chidi & Cahill, 2020; Goode, 2014; Mortan, 2018). Since 1940, maternal mortality ratios among Black women have been at least three to four times higher than their White counterparts (Chang et al., 2003; Luke, 2018). Black women have the fastest-growing MMR and in some American cities, the MMR for Black women is 12 times greater than the rate for non-Hispanic White women (Howell, 2018). West (2001) poignantly depicted that Black people in the United States carry the burden of unprecedented levels of unregulated and unrestrained violence directed at them. A visible example of the violence against Black women in the United States is the Black maternal health crisis.

California has cut the state-wide MMR in half, from an average of 13 per 100,000 live births in the baseline period of 2005–2009, to a 3-year average of 7.0 during 2011–2013 (Main et al., 2018). Although there has been a decrease in the state-wide maternal death rate in California, Black women continue to be disproportionately affected by pregnancy-related death in California (CDPH, 2018; Oparah et al., 2017). In California, Black women experience pregnancy-related death up to four times the rate of women of other racial and ethnic groups, and as high as eight times the rate when deaths from pregnancy-related cardiovascular disease are considered (CDPH, 2018). There is a pressing need to understand the reasons behind the stark racial inequality and examine the broader society and structural conditions that potentially contribute to the maternal health care crisis among Black women.

The adverse maternal health outcomes experienced by Black women can be attributed to inadequate prenatal care (PNC; Howell, 2018; Johnson et al., 2003; Luke 2018). Globally, the lack of PNC is associated with increased maternal morbidity and mortality (WHO, 2018). For that reason, global and national health goals aim to increase the number of women who obtain early PNC (U.S. Department of Health & Human Services [HHS], 2018; WHO, 2018). Reducing racial disparities in PNC utilization has also been a national priority in the United States for decades (Misra et al., 2017). Historically, the adequacy of PNC has been defined by the number of visits to the clinic and how early the care was rendered. However, it is essential to note that the quality of PNC is essential to determine its adequacy.

Adequate Prenatal Care. Prenatal care includes specialized healthcare services for pregnant women during the entire length of pregnancy, starting from pre-conception to postpartum (Howell, 2018). Obstetricians, nurse practitioners, and midwives provide this type of pregnancy care. These medical providers of PNC screen for health risks, provide education about

pregnancy and nutrition, promote healthy lifestyles, monitor medical conditions, test for common gestational health problems, and connect women to community resources for complementary services (Navarro, 2018; Teitler et al., 2012). It is recommended that PNC begin as early as possible in pregnancy, ideally before conception, and consist of up to 14 encounters with a medical provider (Navarro, 2018; Teitler et al., 2012; WHO, 2018).

Adequate PNC is ideal for optimal maternal and infant health outcomes. Maternal mortality is lowest among women who start PNC in early pregnancy (Oparah et al., 2017). Black women are less likely to receive early and complete PNC (Malik, 2000; Park et al., 2007). Black women are also more likely to receive inferior-quality PNC (Howell, 2018). For low-income Black women in the United States, PNC is typically suboptimal thus discouraging the women from proper utilization of PNC (Adams & Thomas, 2017; Malik, 2000).

In California, PNC is federally funded and accessible to all women with proof of pregnancy (CDPH, 2018). Yet, there are persistent differences in the utilization of PNC in California, which speaks to the inability of PNC to meet the specific healthcare needs of Black women (Airhihenbawa, 1995). In a study that focused on Black women's experience with PNC in California, Black women described PNC within the following themes: culturally inappropriate, poor treatment, and distrust of PNC providers (Oparah et al., 2017). The quality of PNC is an important component to determine the adequacy of PNC. The racially-based inconsistency in the utilization and quality of PNC implores the investigation into barriers to high-quality PNC that minority women face.

Barriers to Prenatal Care. Johnson et al. (2003) defined barriers to PNC as any state, condition, or event that hinders or impedes women from obtaining early and adequate PNC services. Women who obtain late or limited PNC, or who lack PNC altogether, miss

opportunities for health interventions that are necessary to prevent pregnancy-related health complications. Black women have the lowest rates of receiving early PNC compared with White and Latino women, and experience twice the number of barriers to PNC than White women (Fryer et al., 2021). The most-reported PNC barriers are psychosocial, such as stress and depression (Johnson et al., 2003; Sander-Phillips & Davis, 1998).

Barriers to early and adequate PNC have been associated with endorsed experiences of racism, discrimination, and stress (Oparah et al., 2017; Prather et al., 2018). Racism, discrimination, poverty, unemployment, and residential segregation are among the social determinants that make Black women more vulnerable to maternal health disparities (Prather et al., 2018; Vilda et al., 2019). Black mothers avoid institutionalized PNC to avoid prejudice and discrimination, which results in poor maternal health outcomes (Morrison & Fee, 2010; Sander-Phillips & Davis, 1998). The lived experiences of Black women in the United States are plagued by greater structural constraints (Vilda et al., 2019). Limited opportunities, psychosocial stressors from individual and institutional discrimination, and structural racism are some of the structural constraints that Black women are faced with. These structural constraints have harmful health risk factors that may contribute to racial disparities in maternal health (Vilda et al., 2019).

Racial disparities in maternal health can also be explained by variations in the quality of maternal healthcare services that racial and ethnic minority women tend to receive (Howell, 2018). Black women who initiate early PNC in the first trimester still have higher rates of poor health outcomes than non-Hispanic White women with late or no PNC, which may be due to the lower quality of PNC that Black women tend to receive. Racial and ethnic minority women are more likely to receive inferior quality PNC, which brings to question the care model of traditional PNC and its adequacy about serving the healthcare needs of racial and ethnic minority

women. Since Black and other racial and ethnic minority women disproportionally experience more barriers and lower quality PNC, the overall improvement in the quality of PNC is likely to yield high benefits for these groups (Howell, 2018).

Quality of Prenatal Care. Ending preventable maternal death is a global health goal with a predictable high return on investment (EWEC, 2015). The sustainability of the global society is heavily dependent on women's health. For that reason, it is important to ensure high-quality PNC for women. Access to early and high-quality PNC is critical to the elimination of maternal health racial disparities (Center for Reproductive Rights, 2014). Black women face the greatest challenges in maternal healthcare and need better care (Sakala et al., 2018).

The United States has the most expensive healthcare system in the world but ranks low on measures of healthcare quality (McCool, et al., 2013). The World Health Organization (2000) ranked the United States 37th in the world regarding healthcare system performance. Patient perception is an essential indicator for evaluating the quality of care, yet it is often overlooked in evaluations of PNC (Michels, 2000). Measuring women's perceptions of PNC is critical to monitoring quality of care (Redshaw, et al., 2019).

A qualitative study on pregnant women's experience with PNC showed that women want to feel respected by the healthcare staff, prefer a clean environment, and expect their medical providers to be caring, competent and accessible (Michels, 2000). Black women desire PNC that is meaningful; cultivates intimate relationships; is relaxed not rushed, holistic, attentive to emotional and mental needs; addresses sources of stress, empowers women, incorporates self-care; is culturally sensitive, non-judgmental, and spiritually aware (Oparah et al., 2017).

Policies such as the Black Maternal Health Momnibus Act of 2021 that aim to reform PNC are necessary to ensure the provision of high-quality PNC and efficiently combat maternal

health racial inequalities (Black Maternal Health Caucus, 2020; Johnson & Hellman, 2021). If PNC is to address the holistic integration of physical, spiritual, emotional, and social needs of Black women, as Black women expect, then alternative PNC practices that incorporate the midwifery model of care ought to be considered.

Midwifery Model of Care and Group Prenatal Care

Adams and Thomas (2017) contended that alternative PNC practices using the midwifery model of care and group prenatal care (GPNC) have greater value for Black pregnant women than traditional PNC. The midwifery model of care and GPNC provide an excellent template for shifting to a more comprehensive and holistic PNC service (Adams & Thomas, 2017; Oparah et al., 2017). The midwifery model of care and GPNC can potentially be a more suitable modality of pregnancy and childbirth care for Black women than the traditional medical model of PNC and, therefore more efficient to ameliorate racial disparities in maternal health.

The midwifery model of care takes a holistic approach to healthcare and goes beyond a sole focus on the physical needs of women to address their spiritual, emotional, and psychosocial needs (Adams & Thomas, 2017; Navarro, 2018). The midwifery model of care is fundamentally and philosophically different from the traditional medical model of PNC. The midwifery model is based on the belief that pregnancy and birth are normal life events and that midwives, rather than of medical doctors, render care before, during and after birth (Midwives Alliance of North America [MANA], 2020). The midwifery model of care is based on developing trusting relationships between midwives and the women they serve to render care that is uniquely nurturing and supportive care.

GPNC is different from the traditional medical model of PNC because it brings a group of eight to 10 pregnant women together for care, rather than a one-to-one consultation between

doctor and patient as in the traditional medical care model of PNC. GPNC allows pregnant women and their healthcare providers to learn from each other in a more meaningful way. Members can form lasting relationships and socialize in ways not possible with traditional PNC (Centering Healthcare Institute, 2021). Group prenatal care is an innovative approach to PNC that offers pregnancy healthcare to women in groups, which enables women to develop supportive relationships with other pregnant women and their health providers, producing better health outcomes than traditional PNC (Novick et al., 2011).

Traditional PNC practices have proven to be inefficient in diverse patient populations (Airhihenbuwa, 1995), and the lack of its efficiency has led to harmful health implications for Black women. In some regions of the United States, Black women's risk of maternal death is similar to the risk of maternal death for women in some developing countries (Howell, 2018). This dangerous healthcare trend proves the exigency of high-quality PNC for the most vulnerable women.

High-quality, culturally informed PNC for Black women may help improve maternal healthcare outcomes for Black women. More specifically, alternative PNC practices using midwives and GPNC is more effective in meeting the needs of pregnant Black women (Oparah et al., 2017). For healthcare systems to end preventable maternal deaths, a reliance on community-based healthcare providers such as midwives is needed (Scott & Mclemore, 2021). Therefore, this study proposes a redesign of traditional PNC to incorporate race-concordant midwives and the midwifery model of care, which have proven to be instrumental to end preventable maternal deaths and ameliorate racial disparities and maternal health (Altman et al., 2020; Ellerby-Brown et. al, 2008; Terreri, 2019).

Theoretical Framework

Reproductive justice is the theoretical framework that informs this research study. Reproductive justice offers a perspective that enables a paradigm shift in how maternal healthcare is understood to one that honors human rights, social justice, equity, and equality. To understand the problem of racial inequality in maternal health, there must be an understanding of the context of society and the violations of reproductive justice against Black women must be addressed (Oparah et al., 2017).

The term *reproductive justice* was coined by a group of 12 Black women reproductive health activists who created the concept from a combination of social justice and reproductive rights (Ross & Solinger, 2017). Three core values define reproductive justice: the right not to have a child, the right to have a child, and the right to parent children in a safe and healthy environment (Ross & Solinger, 2017). The concept of reproductive justice was inspired by the international human rights framework (Oparah et al., 2017). Understanding the problem of racial inequality in maternal mortality through the lens of reproductive justice provides a connection to the broader context of disparities and social determinants that put Black women at risk.

Reproductive justice aims to go beyond the simplistic duality of victim and oppressor to investigate social constructions that affect Black women's reproductive life experiences. In many ways, reproductive justice is a decentered, polyvocal, and co-created theory of justice that offers a strategy to challenge dominant narratives about the experiences of marginalized people (Ross & Solinger, 2017). The framework of reproductive justice was coined and disseminated because of the need for a theory that provides a meaningful explanation of the lived experiences of women of color. Like many other advanced feminist theories, reproductive justice theory uses disciplinary and interdisciplinary resources to challenge masculinist incorporeal abstraction

theories because of the validity of the lived experiences of women of color (Ross & Solinger, 2017).

Reproductive justice operates as a belief system that helps to understand the objective and subjective conditions in which women of color live. Essentially, reproductive justice was created to articulate the rich density and textured meanings of the lived experiences of women of color. It allows an emergence of knowledge from the lived experiences of women of color to describe their relationship to the world (Ross & Solinger, 2017). The theoretical framework of reproductive justice is based on discussions on women of color about sex, sexuality, and reproduction and how current practices and norms fail to meet their unique needs (Ross & Solinger, 2017). Ultimately, reproductive justice is used to examine the processes that shape the competing ideals of equality and the social reality of inequality by pointing out the disparities.

The reproductive justice theoretical framework is uniquely fitting to this qualitative research study aiming to explore the lived experiences of Black women with PNC. Of most importance to this research is allowing Black women to tell their own stories of their experiences with the healthcare system as it relates to their choices around pregnancy and childbirth and whether it achieved or failed to meet their individual needs. This research is a stride toward reproductive justice by providing a space in the literature to share the voices and experiences of Black women, who are often the targets of medical violence, and neglect, and who bear the disproportionate burden of adverse maternal health outcomes.

This study aims to highlight the realities of inequality, systemic racism, and biases within the U.S. maternal healthcare system through the lens of Black mothers. In using reproductive justice theory, this study attempts to underscore the need to honor human rights in maternal healthcare. This study aims to divest from the boundaries of White supremacy, disengage women

of color from an alienating worldview, and contribute to the defense of a human rights culture in the United States and worldwide.

The guiding principle of this research is that race-concordant care by Black midwives who practice collectivism (Hofstede, 1991) and culturally informed care (Airhihenbuwa, 1995), can bolster women's social and cultural capital (Bourdieu, 1986), enhance the quality of care for Black women (Donabedian, 1966; Wilde et al., 1993), and as a result, improve utilization of PNC and health outcomes for birthing Black women (Altman et al., 2020; Ellerby-Brown et al., 2008; Saha & Shipman, 2007; Terreri, 2019; Wren Serbin & Donnelly, 2016).

Problem Statement

Women in the United States and across the globe are suffering from a preventable health problem. Although maternal mortality is largely preventable, progress toward ending the problem has not been achieved (Sajedinejad et al., 2015). The United States has failed to meet global health and national health goals to improve maternal health and reduce maternal mortality (UN, 2012; U.S. Department of Health and Human Services [USDHHS], 2020). The MMR in the United States has actually increased in the last two decades (Galvin, 2020; WHO, 2000).

The Black maternal health crisis is the problem this research aims to address. The MMR for Black women (about 40.8 per 100,000 live births) is almost four times higher than that of White women (about 12.7 per 100,000 live births; CDC, 2019b). Preventable maternal deaths represent a national health crisis of enormous magnitude. The current maternal health crisis merits the attention it is now receiving from the highest level of government in the first-ever White House Maternal Day of Action Summit (Harris, 2021). Through this call to action, Vice President, Kamala Harris, advocated for initiatives to examine the quality of maternal healthcare and support for policies like the Black Maternal Health Momnibus Act to improve maternal

healthcare and expand the maternal health workforce to include midwives (Harris, 2021). Two exigent needs to tackle the Black maternal health problem include improving the quality of PNC for Black women and the promotion of Black midwives.

Black midwives are essential in the fight against maternal mortality and can offer a solution to the disproportionate burden that Black women bear in maternal healthcare. Black midwives are uniquely positioned to provide high-quality care to communities of color (Wren Serbin & Donnally, 2016). Minoritized patients tend to receive better interpersonal care in race-concordant interactions (where patient and practitioner are of the same race; Goode, 2014; Saha & Shipman, 2007). Despite a long history of midwifery practice in Black culture, today, less than 5% of the nation's midwives are Black (Ellerby-Brown et al., 2008; Goode, 2014). The current midwifery workforce is largely White and does not adequately represent the diverse population of women they serve. A racially balanced midwifery workforce with adequate representation of Black midwives and the ubiquitous provision of high-quality, culturally informed PNC can help ameliorate racial disparities in maternal health, yet neither has been achieved.

The underutilization of PNC results in poor maternal health outcomes (Sander-Phillips & Davis, 1998). Black women are less likely to utilize PNC compared to their White counterparts (Oparah et al., 2017). The underutilization of PNC by Black women is in part due to the low quality of care they receive (Howell, 2018). Black women, women in poverty, and working-class women report dissatisfaction with traditional PNC because it feels rushed, impersonal, and indifferent (Davis-Floyd & Sargent, 1996).

Black women are facing dangerous healthcare disparities, and Black midwives are arguably a viable solution to the problem (Kroening, 2021). However, there are not enough Black midwives to represent the diverse population of women who use midwifery services.

While 45.6% of the people who use midwives are non-White, only 12% of midwives are non-White (Kennedy et al., 2006). High-quality, culturally informed PNC requires diversity in maternal health providers (Kennedy et al., 2006), which is lacking in the present-day midwifery workforce.

Purpose of the Study

The purpose of this study is to conduct a qualitative exploration of Black women's experience with maternal healthcare. The study seeks to understand how race, culture, and the healthcare system shape Black women's experiences and interpretation of the quality of care they receive. Examining the lived experience of Black women who receive PNC can provide a bridge to identifying and understanding the problem with the quality of PNC and inform a change in the way maternal care is delivered. Illuminating the voices of Black women to propel change in the way PNC is delivered is fundamental to the purpose of this study. Qualitative studies of maternal healthcare satisfaction demonstrated the usefulness of qualitative research to reveal what women desire in their maternal health experience to drive change (Hagaman et al., 2022).

This study contributes to the body of research regarding knowledge of the experience of Black women with PNC and provides a framework for future examination. Study findings will crystallize Black women's perceptions of the quality of PNC and enable a contrasting view on traditional PNC versus the midwifery model of care with Black midwives. Findings from this study will bolster a shift in the paradigm of PNC to one that is more efficient in an increasingly diverse and multicultural population (Gándara & Mordechay, 2017; Mordechay et al., 2019). Changing how prenatal care is delivered can potentially help solve the problem of preventable maternal death. The quality of prenatal care is a critical lever to combat maternal mortality

globally and nationally. High quality of prenatal care through a diverse midwifery workforce that includes an adequate representation of Black women can help increase the utilization of prenatal care by Black women and, as a result, ameliorate maternal health racial disparities.

Most research into maternal mortality among Black women has focused on biological factors such as body weight and pre-existing conditions, which has not been effective in improving the healthcare experiences of Black women (Oparah et al., 2017). Emerging data shows that the quality of PNC may be more important than the quantity of PNC visits, but there is paucity of theoretical-based research on the quality of PNC (Sword et al., 2012). Besides a lack of theory on the quality of PNC, few studies have considered women's perspectives on the quality of PNC, with much of the focus being on the medical or clinical aspects of care while excluding the interpersonal processes (Sword et al., 2012). Studies that examine Black women's perspective on the quality of PNC are even more limited (Michells, 2000; Oparah et al., 2017). There are few clinical trials in which racial-ethnic women have been the focus of the research (Flores et al., 2021). This study aims to fill a gap in the research on the quality of PNC for Black mothers and develop a novel theoretical framework to define and elucidate the Black women's perspective on the quality of PNC.

The systematic discrediting, devaluing, and elimination of Black midwives and the cruel treatment of Black women by the hospital system have been well documented, yet there are almost no studies focusing on the experiences of minoritized women (Davis-Floyd & Sargent, 1996; Flores et al., 2021). The root cause of maternal health racial disparities can be successfully addressed with research that examines the unique experiences of Black women receiving care for pregnancy and childbirth by midwives (Pranther et al., 2018). A focus on the lived experiences

of Black women is significant to inform prevention efforts to end racism and its health-related impacts on Black women (Pranther et al., 2018).

Black women have been historically blamed for their adverse health outcomes (Davis, 2019; Roberts, 2017). Black women's adverse birth outcomes are typically discussed in terms of what the women do, such as drinking alcohol, smoking, being single, having low income, and having a poor diet that leads to obesity, hypertension, and diabetes (Davis, 2019). There has not been a critical analysis of the healthcare system's role in perpetrating healthcare disparities. For that reason, this research aims to evaluate the quality and effectiveness of the maternal healthcare system from the perspective of Black women.

Research Questions

The following research questions will guide this study:

1. What are Black women's perceptions of the quality of PNC via the traditional medical model?
2. What are Black women's perceptions of the quality of PNC via the midwifery model by Black midwives?
3. How does the Black women's perception of the quality of care in the traditional model of PNC compare to the Black women's perception of the quality of care in a race-concordant midwifery model of PNC?

Importance of the Study

This study underscores the importance of a diverse and inclusive midwifery workforce as key to improving the quality of PNC for Black women. The study aims to contribute to the current literature on the importance of Black midwives for Black mothers and incentivizes strategies to promote diversity in the midwifery workforce. It aims to promote alternative PNC

models that provide high-quality, high-quality, culturally informed care to increase utilization of and satisfaction with PNC among Black women who are disproportionately plagued with poor-quality PNC and maternal mortality.

The experience of Black women with PNC and their perspective of the quality of PNC is at the center of this investigation. Qualitative methodology is useful to elicit pertinent data about the lived experiences of Black women as recipients of traditional PNC and the midwifery model of PNC. Employing qualitative methodology provides an opportunity to examine personal perceptions of Black women about the quality of care of two different modalities of pregnancy and childbirth care. This unique perspective allows an understanding of the lives of those most vulnerable to poor maternal health outcomes.

The promotion of PNC to mitigate poor maternal health outcomes has historically focused on early onset and quantity of PNC visits rather than the improvement of the quality of care (Sword et al., 2012). Quality PNC is a critical lever to address maternal health racial disparities (Howell, 2018). The midwifery model of care with Black midwives can be pivotal to the improvement of the quality of PNC for Black Women and, as a result, may help combat the MMR and ameliorate maternal health racial disparities.

Definition of Terms

- *Black Women:* Black, African American, Afro-Latina, Afro-Caribbean, and women of African descent (Oparah et al., 2017).
- *Doulas:* Those who serve as alternative caregivers because their philosophy of care is aligned with the midwifery model of care, which is holistic. They differ from midwives in that they do not provide medical care and instead focus on

complementary health services such as education, assistance, and labor support (Adams & Thomas, 2017).

- *Grand Midwives:* Black midwives, who often were older women and experienced in assisting women during labor and birth, were known in their communities as "granny" midwives (Logan & Clark, 2014; Robinson, 1984; Thompson, 2016). The term "granny midwives" was carried on from slave days and today the name is considered by some to be disrespectful, so it has been rebranded to grand midwives in honor of their legacy (Greenfield, 2019; Hallerman, 2021; National Black Midwives Alliance, n.d.).
- *Group Prenatal Care (GPNC):* Prenatal care that is delivered in a group setting where pregnant women of similar gestational age gather together with their respective medical providers (Novick et al., 2011).
- *Lay Midwives:* Midwives who did not receive any formal training and learned their trade as apprentices from their grandmothers, mothers, or other senior midwives in the community (Canty, 2020).
- *Maternal Mortality:* Pregnancy-related death (WHO, 2018).
- *Midwives:* A responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labor and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant (International Confederation of Midwives [ICM], 2017).
- *Nurse-midwives:* Graduate-level educated midwives who pass a national certification exam, have an active registered nurse license, and whose scope of practice

encompasses a full range of primary health care services for women from adolescence beyond menopause, including the independent provision of primary care, gynecologic, and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections (American College of Nurse-Midwives [ACNM], 2021).

- *Prenatal Care (PNC):* Specialized healthcare service to pregnant women during the entire length of pregnancy, starting from pre-conception to postpartum (Howell, 2018).
- *Quality of Care:* The extent to which healthcare services meet desired health outcomes and patient expectations by providing safe, efficient, timely, effective, equitable, and patient-centered care (WHO, 2020).
- *White Women:* Non-Hispanic White women.
- *Women of Color:* A term with political and ideological meaning, not seen as a biological designation used to define solidarity and a commitment to work in collaboration with other oppressed women who have been marginalized and minoritized, including, but not limited to Black women, Latino women, and African American women (Ross et al., 2017).

Chapter 2: Literature Review

Overview

This literature review begins with a historical analysis of childbirth and maternal healthcare practices in the United States, followed by a detailed historical exploration of the role and impact of Black midwives on maternal healthcare. The literature review further explores cruelty endured in maternity wards from physician-dominated births and the dynamics that led to the present-day midwife suppression. From there, literature on the topics of discourse, authoritative knowledge, social capital, and cultural capital are discussed. Finally, the literature review ends with a discussion of reproductive justice and the importance of Black midwives for Black mothers to ameliorate racial disparities in maternal mortality.

In the following paragraphs, a comprehensive examination of the multifaceted dynamics contributing to racial disparities in maternal mortality is provided. The exploration begins with a historical analysis of childbirth, midwifery, and medical practices in the United States, and it culminates with a deconstruction of the present-day medicalization of childbirth. The narrative frames the problem of racial disparities in maternal health outcomes as attributed to a variety of factors, including the sparsity of Black midwives (Goode, 2014; Wren Serbin & Donnelly, 2016), racism (Prather et al., 2018), low-quality PNC (Howell, 2018) and the medicalization of childbirth (Cahill, 2001).

The importance of the role Black midwives have in reducing racial disparities in maternal health outcomes is explained (Adams & Thomas, 2017; Goode, 2014; Novick et al., 2011; Sanders-Phillips & Davis, 2017). The premise of this review is that race-concordant pregnancy care by Black midwives (Saha & Shipman, 2007) is innately culturally reverent (Airhihenbuwa, 1995), collectivist (Hofstede, 1991), and can facilitate the cultivation of women’s social and

cultural capital (Bourdieu, 1986). This type of empowerment embedded into race-concordant PNC based on the midwifery model of care has the potential to enable women with authoritative knowledge (Jordan, 1992) in childbirth, enhance the quality of care (Donabedian, 1966; Wilde et al., 1993), and as a result increase utilization of PNC by Black mothers and ameliorate race-based disparities in maternal health.

Social Birth at Home

Before the 17th century, in most parts of the world, birth was exclusively a female dominated event that took place in the home (Johanson et al., 2002). When the English settled in the United States, they brought traditional English practices that made birth the exclusive province of women for most of the colonial period (Wertz &Wertz, 1989). Women harbored all knowledge and control surrounding birthing practices, while men were excluded from the event by laws and customary norms (Leavitt, 2016; Wertz & Wertz, 1989). For centuries, female midwives were the gatekeepers of pregnancy and childbirth (Banks, 1999; Edwards & Waldorf, 1984; Leavitt, 2016; Wertz & Wertz, 1989; Yankauer, 1983). The customary practice was that expectant mothers would seek out the help of female midwives for a skillful assistance with their childbirth (Wertz & Wertz, 1989).

The success of childbirth depended on the medical skills of a midwife in addition to the attendance of various female friends, family and community members who provided emotional and practical support in the home (Leavitt, 2016; Wertz & Wertz, 1989). Women attended births because they sought to hearten the expectant woman, share their own knowledge and experiences of birth, and to prepare themselves for their own future deliveries (Wertz & Wertz, 1989). Childbirth was an opportunity for women to gain confidence and psychological support through social interactions that provided an undeniable medical value to women (Wertz & Wertz, 1989).

The Shift from Home to Hospital

The empowerment that women cultivated from social home births was truncated once birth was removed from the home setting. An unfolding of various interdependent political events led to the eventual usurpation of childbirth from midwives at home by physicians in the hospital. The impetus for the shift from home to hospital birth was women's view of birth as a painful, health-hazardous event (Kaplan, 2012). Women's desire for safer, painless, and more controlled births propelled the transition to the hospital setting for births.

The notion that births were pathological became the zeitgeist of the 17th century (Wertz & Wertz, 1989). Childbirth presented a time of high-risk for maternal death (Kaplan, 2012). Women who survived home births frequently suffered from lifelong morbidities like fistulations from unrepaired lacerations, incontinence, painful intercourse, and difficulty with future pregnancies, which incentivized their desire for medical intervention (Kaplan, 2012). Without evidence of any proven medical advantage or increase in maternal satisfaction, women's perception of pregnancy as an illness was the impetus for the transition to medicalized childbirth (Cahill, 2001).

Before the 1900s, birth statistics in the United States were nonexistent (Yankauer, 1983). Midwives had no record of having caused epidemics or infections during the birth process (Wertz & Wertz, 1989). A distinguished medical historian calculated that Black midwives in Virginia spread less infection than did doctors, who were responsible for an outbreak of birth infections (Wertz & Wertz, 1989). However, the fear of death related to childbirth and doubt in female midwifery competence began to slowly grow in the 17th century. Women's perception of birth began to change once fear around the safety of birth was cultivated. The construct of birth

as an illness became the model that led to the inception of male physician managed hospitalized births in the 1760s (Leavitt, 2016).

Hospitalized Births

The 17th century represented a major turning point for the field of medicine after the acceptance of Cartesian philosophy, which made a pivotal distinction between the physical body and the spiritual mind (Cahill, 2001). Descartes revolutionized medicine by claiming a dualism of the mind and body, contrary to the orthodox Christian belief of the oneness of the mind and body. This philosophy unleashed the religious view of the physical body, enabling medical practice to govern the human body medical revolution later allowed medical authority to penetrate governance into women's health (Cahill, 2001).

Physicians' active intervention in birth procedures with instruments and drugs contributed to the change in Americans' perception of birth from being a normal physiological event to an event that could be remedied and manipulated by doctors (Leavitt, 2016). Although physician-managed hospital births began to gain popularity, the larger part of society believed that midwives were more competent than the inadequately trained general medical practitioner (Yankeur, 1983). Before the invention of forceps, male physicians had only been involved with difficult deliveries, using destructive instruments that resulted in many maternal and infant deaths (Johanson et al., 2002).

The transition from home to standardized hospital-based births managed by formally trained physicians resulted in a paradigm shift in the norms of maternal healthcare. This change in birth practice was prompted by women's desire to have a safer and more controlled birth (Leavitt, 2016). However, the promises of a safer and more comfortable birth in the hospital setting by physicians were unrealized. Women who sought hospitalized births relinquished their

reproductive rights; control; and social and cultural capital to the dominance of White male physicians.

White Male Physician Dominance of Births

For centuries, birth was regarded as a natural human process managed by the care of skilled midwives and supportive women in the community. By the late 19th century, society changed its ideology around birth and framed it as a life-threatening event that required medical intervention (Banks, 1999). Women began to choose hospitalized births because of their desire to have safe and controlled births (Leavitt, 2016), but hospitalized birth was a choice only privileged middle-and upper-class White women could afford. The paradox of childbirth was that women's desire to secure control over birth steered their surrender of power to the male physician dominance of birth.

As hospitalized childbirth became more common practice in the 20th century, male physicians became the new authority over birth practices and revoked women's control over childbirth (Leavitt, 2016). Physicians effectively executed a smear campaign against midwives that resulted in their exclusion from the birth process. A disparaging discourse about midwives was driven by a body of mostly White male obstetricians who described the birth process as a horrifying ordeal that required the aid of surgical intervention rather than care from incompetent midwives (Edwards & Waldorf, 1984).

The female midwifery workforce began to plummet as a result of its victimization by a combination of destructive forces driven by White male physicians to monopolize the childbirth process. Midwives were delegitimized, women were discouraged from practicing medicine, doctors insinuated female midwives were incompetent and projected severe competition against physicians (Cahill, 2001; Wertz & Wertz, 1989). The exclusion of female midwives from birth

work gave obstetricians a sexist bias by making maleness a necessary attribute of safety, and femaleness a condition in need of male medical control (Cahill, 2001; Wertz & Wertz, 1989). Eventually, midwives began to largely disappear from the birth setting, except for in Black, ethnic, immigrant, and poor and isolated White communities (Wertz & Wertz, 1989).

Black Midwives

In the early 1900s, midwives attended to 50% of all births in the United States, and in Black, indigenous, and immigrant communities, midwives attended to 90% of births (Niles & Drew, 2020; Thompson, 2016). Some midwives were White, but before the 20th century, most midwives in the Northeast were immigrant women, and most midwives in the South were Black women (Thompson, 2016). The Deep South harbored a legacy of midwives deeply engrained in the Black culture (Ellerby-Brown et al., 2008; Goode, 2014; Goodwin, 2020; Luke, 2018; Terreri, 2019). The root of Black American midwifery transcends from the arrival of slave ships in the 17th century to the Black midwives who attended births well into the 1950s (Bonaparte, 2007; Goode, 2014; Robinson, 1984). African remedies and birthing traditions were secretly passed down through generations and circulated through Black midwives (Logan & Clark, 2014; Luke, 2018; Robinson, 1984; Smith & Holmes, 1996; Townes, 1998).

In the early 17th century, the slave trade brought many enslaved Africans to the United States, and among them were women with generations of knowledge, traditions, folklore, and art related to the midwifery practice from their mother country (Ellerby-Brown et al., 2008; Robinson, 1984; Terreri, 2019). Certain women from West African villages were strategically captured for their knowledge and skills on birthing practices to be used on American plantations where enslaved Black midwives were to deliver babies for other enslaved women and their slave owners (Hallerman, 2021). African midwives handed down the skill of midwifery from mother

to daughter in an apprenticeship model and kept strong ties to African-based rituals and customs (Bonaparte, 2007; Ellerby-Brown et al., 2008; Hallerman, 2021; Robinson, 1984).

Midwives traditionally occupied a prominent position in Black communities as advocates, healers, and spiritual leaders (National Museum of African American History and Culture, 2022; Robinson, 1984). Midwives believed they were called by God, through visions and dreams, to pursue the vocation of birth work (Robinson, 1984). Many midwives were said to be born with “the veil,” which symbolized a special connection to the spiritual world (Maxwell, 2009, p. 4). “The veil” refers to a unique perspective of the world, known as the “second sight,” that enabled midwives to have a deep understanding of the world (Maxwell, 2009, p. 5).

The abolition of the international slave trade in 1807 presented a threat to the booming cotton industry that relied heavily on the work of slaves, and thus became the catalyst for slave owners’ dependence on the natural reproduction of enslaved people for business sustainability (Davis, 1981). Slave owners’ focus on the reproductive health of enslaved Black women was about breeding humans, a significant form of investment for the slave owners who aimed to have healthy births and babies for monetary gain (Hallerman, 2021). Black women were dehumanized and used as tools for reproduction to increase the workforce and profit for slave owners. Enslaved Black midwives labored under inhuman conditions and received no compensation, but generated income close to multi-billions of dollars for slave masters (Robinson, 1984). The dependence on the growth of the domestic slave population placed a premium on the enslaved woman’s reproductive capacity (Davis, 1981).

The so-called father of American gynecology, J. Marion Sims, conducted hundreds of experimental, non-anesthetized surgeries on enslaved women in his plantation from 1845 to 1849 (Smith & Holmes, 1996; Townes, 1988). He performed 13 experimental surgeries within four

years on an enslaved Black woman named Anarcha, until he finally succeeded in the repair of a vaginal fistula (Townes, 1988). The repair of vaginal fistulas was an essential revolution to the reproductive health of enslaved women. Doctors, at the behest of slave owners, attempted to manage enslaved women's reproductive health, sexuality, fertility, and childbirth to increase slave owners' revenue via slave labor (Luke, 2018). Since the first documentation of Black women's reproductive health, in the 1680s, there has been an exceptionality placed on Black women's fecundity. Black women have been depicted as being exceptional at production, especially after the slave trade ended and the nation's economic growth depended on the offspring of enslaved women, who would inherit the slavery status (Cooper & Pimentel, 2021).

The history of American obstetrics is painfully intertwined with slavery, with impacts on the current maternal health disparities. The pioneer status in obstetrics that Dr. Sims was able to achieve after his successful repair of the vaginal fistula required a fundamental dehumanization of Black women. His elitist recognition in obstetrics was only achieved with the indispensable assistance of three medically trained, illiterate, enslaved Black women named Lucy, Betsey, and Anarcha (Cooper & Pimentel, 2021). Originally, Dr. Sims, a slave owner, was assisted by two formally educated, White male surgical assistants, who could not help him succeed with the repair of the vaginal fistula. Later he trained and sought help from enslaved Black women, Lucy, Betsey, and Anarcha (Cooper & Pimentel, 2021). It was not until Sims received assistance from Lucy, Betsey, and Anarcha, that he was able to find a solution to the vaginal fistula, and these heroines, whose stories remain largely untold, are now being recognized as the mothers of gynecology (Cooper & Pimentel, 2021).

Grand Midwives

American obstetricians have a long history of not listening to, caring for, or attending to Black women. Contrary to medical doctors who historically treated Black women inhumanely and only provided medical attention motivated by greed, Black midwives labored with love. The domestic work of midwives to heal and tend to the needs of women, men, and children was of maximum importance in the social life of slaves because it was the only meaningful labor for the slave community (Davis, 1981). Given the egregious treatment of Black people by White physicians, enslaved people favored the care of midwives over doctors. The commitment to provide high quality care to the Black community in the face of a violent and racist medical regime is a legacy that Black midwives cultivated from the nation's inception.

Midwives were the solace of enslaved people with illnesses, pregnancy, and childbirth. When enslaved people became ill, they were required to report their infirmities to overseers who would then refer them to physicians for treatment. The health of enslaved people often became worse after treatment from medical doctors (Townes, 1998). Due to the legacy of harm that Black people endured at the hands of White medical doctors, a reliance on midwives, older women, and indigenous healers was preferred rather than reporting illnesses to overseers (Smith & Holmes, 1996; Townes, 1998).

The reliance on the legacy of trustworthy midwives in the Black community continued through generations beyond slavery and grew even stronger in the post slavery era through the work of Black midwives. After the slavery period, midwives continued to be an integral part of life in the South for the Black community who did not have access to standardized healthcare. Midwives were the preferred caretakers in Black communities because of the level of trust that they harbored (Hallerman, 2021). The trust and reliance on midwives as leaders in healthcare within the Black community is fundamental to the transgenerational legacy of Black midwives.

Black midwives, who often were older women and experienced in assisting women during labor and birth, were known in their communities as “granny” midwives (Logan & Clark, 2014; Robinson, 1984; Thompson, 2016). The term “granny midwives” was carried on from slave days and today the name is considered by some to be disrespectful, so it has been rebranded to grand midwives in honor of their legacy (Black Midwives Alliance, n.d.; Greenfield, 2019; Hallerman, 2021). For generations, grand midwives were the sole providers of maternity care to most women in the South (Luke, 2018; Robinson, 1984; Tunc, 2010). Pregnancy care for Black women was rendered solely by Black midwives from the 1600s to the mid-1900s (Robinson, 1984; Tunc, 2010).

At the turn of the century, the average cost of a midwife’s services, which included PNC, labor support, childbirth, after birth care, housekeeping, and mother assistance with newborn care and childcare, was between $2-$10, while a physician charged between $10-$25 just for a delivery (Thompson, 2016). The payment received by midwives for birth work varied within communities, and many times midwives received gifts instead of cash payment (Robinson, 1984). Women of color preferred Black midwives because of the low cost of care and the psychological support, unique comfort, and the practical help that Black midwives provided (Thompson, 2016). Black midwives served their communities tirelessly and provided care for generations of families, including White plantation owners (Niles & Drew, 2020).

Grand midwives delivered care to the women they served beyond their birthing needs. During the birthing experience, midwives assisted women with household chores, cooking, cleaning, and childcare (Logan & Clark, 2014). Maude Evelyn Daniel Callen, a nurse-midwife known as “Angel in Twilight” in the early 1900s, taught an innumerable number of children how to read and write, held immunization clinics in local schools, distributed clothing and supplies to

the needy, helped with transportation needs for the gravely ill, started the United States' first venereal disease clinic and provided nutritional support to community health clinics (Maude Callen Clinic, 2017).

Grand midwives established a system of mutual aid, self-help, cooperation, and assistance that grew out of kinship, neighborhood, church, and family connections (Smith & Holmes, 1996). Fundamentally, grand midwives provided essential health and social services for the most vulnerable women in the United States. Many Black midwives like Maude Callen, were the sole healthcare providers to many former enslaved men and women who were left without access to basic medical care after the Civil War and through the Jim Crow era (Maude Callen Clinic, 2017).

In the early 1900s, Beatrice Borders, a Black lay midwife known as Granny Doctor owned and operated the only Black owned birthing center in Georgia and cared for many White women who, as customary practice stemming from the antebellum years, wanted their own private nurse (LaVern, 2019). The legacy of outstanding humanitarian work by Black midwives was omitted in state and national historic registries (LaVern, 2019). The hostility that Black midwives endured from White physicians stands in stark contradiction to the admiration and respect grand midwives earned in their communities (Smith & Holmes, 1996).

Grand midwives were medical providers for both Black and White families in the South. Due to physicians' poor training and philosophy of interference in birth, lay midwives delivered safer care than the average physician (Devitt, 1979). Although grand midwives filled a void in healthcare for the most vulnerable and marginalized communities, they were humiliated, villainized, and ostracized by medical doctors (Logan & Clark, 2014; Luke, 2018; Smith & Holmes, 1996). As Goode (2014) stated,

> It is interesting that despite being labeled as dark, dirty, evil, ignorant, unfit, untrained, and incompetent, the value of early Black and immigrant midwives, specifically to the burgeoning obstetrics profession, is that they worked with 50% of the nation's population at the time. (p. 12)

Persecution of Grand Midwives. Despite a demonstrated record of safe birth work, the American Medical Association (AMA) executed a campaign in the early 20th Century to mar women's faith in midwives (Wilkie, 2003). Obstetricians of the South were largely responsible for the high national MMR in 1910, but they condemned midwives for the problem (Logan & Clark, 2014; Smith & Holmes, 1996). Doctors were never scrutinized for the MMR even though White women who received medical care by doctors had higher MMR than poor and rural Black women who received midwifery care (Smith & Holmes, 1996).

The despotism of doctors, who self-proclaimed their medical supremacy, labeled grand midwives as incompetent, inept, obsolete, unsanitary, and overall dangerous (Luke, 2018; Wilkie, 2003). Physicians believed that the Black nervous systems were inferior to White nervous systems and child-like and thus Black people necessitated absolute dependence on Whites (Townes, 1998). This belief denigrated the intelligence of Black people and influenced medical doctors' belief in Black midwives' inability to function independently (Luke, 2018). Medical doctors formed an organized course of action against Black midwives based on the eugenic ideology of the inferiority of Black people. Obstetricians used racist campaigns as tactics to gain authority in the maternal healthcare industry, which was necessary for obstetricians to gain recognition as a medical specialty (Dawley & Walsh, 2016). Racist and misogynistic campaigns were strategically designed to persuade public opinion and achieve maternal healthcare reform (Goodwin, 2020).

The professionalization of medicine created conflict between obstetricians and midwives (Maxwell, 2009). Doctors saw midwives as competitors and feared midwives were blocking their professional status and revenue from birth work (Thompson, 2016). Eventually, gynecologists revealed that they minimized and excluded midwives from maternal healthcare for selfish financial gains, recognition, and control (Goodwin, 2020). Medical doctors persecuted grand midwives to eliminate them from practice and thus obtain medical hegemony.

Elimination of Grand Midwives. As slavery came to an end, grand midwives represented a real threat to and competition for the emerging workforce of White male obstetricians and gynecologists who sought to enter the practice of childbirth (Goodwin, 2020). Physicians documented their advocacy for the elimination of grand midwives with various articles published in multiple medical journals (Bonaparte, 2007; Goode, 2014). For example, Dr. Thomas Darlington, Commissioner of Health for New York City, wrote that grand midwives were dirty, ignorant, and totally unfit for the healthcare services she provides (Goode, 2014). Doctors began to frame the narrative that criminalized midwives as “the midwife problem,” and used this discourse as their centerpiece in the anti-midwifery campaign (Goode, 2014, p. 12).

The decline of the Black midwifery workforce was in part due to the Sheppard–Towner Act of 1921, which resulted in the mainstream regulation of Black midwifery practice in the South (Devitt, 1979; Tandy, 1937). Moreover, in 1948, there was a push to standardize medicine and eliminate lay healers, which was propelled by the formation of the American Medical Association (AMA; Robinson, 1984). Many women were forced to transition pregnancy care from midwives to physicians with the inception of the standardization of medical care for pregnancy and childbirth (Tunc, 2010). This trend, along with the subsequent regulation from the Sheppard–Towner Act, resulted in the gradual elimination of many Black midwives (Yoder &

Hardy, 2018). By 1972, 1% of all births in the United States were attended by midwives (Devitt, 1979).

Midwives were declared illegal in 1976 (Logan & Clark, 2014). Renowned midwives in the South with impeccable birth records like Margaret Charles Smith and Onnie Lee Logan were barred from birth work (Logan & Clark, 2014; Smith & Holmes, 1996). Although lay midwives commonly supervised births for Black and White women in the South, state legislature required midwives to be licensed and supervised, and many found their requests for license renewals were denied, which effectively forced them to retire (Wilkie, 2003).

The Effect of Eradicating Black Midwives

Once the prevalence and utilization of hospital births grew in popularity and male physicians began to attend more births, the presence of a male authority figure changed the power structure in birthing practice in the United States (Thompson, 2016). The power shift created a new form of maternal healthcare practice that nullified women's authority over their own bodies and birthing experiences. The eradication of midwives left Black and immigrant women, who relied more heavily on midwives, more severely affected. The elimination of grand midwives was not only detrimental to vulnerable communities of color, but to the reproductive rights of all women who benefitted from the protection and support of uniquely skilled, culturally competent Black midwives.

According to Shafia Monroe, dubbed "Queen Mother of a Midwifery Movement," the systemic eradication of African American midwives from Black communities was one of the darkest moments in the nation's history, which resulted in a legacy of birth injustices (Terreri, 2019). The effects of the eradication of Black midwives produced disadvantages to the

reproductive health of women, the wellbeing of their communities, and to the American midwifery profession as a whole.

Black grand midwives played a vital role in both caring for their communities and contributing to the American midwifery tradition and skills (Quickening, 2021). Not only were Black midwives essential to the livelihood of their communities; they were also an integral part of the foundation of American midwifery birthing practices. Black midwives like Onnie Lee Logan, Mary Coley, Margarete Charles Smith, Biddy Mason, Gladys Nichols Milton, and many of their unnamed counterparts, were heavily influential in the establishment and sustainability of the art and science of American midwifery (Quickening, 2021).

Black midwives provided a unique service to Black and White families for generations. A midwife’s pivotal position in the community, as a transmitter of culture, folklore, health, and spirituality, was a source of empowerment and an unprecedented level of healthcare (Luke, 2018; Robinson, 1984). The eradication of grand midwives had a profound impact on all women, particularly Black women. Once grand midwives were eliminated, women had to succumb to physician-led hospital births (Wilkie, 2003). This meant that in one of the most racially charged eras in American history, the health of Black women was placed in the hands of negatively predisposed White male physicians (Thompson, 2016). As a result, many Black women in the Jim Crow South avoided medical attention for birth (Logan & Clark, 2014; Luke, 2018; Stoney, 1952).

The damaging discourse spread by the anti-midwifery campaign was not founded on factual data, statistics or premised on quality-of-care measures. The anti-midwifery campaign was an unfounded racist and sexist attack by White male professionals on the entire class of midwives of color (Thompson, 2016). The anti-Black racism and xenophobia attacks by male

White supremacists in healthcare convinced Black women and northern immigrants that midwives were to be bypassed and that a responsible mother ought to seek out the care of White male physicians, who were presumed to be the experts on the disease of pregnancy (Niles & Drew, 2020).

The damages of systemic racism on the health and wellbeing of the Black community have been pervasive and extensive. The appendages of racism are evident within the healthcare system, medical organizations, medical discourse, health policies and laws that were strategically designed to eliminate Black midwives and subsequently harm the people they served. The nation continues to suffer the consequences of the elimination of Black midwives from the community and the entire women's heath arena.

Elimination of Black Midwives from the Nurse-Midwifery Profession

As a direct result of the anti-midwifery campaign and The Sheppard-Towner Act, a group of White public health nurses emerged who perpetuated oppression against Black midwives and maternal health racial disparities. The Sheppard-Towner Act espoused support to end maternal and infant mortality, yet in practice, it became another tactic against Black midwives (Thompson, 2016). It established a hierarchical model in which White public health nurses were given the power to dictate which midwife, from a group of predominantly Black midwives, had the potential to be trained and which midwife should be eliminated from practice (Thompson, 2016). Again, the fate and livelihood of Black women, in this case, Black midwives, were placed in the hands of negatively predisposed White authoritative figures, the public health nurses.

White public health nurses provided healthcare that was neither culturally congruent nor women-centered while supervising Black and immigrant midwives on the proper techniques of care (Niles & Drew, 2020). These White public health nurses evolved their scope of practice to

become nurse-midwives and served to further the agenda of the White supremacy movement in maternal healthcare. The former public health nurses who became nurse-midwives, did not help redeem and recover the once prominent and diverse workforce of midwives, but instead worked as a racial and class barrier to the profession (Thompson, 2016).

White nurse-midwives controlled, suppressed, and eliminated the Black, Indigenous, and immigrant midwives from the profession during 1920-1945, both as teachers and as state agents of legal and regulatory enforcement (Niles & Drew, 2020). Mary Breckinridge was a White supremacist, eugenicist, and granddaughter of a former U.S. president, who started the nation's largest nursing education program. She prohibited Black nurses from entering the program and denounced the work of local grand midwives as a strategy to monopolize the region's maternal healthcare (Niles & Drew, 2020).

Cruelty in Maternity Wards with Physician-Dominated Births

Doctors during the 19th century were classified into two groups: (a) the elite doctors who graduated from prestigious medical schools and (b) the poorly educated doctors who graduated after a few months without any practical or clinical knowledge (Wertz & Wertz, 1989). The majority of the 19th-century doctors were poorly educated and were ill-prepared to manage the complexities of early hospital births which resulted in catastrophic birth outcomes for women. Women who intended to have more control of their births were instead subject to the inhumane operations of hospital births.

Between 1910 and 1913, maternity care by obstetricians was deplorable and about half of all deliveries in America were still performed by unlicensed midwives (Logan & Clark, 2014; Smith & Holmes, 1996; Yankauer, 1983). By the 1920s, birth moved from home to hospitals, but only for those who could afford it (Wertz & Wertz, 1989). Wealthy women pressed physicians to

use drugs such as ether, chloroform, and scopolamine-morphine (or twilight sleep) for a painless birth. However, poor training, lack of standardization, and improper use of anesthesia caused many complications and fatalities for mothers and babies (Kaplan, 2012; Leavitt, 2016).

By 1930, midwives only attended 15% of all births in America, mostly in the South, where there was a physician shortage and a high population of Black, poor, and rural citizens (Logan & Clark, 2014). During most of the 20th century, the unique political, social, and economic climate of the rural South forced dependence on grand midwives who fervently served their communities and provided care for most birthing Black women (Luke, 2018; Smith & Holmes, 1996; Stoney, 1952). In 1933, midwives were banned from mainstream birthing, only left to serve the Black population of the rural South (Yankauer, 1983). The decrease in midwifery practice allowed for the White male physician dominance of birth and with it, an increase in the incidence of cruelty in maternity wards.

In the 1950s, 95% of all births happened in the hospital where women were confined to hospital beds, separated from their newborns, dehumanized, and treated as if childbirth was a life-threatening illness (Wertz & Wertz, 1989). During this time, egregious stories were told of laboring women who were strapped to tables; abandoned; neglected; forced to delay their birth to wait for a doctor, and verbally and physically abused by nurses and doctors (Edwards & Waldorf, 1984). In hospitals, women had no input into the drugs and procedures they received, which made women feel disillusioned, terrified, and distressed after childbirth (Kaplan, 2012).

The cruelty in U.S. maternity wards that occurred in the 1950s was poignantly depicted in an article by Schultz (1958). Decades later, women continue to be victimized by the violence and injustices of the healthcare system (Goer, 2010). On April 17th, 2020, in New York City, a young African American woman by the name of Amber Rose Isaac, publicly revealed disappointment

with her maternal care, and no more than four days later she died from complications related to her pregnancy and childbirth (Villareal, 2020). Unfortunately, this is a lived experience that many Black women share. The story was widespread in American news as it reveals the horrendous truth about the lethal effects of poor maternal healthcare experienced by women of color in the United States.

Black women are disproportionately affected by poor quality maternal care and by maternal death in the United States. It is important to find a solution that will provide relief for the heavier burden that Black women bear with adverse maternal health outcomes. The problem of maternal health racial disparities brings into consideration the importance of Black midwives. Black grand midwives proved to be capable of providing good quality healthcare and gaining the trust of the community they served. Not only did grand midwives earn a respectable reputation within their communities, but they also established themselves as the safer option for low-risk women of color. Yet, the suppression of Black midwives and its effect on Black maternal health outcomes persist.

Present Day Black Midwife Suppression

While the U.S. population is increasingly diverse, the midwifery workforce remains mostly White. The effects of racism continue to permeate the present-day midwifery profession to systemically suppress Black midwives and Black women from the services of Black midwives. Although midwifery practice has historically been carried out mostly by women of color, over the past two decades the membership of the American College of Nurse-Midwives (ACNM) has remained more than 90% White (Goode, 2014). Evidently, the long history of racist attacks against Black midwives has had lasting effects that work to hinder the diversity, equity, and inclusion of the present-day midwifery profession.

Thompson (2016) argued that the present-day demographics of the midwifery workforce consistent with a lack of diversity are symptoms of the White centeredness of feminist and pregnancy discourse today. Additionally, the scarcity of Black midwives is intimately connected to the excessive regulation and medicalization of pregnant bodies of color that began alongside the anti-midwifery campaign. Both the anti-midwifery campaign and the medicalization of childbirth led to the vastly disproportionate and discriminatory treatment of Black pregnant women and midwives (Thompson, 2016). The racially charged regulations on midwifery practice that ousted Black women and women of color from the practice was followed by the medicalization of childbirth.

Medicalization of Childbirth

The medicalization of healthcare is centered on identifying and treating pathology rather than promoting and supporting the natural, normal functioning of the body (R. Reed, 2021). Racial disparities in maternal health are indicative of a problem with the institutionalization and the medicalization of childbirth (R. Reed, 2021). Thompson (2016) defined medicalization as, "the identifying or viewing of a condition or behavior as being in need of medical intervention, treatment or control" (p. 37). The medicalization of pregnancy and childbirth results in the excessive implementation of unnecessary and harmful interventions (R. Reed, 2021). Growing rates of maternal mortality in the face of increased hospital-based births bring to question the impact of the medicalization of childbirth (WHO, 2020).

The medical conceptualization of pregnancy and childbirth from the medical point of view is completely male-centered and patriarchal. It stems from the ideology of a patriarchal society that views the male body as the norm by which the female body is understood and thus views pregnancy as a stressor that compounds the already inferior female body (Katz Rothman,

1982). From its inception, the development of medical knowledge has been based on the male body (R. Reed, 2021). The working model of pregnancy from the lens of medicalization is one that compares it to a parasite growing inside of a woman and views pregnancy as an entirely mechanical event external to the woman rather than as a part of her (Katz Rothman, 1982).

The conceptualization of pregnancy as separate from women themselves and its objectification as dangerous to the health of women, was born of the Cartesian dualism upon which the medical gaze is based. The Cartesian model of the body views the body as a machine and the physician as the technician (Katz Rothman, 1982). In the biomedical model of Western medicine, health and disease are explained through an engineering metaphor in which the body is seen as a series of separate, interdependent systems (Townes, 1998). Thus, when the body is seen as being damaged by the illness of pregnancy and childbirth, the hospital is seen as the repair shop where the body needs to be taken to be restored. The problem with this model is that often the relationship between the mind and the body is not explored with great vigor and individuals and groups are separated from their social and cultural context (Townes, 1998).

The medicalization of childbirth has transformed the way in which a natural human phenomenon is seen as an infirmity that necessitates medical service. The medical model treats women as patients, places them in the sick role, and views pregnancy as a condition that happens to women, rather than what a woman is (Katz Rothman, 1982). While the medical model is based on dualism, the midwifery model is based on oneness, viewing pregnancy and the woman as one within an integrative and holistic approach to care (Katz Rothman, 1982).

Discourse, Authoritative Knowledge, Social Capital, and Cultural Capital

Within the medical model, healthcare social systems are rigid authoritarian hierarchies that are resistant to change and allow doctors to have unrestrained power (Goer, 2010). The lack

of balance of power in healthcare systems enables physicians to misuse power and perpetuates injustices, especially for the most vulnerable. The power that male physicians have been able to harbor in their misappropriation of childbirth under the guise of medical experts and saviors from the danger of pregnancy can be explained through medical discourse (Foucault, 1976) and authoritative knowledge (Cahill, 2001; Jordan, 1992). The pivot from home birth to hospital birth stripped women of their control, reproductive rights, human rights, and their social and cultural capital around the birthing process (Bourdieu, 1986).

For centuries women were empowered with social and cultural capital by midwife-managed social home births. The once female-centered event deeply fortified women's inherent mastery in maternal healthcare and validated their positions in the collective process. Traditional home births created opportunities for women to build social and cultural capital through shared knowledge and encouragement (Foucault, 1976). Before the medicalization of childbirth, female midwives held authoritative knowledge on childbirth. The shift away from the original paradigm of childbirth transferred the authority in childbirth to doctors. Medical discourse identified White male doctors as superior in childbirth and discredited midwives (Cahill, 2001).

In an article published in *Public Health Nurse* in 1921, the very first year of midwife regulation, the discourse used portrayed grand midwives with ineptitude, illiteracy, and in need of intervention from government health officials (Maxwell, 2009). It was common for medical journals of the mid-1920s to display images and use dialect that represented African American midwives in a stereotyped and degrading manner (Maxwell, 2009). The use of discourse aided medical doctors in acquiring authoritative knowledge of births.

Medical Discourse

In the 18th century, medical philosophy separated illness from the person. The person was regarded as only an external factor in relation to the illness (Foucault, 1976). Medicine focused on the cure of the disease through medical interventions rather than taking care of the whole person. Withholding of medical intervention was considered maleficence (Foucault, 1976). This philosophy romanticized male doctors, portraying them as the saviors of women who suffered from pathological births. The objectification of childbirth framed pregnancy as an illness that required medical remedy and stripped women from their social and cultural capital in the birthing process.

In the 19th century, medical science was characterized by its objectification of illnesses and discourse that stemmed from a body of knowledge establishing a shared consensus on the definition of disease as separate from the person (Foucault, 1969). Medicine, as an institution possessing its own rules, body of knowledge, practice, and authority recognized by public opinion and law, established the objectification of pathologies (Foucault, 1969). Since childbirth was considered a pathology in the 19th century, it was subject to medical jurisdiction and thus enabled the medicalization of childbirth.

Medicalization describes the expansion of medical jurisdiction into the realms of other previously non-medically designated problems, such as childbirth (Cahill, 2001). The process of medicalization serves the interests of medicine with an increased focus on the indicators of disease rather than the individual's experience of health and illness (Cahill, 2001). Through the application of medicine within a male-dominated group who served a large number of healthy women, a covert mechanism of social control over birth was established and was frequently seen under the guise of benevolent help to women in need (Cahill, 2001).

Although male physicians were unsuccessful in proving their self-proclaimed superiority in childbirth for many years, their monopoly over birth was achieved because of their ability to organize and establish a body of authority in the l800s through the establishment of the American Medical Association (Cahill, 2001). The process of medicalization was furthered by advances in medical technology such as instrumentation and drugs (that further reinforced women's dependence on the medical profession for the resolution of painful and complicated births; Cahill, 2001). Once childbirth was redefined as a health risk, it became a justifiable domain for medical control and intervention.

Midwives had their medical authority revoked by doctors and empirics because of the changing preferences among middle-and upper-class women, who believed that the new way of medicalized childbirth was safer and more respectable (Wertz & Wertz, 1989). The acceptance of birth as a pathological event that is only remedied by the skills of a doctor has stood the test of time. This perspective of the savior-scientist that offered protection to women against the dangers of their own pregnancy prevailed (Edwards & Waldorf, 1984). Medical doctors secured their control over birth and maintained this discourse by excluding midwives from practice.

Well into the 20th century, medical care was provided by multidisciplinary practices including midwifery, healers, and doctors who shared medical authority until the Flexner Report of 1910. This report placed the medical profession in a position of cultural authority, economic power, and political influence (Jordan, 1992). Starr (1982) defined cultural authority as the probability that definitions of reality and judgments of meaning and value will prevail as valid and true. Since the acquisition of birth work by doctors, they became in charge of the facts and authorized to determine who is sick or well, and competent or incompetent (Jordan, 1992). Once

doctors assumed authoritative knowledge in childbirth, they were able to further secure unrestrained power around birth.

Authoritative Knowledge

There has been a historical transition of authority in childbirth in the United States. Midwives held authority over birth practice until it was stripped away by medical doctors, who have since maintained their authority. When the authority of doctors grew, they began to gain social and economic power (Starr, 1982). Medical doctors primarily exercise social authority over nurses, midwives and other subordinates in the medical hierarchy as physicians aim to regulate their actions (Kumbhar, 2020). The medical hegemony of childbirth was accomplished in part through the gain of authoritative knowledge in maternal healthcare. Authoritative knowledge can be defined as a globally accepted governing body of knowledge that is structurally superior and efficacious (Jordan, 1992). The male appropriation of childbirth was buttressed by the establishment of medical authoritative knowledge.

For any domain several knowledge systems exist, some of which, by consensus, have more value than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both (Jordan, 1992). Frequently, one kind of knowledge is more dominant and legitimate than others. A consequence of establishing authoritative knowledge is the devaluation, and often dismissal, of all other kinds of knowing. Those who espouse alternative knowledge systems tend to be seen as backward, ignorant, naive, or labeled as troublemakers. Authoritative knowledge also carries the possibility of powerful sanctions, ranging from exclusions from social groups to physical coerciveness (Jordan, 1992, p. 3).

Medical doctors have been able to sustain their medical dominance in birth practice by acquiring authoritative knowledge in childbirth. Medical doctors have benefitted from exclusivity in the medicalization of childbirth by gaining legitimacy from laws and policies that empower medical doctors and exclude midwives. Although the medicalization of childbirth has become the norm in U.S. maternal healthcare, the medicalization of childbirth and the male physicians' dominance of the birthing process have failed to demonstrate a medical advantage over midwives and the midwifery model of care (as evidenced by the worsening MMR and the Black maternal health crisis in the United States).

The Fight to De-medicalize Birth. The publicized cruelty in U.S. maternity healthcare spaces in the 1950s revealed the dark truth of inhuman treatment against women in medicalized childbirth, which served to revolutionize the U.S. maternal healthcare system (Goer, 2010). Women across the nation of all races and socioeconomic statuses fight to reclaim their power over childbirth. On the contrary, medical doctors see de-medicalized childbirth as a threat to their medical authority and resist any changes to the status quo (Edwards & Waldorf, 1984). Advocacy for the protection of women's basic human rights during childbirth remains insatiate. There is an urgent need to combat injustices and institutionalized violence against childbearing women, particularly Black women, in medicalized births.

Modern medicine has helped heal the world of many global infirmities, but during normal births, it has caused a problem of excessive, unnecessary interventions that have resulted in poor maternal health outcomes. The utilization of medical interventions is rising because the maternity system was never set up to promote health or support evidence-based, woman-centered practice (R. Reed, 2021). The medical institution's fundamental aim to sustain the medical model of healthcare and control women's reproduction has proven to be effective (R. Reed, 2021).

Cultural Capital

Capital is an accumulated material or embodied form of labor which, when appropriated on a private, exclusive, basis by agents or groups of agents, enables them to appropriate social energy, in the form of concrete or lived labor (Bourdieu, 1986). Capital in its objectified or embodied forms accumulates over time and has the potential capacity to produce revenue for those who have it (Bourdieu, 1986). Cultural and social capital can be used to explain inequalities in maternal healthcare by showing how influential they have been to the changing dynamics of childbirth in American history.

Cultural capital can be embodied, objectified, and institutionalized. Embodied cultural capital can be in the form of acquired long-term knowledge. In physical and mental health, objectified cultural capital can be in the form of material possessions like medical instruments. Institutionalized cultural capital can be in the form of licensures, accreditation, and validations by governing institutions (Bourdieu,1986). Cultural capital can be broadly defined as people's symbolic and informational resources (such as knowledge, value, behavioral norms) that are acquired usually through social learning (Abel, 2008). Midwives and women in the community who were involved in the original behavioral norm of pregnancy and childbirth care, described in chapter one as the women-centered social home births, acquired cultural capital based on the knowledge and value they gained through birth work.

Empirical studies have associated health inequality with cultural capital and postulated that culture-based activities, knowledge and perception represent a type of health-related capital (Abel, 2008; Khawaja & Mowafi, 2006; Malat, 2006). Based on this understanding of cultural capital relating to health, cultural capital can be used to explain racial disparities in maternal health. Seeing the midwifery model of care as a way for midwives and women to acquire cultural

capital can offer a way to ameliorate racial inequalities in maternal health by improving health through race-concordant, culturally informed midwifery care. In other words, women who rendered and received care for pregnancy and childbirth within the social homebirth setting using the midwifery model of care and culturally informed race-concordant care can cultivate cultural capital. According to Abel (2008), cultural capital is instrumental to behavioral transformation of social inequality into health inequality. Normal, uncomplicated, healthy childbirth is the profit women can obtain from the healthcare industry through the distribution of cultural capital between races and ethnicities (Bourdieu, 1986).

Understanding maternal health racial disparities through the lens of cultural capital can demonstrate that midwives once had embodied cultural capital as the gatekeepers of knowledge, power, and skill in the domain of childbirth. Midwives also once held objectified and institutionalized cultural capital as evidenced by the respected positions they once had with other women, their communities, and societal norms.

With the elimination of midwives from childbirth and the suppression of Black midwives, Black midwives have been stripped from their embodied, objectified, and institutionalized cultural capital. Obstetricians have now gained embodied cultural capital as they are seen as the experts in the field of maternal healthcare. Medical doctors objectified cultural capital with their stronghold on drugs and medical instruments necessary at birth, and institutionalized cultural capital by having their medical authority in maternal health validated by hospital systems, academia, and law.

Social Capital

Black women and other women of color can be given the opportunity to acquire, build, and leverage their inherent cultural capital in birth through supportive environments such as with

midwives of color and GPNC. Bourdieu (1986) described social capital as an individual's social relationship with networks that can help to build one's knowledge and skillset. Social capital can be edified in social groups such as in GPNC. GPNC offers women of color the opportunity to harness social capital through the network and connections they form with other pregnant women and their midwives.

The medicalization of childbirth creates a multifaceted burden to women, families, and society, because it disarms women from their human rights in the same space that is intended to provide a safe birth (Foucault, 1976). Allowing women to protect and nurture the health of their pregnancy and birth at home creates an opportunity to build social and cultural capital, through shared knowledge and encouragement (Foucault, 1976). Displacing natural births into medical institutions has caused women to surrender their social and cultural capital that was anchored in traditional home births with midwives and other women in the community. Cultivating a legacy of resourcefulness and resilience from within the community through partnerships and networking done in GPNC is part of the solution to inequalities in the health and well-being of women of color (Airhihenuwa, 2006).

An empowering model of PNC is one where midwives provide culturally informed care, build on the existing strengths in the social network of women, and galvanize their social and cultural capital. It is imperative for healthcare professionals who provide care to a multicultural and multiethnic population of women to have the necessary competencies to deal with the complex and specific needs of such populations, empower them with social and cultural capital, and protect their human and reproductive rights.

Reproductive Justice

Reproductive justice, in the context of this research study is about returning to women their unequivocal human right to reproduce in a safe and healthy environment. The premise of this research is based on the principles of reproductive justice. It is impossible to confront the problem of maternal health racial disparities without first addressing historical assaults on Black women's reproductive rights. Throughout the nation's history there have been various governmental regulations on Black women's procreativity and a systematic, institutionalized denial of reproductive freedom that began from the time slave masters had an economic stake in bonded women's fertility (Roberts, 2017). The advocacy for reproductive rights has omitted the concerns of Black women, but reproductive justice is of particular importance to Black women given that the reproduction of Black people has long served the interest of White supremacy (Roberts, 2017).

Reproductive justice is based on three principles: the right not to have a child, the right to have a child, and the right to parent children in safe and healthy environments (Ross & Solinger, 2017). The attainment of reproductive justice is necessary to end preventable maternal deaths and ameliorate maternal health racial disparities. Assaults to the reproductive justice of Black women began with slavery and have been supported by laws and policies that control the reproduction of Black women, eliminate Black midwives, medicalize birth, and impede people of color from accessing high quality healthcare and resources. The premise of reproductive justice claims that all persons who become parents require a safe and dignified context for these fundamental human experiences that require access to high-quality care, a healthy environment, and a safety net for times when these resources fail (Ross & Solinger, 2017).

The MMR and its complicated racial inequality underscore the importance of upholding reproductive justice for all women, especially for those whose race, class, or socioeconomic

status often compel them to relinquish their right to reproductive justice (Davis, 1981). Black people in the United States are different from other modern people because no other people have been subject to constant physical violence and coercion for the primary purpose of controlling their minds and exploiting their bodies for nearly four hundred years (West, 2001). White supremacy has left its indelible mark on Black humanity through slave trade and slave labor and all spheres of American life, including the maternal healthcare system (West, 2001).

The reproductive justice framework draws attention to the persistent history of White supremacy and the ways in which it operates in a capitalist nation, penetrating healthcare systems and targeting women of color in distinctive and brutal ways (Ross & Solinger, 2017). Reproductive justice was born from women of color who claimed the right to decide to become mothers and the right to the necessary resources to maintain a healthy pregnancy and childbirth (Ross & Solinger, 2017). Access to high quality maternal healthcare that is personal, race-concordant, and culturally informed is key to the attainment of reproductive justice. The fight to end maternal mortality is accomplished by advocating for reproductive justice for all women.

The reproductive justice movement focuses on U.S. antiracism and human rights (Ross & Solinger, 2017). Historically, reproductive justice movement activists organized against (a) laws and policies that amounted to official reproductive abuse of people of color and their communities such as coerced sterilization; (b) welfare and fostering policies that punished poor women for “illegitimate” motherhood; and (c) the Hyde Amendment, which denied federal aid to poor women seeking abortions (Ross & Solinger, 2017). The Supreme Court has elevated reproductive liberty to the highest level of constitutional rights, but Black women’s reproductive rights seem to fall outside of this protection (Roberts, 2017).

In addition to the actions carried out by White male physicians, public health nurses, nurse- midwives, medical organizations, academics, and legislators, the mainstream feminist movement has also actively engaged in effective actions to deprive reproductive rights from Black women. For example, in the early part of the century, the birth control movement led by mostly White female activists, collaborated with eugenic movements, and adopted the population control philosophy used to advocate for birth control as a tool of social control by the White elite (Roberts, 2017).

History shows how White supremacy continuously motivated laws and policies, terrorized women of color, and impinged on their reproductive rights. To better understand the current problem of racial disparities in maternal health outcomes, an exploration of the nation's historic assaults on Black women's reproductive rights is necessary. Ross and Solinger (2017) recanted:

> We see how, as enslaved people, parents were unable to protect their children from sale or to assert their authority as parents. After White settlers and armies began moving westward across the North American continent, many Native Americans lost their land and also lost their pregnancies and children to genocidal wars and forced marches, and then to the boarding school system that aimed to drain Native culture from the minds of children who were being remade as "Americans." All these brutalities and indignities and other constitute a catalog of reproductive injustices: they name the reproductive dangers that many persons experienced in the past and that many continue to experience in nuanced forms today. (p. 13)

The White supremacy control of Black women's reproduction did not end with slavery. After the end of slavery, there was a shift from the focus on expanding the enslaved Black population to minimizing the free Black population and as Taylor (2021) stated,

> Under the guise of the pseudoscience of eugenics-the pursuit of perfection of the (white) human race through controlling the reproduction of people perceived to be physically, intellectually, or morally "unfit," compulsory sterilization began to be used as a form of reproductive control over women of color and low-income women where Black and Native American women were the main targets. (para. 8)

The dangers of a racist healthcare system remain persistent. The disproportionate death rate of Black childbearing women in the United States and the differences in the quality of maternal healthcare that women of color tend to receive compared to their White counterparts is a direct reflection of the racial injustices perpetrated by the U.S. healthcare system. Historically, the lack of appropriate reproductive healthcare has drastically shaped the lived experiences of generations of women of color (Ross & Solinger, 2017). The lived experiences of women of color who are faced with constant attacks from a racist healthcare system is adequately depicted by Davis (1981):

> When Black and Latino women resort to abortions in such large numbers, the stories they tell are not so much about the desire to be free of their pregnancy, but rather about the miserable social conditions which dissuade them from bringing new lives into the world. (p. 204)

Behind the racially disproportionate MMR in the United States are countless stories of Black women who have been mistreated, denied care, neglected, overlooked, and discriminated

in the healthcare system. As Taylor (2021) stated, "Behind the statistics are personal stories of people of color, across geography, socioeconomic status, and health profile, who have been denied access to lifesaving care, even as their expressions of pain, discomfort, and illness have been ignored" (para. 1). Far too often, this neglect, abandonment, and withholding of necessary care to women of color lead to preventable deaths, as seen with the MMR.

When the male-dominated workforce of obstetricians and gynecologists professionalized, they dethroned traditional women-centered home births. They outlawed midwives, which resulted in enslaved women becoming subject to experimentation by burgeoning physicians. In contrast, midwives were discredited, and their age-old traditions were degraded and lost (Ross & Solinger, 2017). Consequently, public policies relegated childbearing women of color to underfunded public health programs and required that some give birth in deteriorated public institutions under dangerous and alienating conditions. These actions caused permanent health-related damages to their communities for generations (Ross & Solinger, 2017). The permanent health-related damage is reflected in the present-day maternal health crisis among Black women and the worsening maternal mortality rate in the United States.

Reproductive justice underscores the exigency to protect against coercive laws, policies, and inhuman treatment of women during pregnancy and childbirth. The reproductive justice/human rights framework demands the healthcare system to block institutional degradations of maternal health and protect women's maternal health rights (Ross & Solinger, 2017). Ultimately, optimal maternal health and wellbeing is a basic human right, and its absence has degraded, and damaged millions of women affected by preventable adverse maternal health outcomes such as pregnancy-related death. Honoring women's basic human rights is critical to the achievement of reproductive justice and elimination of preventable pregnancy-related deaths.

Women's desire to control their reproductive system is as old as human history (Davis, 1981). As early as the 1800s women have been fighting to reclaim their reproductive rights and expressed their desire to control their reproductive systems. Reproductive rights are human rights and in the United States, which was founded on the idea of freedom and equality; reproductive justice must be upheld and guaranteed for all women.

Human Rights

Reproductive justice claims that access to material resources such as high-quality PNC is justified on the grounds that safe and dignified pregnancy and birth are fundamental human rights. The reproductive justice theoretical framework supports the need for adequate PNC, as a basic human right. Human rights are what governments owe to the people they govern. Reproductive justice uses a human rights framework to draw attention to and resist laws and policies that deny people the right to control their bodies, interfere with their reproductive decision making, and prevent many people from being able to experience a dignified, safe, and healthy pregnancy (Ross & Solinger, 2017).

Black women have faced barriers to the safety, dignity, and human rights that all reproducing persons are deserving of. The historical and present-day abuses of women's reproductive bodies have incentivized reproductive justice activists to define the topic of reproductive dignity and safety in terms of human rights (Ross & Solinger, 2017). In other words, reproductive justice is an extension of human rights. For that reason, it is important to establish an understanding of human rights as it relates to reproductive justice.

According to the Universal Declaration of Human Rights (UDHR) adopted by the United Nations, human rights contain four principles that pertain to maternal healthcare (Oparah et al., 2017):

Article 3: everyone has the right to life, liberty, and security of person.

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 7: All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 25: (1) Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing, medical care, and necessary social service […] (2) Motherhood and childhood are entitled to special care and assistance. (pp. 25–26)

Women have acquiesced to the governance of birth by White male physicians and since then have suffered the repercussions of the decision. The medicalization of birth managed by White male physicians within a standardized medical healthcare system enabled violations of basic human rights for women, especially for Black women. Medicalized maternal healthcare in the United States has cultivated a culture of violence against women.

This paper aims to deconstruct the traditional medical model of maternal care in the United States and identify ways it has victimized Black women and contributed to the Black maternal health crisis. Furthermore, this paper submits that the U.S. healthcare system needs to be dismantled and redesigned for women to regain their reproductive rights and empowerment with authoritative knowledge; and social and cultural capital around birth, like they once had with midwives assisting with births at home.

The United States is the only developed country with a worsening maternal death rate, an increasing shortage of maternity healthcare providers, more obstetrician-gynecologists than

midwives, and 90% of total midwives being White. It is important to explore the role of Black midwives, culturally informed maternal care, authoritative knowledge, and social and cultural capital in birth to help combat maternal mortality and maternal health racial disparities. Race-concordant care has shown to have the benefit to healthcare outcomes for people of color (Saha & Shipman, 2007; Wren & Donnelly, 2016).

Black Midwives for Black Mothers: Race-Concordant Care

The maternal health crisis in the United States is a problem that disproportionately affects Black women, who die at three to four times the rate of White women (CDC, 2019).

Black communities in the deep South where Black midwives were the only trusted healthcare providers accessible to families in need, had the highest number of maternal deaths when Black midwives were eradicated from birth work in 1978. Even present-day maternal health statistics show states like Louisiana, Georgia, and Alabama with the highest maternal mortality rates in the nation (World Population Review, 2022).

Since slavery, Black midwives have been fundamental to the reproductive health of women and uniquely essential to the health of Black women. Midwifery has deep roots in the Black community (Goode, 2014; Haynes, 2003; Robinson, 1984; Smith & Holmes, 1996; Stoney, 1952). The lack of diversity in the midwifery workforce today is an explicit structural barrier impeding people of color's access to high-quality care from Black midwives (Goode, 2014; McLaughlin, 2013; Wren Serbin & Donnelly, 2016). As people of color themselves, Black midwives are uniquely positioned to understand the economic, political, and social forces affecting the lives and health of people of color and thus provide a substantial benefit to their health (Ellerby-Brown et al., 2008; Goode, 2014; Saha & Shipman, 2007; Terreri, 2019; Wren Serbin & Donnelly, 2016).

A powerful excerpt from an essay addressing the murder of George Floyd and its effect to the Black community, written by the Chair of the American College of Nurse-Midwives (ACNM) Black Midwives Caucus for Reproductive Justice and Birth Equity, poignantly depicts the virtue of deep care and understanding that Black midwives have for Black women. Dr Drew (2020) wrote:

> As Black health care providers serving Black communities, we feel the burning pain of White supremacy directed at us, but also at the families we serve and the babies welcomed into the world. We are fearful for the future of our young people as they grow and come of age, when we know that today a young Black man has a better chance of going to prison than graduating from college. We worry for the mothers we care for. We look at all that impedes their ability to thrive, but in real time we reconcile how to help them simply survive birthing their babies. (p. 451)

The current workforce of midwives in the United States is disproportionately White. There is a clear need for the promotion of diversity, inclusion, and belonging in the midwifery profession. Racial and ethnic diversity in midwifery is important in the fight to end maternal mortality racial disparities. Black midwives are key players in the aim to provide high-quality, culturally informed care to communities of color, but given that over 90% of midwives in the United States are White, the feasibility for people of color to receive the benefits of race-concordant care is constrained.

Race-concordant care is important because health professional from underrepresented groups disproportionately care for underserved populations and minority patients tend to receive better interpersonal care in race-concordant care (Saha & Shipman, 2007). An excellent example of the health benefits that come from race concordant care is seen in the study of the Florida

hospital that found that the infant mortality was improved among infants who received race concordant care by Black doctors (Greenwood et al., 2020). In the state of Florida, 1.8 million hospital births were examined between 1992 and 2015 to find that when Black newborns are cared for by Black physicians as opposed to White physicians, their in-hospital death rate is a third lower (Greenwood et al., 2020). This groundbreaking study about the positive health impact of race-concordant care demonstrates that the survival rates of newborns improved when newborns and the physicians caring for them were of the same race. This Florida hospital based study is the first of its kind to show evidence of the effectiveness of race-concordant care to ameliorate racial health disparity (Plain, 2020).

Greater diversity in the healthcare workforce will improve quality of care for patients of color and is important in reducing racial disparities in health (Saha & Shipman, 2007). Black Midwives demonstrate a deep commitment to caring for underserved communities, and thus increasing the racial diversity of midwives is likely to improve healthcare outcomes for communities of color (Wren Serban & Donnoly, 2016).

Providing culturally informed care for women requires an understanding of their beliefs, needs, and desires, that can only be offered by having a wide range of diverse clinicians (Kennedy et al., 2006). Black midwives are personally committed to the mission of ending racial health inequality and believe that providing racially concordant care is fundamental to building safe, meaningful relationships with clients (Almanza et al., 2019). Therefore, the promotion of Black midwives is an essential intervention against the Black maternal health crisis. Black midwives possess a universally high level of critical analysis and commitment to eliminating racially based maternal health disparities (Almanza et al., 2019). For Black midwives, racial

justice, combating racism, and improving health equity are fundamental to their work in which they are personally invested (Almanza et al., 2019).

Racism

Racism structures opportunity and assigns value based on how a person looks, which results in conditions that unfairly advantage some and unfairly disadvantage others, such as preventing some people the opportunity to attain their highest level of health (American Public Health Association [APHA], 2021). There is a dearth in the research that explains race-associated differences in health, such as in maternal mortality racial disparities. Race is only a rough proxy for socioeconomic status, culture, and genes, but it precisely captures the social classification of people in a race-conscious society (Jones, 2000). According to Jones (2000), "The variable 'race' is not a biological construct that reflects innate differences, but a social construct that precisely captures the impacts of racism" (p. 1212).

Research has established that race-associated differences in health outcome are due to the effects of racism (Jones, 2000). Jones (2000) postulated that there are three levels of racism: (a) institutionalized racism, which is the differential access to goods, services and opportunities of society by race, and often evident as inaction by an institution in the face of need; (b) personally mediated racism, which is intentional or unintentional prejudice and discrimination and is manifested as lack of respect (poor or no service, failure to communicate options), suspicion, devaluation (surprised at competence, and stifling of aspiration), scapegoating and dehumanization towards others according to their race; and (c) internalized racism, which is members of the stigmatized races accepting negative messages about their own abilities and intrinsic worth, and characterized by accepting limitations to one's own full humanity, embracing *whiteness*, self-devaluation, resignation, helplessness and hopelessness. In the current

maternal health crisis, the evidence of all three forms of racism has an effective role in putting at risk the maternal health outcomes of Black women.

A careful examination of historical factors related to racism is essential to effectively address the current healthcare crisis of Black women (Pranther, et al., 2018). The damage of slavery centuries ago still has an impact on the lives of Black women today (Wyatt, 1997). The United States' racist origins have permeated into present-day healthcare institutions and have a major influence on maternal mortality racial disparities. The historical racist narrative about Black inferiority has contributed to discriminatory healthcare practices and has negatively impacted the quality of care and the type of healthcare services provided to Black Americans (Pranther, et al., 2018). Racism was built into the fibers of academic hospitals where Black patients are directed to be seen by doctors in training and White patients are seen by seasoned attending physicians, a medical injustice that is product of a racist healthcare system (Vinekar, 2021).

The combination of significant historic race-based events, including slavery, Black Codes/Jim Crow, Civil Rights, and post-Civil Rights, play a significant role in the current reproductive health status of Black women (Pranther, et al., 2018). The increased rate of maternal mortality among Black women and their propensity to receive poor PNC are suggestive of a racist healthcare system. The negative impact of racism, which is deeply embedded into the institutions of American society, are inevitably experienced by Black women and for that reason, their risk of adverse reproductive health outcomes is increased (Pranther, et al., 2018). The historical context of racism continues to shape the present-day maternal health outcomes of Black women.

Transgenerational poverty and limited education that originated in slavery, continue to disproportionately affect Black Americans. Given the well-established link between racism, poverty, and health, the socioeconomic conditions associated with institutionalized racism make Black women more vulnerable to reproductive health problems (Pranther, et al., 2018). Addressing the maternal health crisis through a historical lens and ensuring the implementation of culturally informed care will likely improve public health equity and the health of Black women (Pranther, et al., 2018).

Culturally Informed Maternal Healthcare

North American populations are increasingly becoming ethnically diverse, and midwifery clients require health care that is culturally sensitive and inclusive (Tyson & Wilson-Mitchell, 2016). Addressing the shortage of Black health professionals is significant for improving the provision of high-quality healthcare (Panther, et al., 2018). Having a diverse workforce of maternal healthcare providers can help in the provision of culturally informed care and therefore help ameliorate racial disparities in maternal health outcomes. Attempts to improve the disparities in the current maternity care system must be grounded in cultural awareness (Luke, 2018).

Health is not merely the absence of disease. Health is a product of culture (Airhihenbuwa, 1995; Townes, 1998) and understanding this concept enables people to have a perspective that considers the variety of ways in which health is defined and influenced. Airhihenbuwa (1995) postulated that health is a process of adaptation to a socially constructed reality. Rather than being purely instinctual beings, people are autonomous and create cultural responses to health and disease (Townes, 1998).

In an increasingly globalized society, it is essential for health care providers who serve a multicultural patient population to understand the unique perspectives and beliefs of patients in order to enhance the quality of care they provide (Airhihenbuwa & Liburd, 2006). The traditional medical model of healthcare has historically shown a detrimental lack of cultural appropriateness (Airhihenbuwa, 1995; Townes, 1998).

Developing programs that adapt preventative-health initiatives to fit the needs of the community and its cultural contexts is an effective way to improve health care in a community (Townes, 1998). The culturally informed health promotion has the most promise in attaining this goal. Unfortunately, most culturally informed healthcare programs in Black communities tend to be based on White experience. The principal weakness of these models is their failure to ground the person in her or his sociopolitical context. This devalues and dismisses the dynamic nature of who Black people are as individuals and the vital role communal cultural values play within any health condition (Townes, 1998). The essence of culturally informed healthcare is that it recognizes the daunting realities and idiosyncrasies of Black people in the United States in relation to their health.

Collectivism

The traditional medical model of healthcare is centered on Western cultural values characterized by individualism (Hofstede, 1991). However, most women who received healthcare from midwives identify with cultures of collectivism. In the United States, non-hospital based certified nurse-midwives serve a clientele that is 65% nonwhite and 44% immigrant (Declercq et al., 2001). Black women and women of color are not satisfied with the traditional medical model of PNC. The dissatisfaction and underutilization of PNC by Black

women supports the need for a change in PNC to one that is more appropriate for the unique needs of a multicultural patient population.

Individualism and collectivism are defined using a Western mental model in which individualism represents a society where the ties between individuals are loose and collectivism is present in societies where individuals are integrated into tight-knit and cohesive groups from birth and throughout the lifespan (Hofstede, 1991). The United States is a nation in which individualism is prevalent, but most women who receive PNC from midwives come from countries and cultures where collectivism is dominant. In societies predominant of individualism, everyone is expected to take care of themselves (Hofstede, 1991). On the contrary, with collectivism, there is a stress on belonging and relationships rather than privacy and task completion. In collectivist communities, maintaining harmony is more important than standing out with an individual opinion, and people expect to be protected by loyal family members and groups (Hofstede, 1991).

The cultural differences depicted in Hofstede's (1991) concepts of individualism and collectivism highlight the importance of culturally informed care. The traditional medical model of PNC is based on individualism and has been culturally inept for the care of Black women who identify with cultures of collectivism. To improve the quality of PNC for Black women, the transition to a collectivist model of PNC in lieu of an individualist model of PNC may be a suitable consideration.

Group Prenatal Care. Group prenatal care (GPNC) is different from the traditional medical model of PNC. The essential purpose of GPNC is to develop a community among pregnant women where women can learn from the medical provider and learn from each other in a face-to-face group setting. GPNC aims to empower pregnant women to take control of their

own health (Adams & Thomas, 2017; Navarro, 2018). GPNC is equal or superior to traditional PNC regarding maternal health outcomes for Black women (Adams & Thomas, 2017). GPNC also has better rates of healthcare utilization among high-risk women (Adams & Thomas, 2017).

Social support is an essential element of GPNC to reduce stress levels among pregnant women and provide them with a more positive pregnancy experience (Adams & Thomas, 2017). Given that Black women are more vulnerable to chronic stress and racism as a health risk factor, social support from GPNC is an important buffer for the maternal health of Black women in the United States. Black women are more likely than White women to participate in GPNC which Adams and Thomas (2017) attribute to minoritized people's history of reliance on their community for various needs, including health-related needs.

Black American culture is aligned with collectivist social norms. Therefore, PNC that is culturally informed for Black women should adapt to a model of care centered in collectivism, such as GPNC. Black women are more likely to use GPNC because of their historical reliance on their groups, family, and community for health needs (Adams & Thomas, 2017). The change in design of PNC model from one that is fundamentally individualistic, such as in the traditional medical model, to one that is collectivist, such as GPNC, may help improve the quality of PNC for Black women.

Quality of Care

According to the World Health Organization (2022), quality of care is defined as the degree to which healthcare professionals provide evidence-based healthcare services that increases the likelihood of achieving desired health outcomes. Although the definition of quality of care may vary, there is growing consensus that quality of care ought to be effective, safe, people-centered, timely, equitable, integrated and efficient (WHO, 2022a). The provision of

adequate quality maternal healthcare can result in a safe and positive childbirth experience with respect and dignity for women (Iro, 2018). The WHO recommends that midwives lead the way in providing PNC because it is the type of care preferred by women and it has proven to reduce preterm birth by 24%, a key factor in improving infant health (Iro, 2018).

Improving the access to good quality healthcare is a global health goal that remains significantly challenging to achieve (WHO, 2022a). The provision of quality care requires action from the government, healthcare system, citizens, patients, and healthcare workers. A skilled and competent health workforce that is supported and motivated is part of the requirement to improve quality of care (WHO, 2022a). Quality of care is necessary to improve health and to obtain positive health outcomes. On the contrary, poor quality care is responsible for more preventable deaths around the world than the lack of access to healthcare (WHO, 2022a). In other words, good quality of care is critical and necessary to end preventable deaths, which is particularly important in ending the problem with maternal mortality.

Maternal healthcare is a critical area of concern for the need of quality of care (WHO, 2021). Quality care is a key element of universal health coverage and it requires vision, planning, investment, compassion, meticulous execution, and rigorous monitoring from national level to clinic level (WHO, 2021). Given the importance of quality healthcare to save lives, research on the quality of care is therefore important to inform interventions necessary to end preventable deaths. Standardized data on the health of women who are pregnant or who have recently given birth is crucial to inform the design of interventions to help safeguard their lives and well-being (WHO, 2022b). Healthcare systems that operate based on quality data help ensure that healthcare delivered to women is of high quality, respectful, safe and dignified (WHO, 2022b).

The Nigeria Federal Ministry of Health collaborated with the WHO to provide an excellent example of the importance of investigating the quality of maternal health to understand how to improve quality of care and positive health outcomes (Tukur et al., 2022). The investigation provided surveillance of maternal and perinatal data, including the use of selected quality of care indicators, for periodic assessment of hospital performance and quality improvement. Information on the quality of care for women and their babies was collected from all women, and revealed areas of improvement, potential intervention strategies that could help maternal and newborn survival. One of the research findings was the association between the risk of death for women and their babies when they lacked a companion of their choice during childbirth, and when the labor was not monitored with appropriate tools (Tukur et al., 2022).

Qualitative research on the quality of care is necessary to better understand women's experiences with care during their pregnancy and birth. A qualitative study on women's perspective of the quality of maternal care revealed that a women's primary desired outcome and main reason for satisfaction with care, was a healthy and safe childbirth (Hagaman et al., 2022). Secondary to a birth experience absent adverse outcomes, women described quality of care as satisfaction with their health provider's interpersonal behavior (e.g., supportive communication) and the facility's amenities (e.g., bathing, cleaning, water, coffee). Lastly, family support and material resources helped to buffer negative experiences and improve a women's overall satisfaction with the quality of care (Hagaman et al., 2022). These research findings underscored the importance of understanding a women's expectations, past experiences, and social support as influential to their perceived quality of care.

Donabedian (1966), a pioneer researcher in the quality of care from a patient's perspective, developed a theoretical model using the aspects of structure, outcome, and process

as indicators of quality of care. Structure refers to the fixed part of the health practice setting, process refers to the activities of health services, and outcome refers to the consequences of healthcare activities on the patient's health (Donabedian, 1966). According to Wilde et al.'s (1993) theoretical model of quality of care from a patient perspective, quality of care is formed by patients' systems of norms, expectations, experiences, and by their encounters with an existing care structure.

Standard of Care

According to the National Cancer Institute (2011), standard of care is defined as medical practice that is accepted by medical experts as proper in the treatment of a certain type of disease, that is widely used by other medical practitioners, and considered best practice. Standard of care can vary and it is sensitive to time, person and place. Without a concrete definition of standard of care, it is challenging for medical practitioners to adhere to it (Grady, 2005). In general practice, medical providers are expected to adhere to standards of care and if deviating from them, be convinced that it is soundly justified.

In the field of healthcare, medical practitioners such as physicians and midwives have a legal, moral, and ethical responsibility to practice within the standard of care. The concept of "standard of care" is often used in healthcare to evaluate and perform care on patients, yet the meaning of the term lacks clear consensus (Moffett & Moore, 2011, p. 109). Exploring the evolution of the definition of the standard of care can help to further understand the concept. Historically, standard of care has been known to signify a reasonably prudent way of practice. Medical precautions that are critically important towards the practice of beneficence and prevention of harm may be used as a measure of the standard of care (Moffett & Moore, 2011).

Multiple legal cases have shown that the way things are customarily done by medical providers does not fully encompass the definition of standard of care (Moffett & Moore, 2011). Customary practice may not be sufficient when reasonable prudence is necessary in determining the standard of care. In a recent legal case that evaluated a physician in question for malpractice, the definition of the standard of care was explicated by Chief Justice C.J. Robertson Medical as follows (1985):

> Malpractice is a legal fault by a physician or surgeon. It arises from the failure of a physician or medical practitioner to provide the quality of care required by law. When a physician undertakes to treat a patient, he takes on an obligation enforceable at law to use minimally sound medical judgment and render minimally competent care in the course of the services he provides. A physician does not guarantee recovery. If a patient sustains injury because of the physician's failure to perform the duty he has assumed under our law, the physician may be liable in damages. A competent physician is not liable *per se* for a mere error of judgment, mistaken diagnosis or the occurrence of an undesirable result. (p. 9)

Legally, the practice of healthcare requires medical practitioners to demonstrate minimal competence, which may differ from customary practice, and not guaranteed to produce positive outcomes (Moffett & Moore, 2011). In other words, a healthcare provider who performs with reasonable prudence, outside of the traditional way of practice, and has a deleterious outcome or misses a diagnosis in the care of a patient does not necessarily mean that the standard of care was not met. In summary, standard of care is an evolving concept. Healthcare providers who fail to perform in the most reasonably prudent way, although within customary practice, may be found guilty of negligence or medical malpractice (Moffett & Moore, 2011). Reasonable healthcare

practices that are outside of the normal standards of practice, in some cases, may be considered as the best practice.

Standard of care, in juxtaposition to quality of care, reveals there are common principles among both concepts such as the relativity of their meanings. Of note is the fundamental difference between the concepts of standard of care and quality of care. While standard of care usually refers to the most widely used medical practice requiring minimal competence from medical practitioners, quality of care usually signifies best medical practices rendering desired health outcomes. Standard of care meets the quality of care required by law and does not guarantee a positive health outcome.

This study focuses on the importance of achieving desired health outcomes in the care of pregnancy and childbirth and thus a focus on the quality of care is made. Qualitative research on Black mothers' perception of the quality of maternal healthcare aims to inform ways on how to improve the quality of maternal healthcare for Black women in order to ameliorate racial disparities in maternal mortality.

Chapter 3: Methodology

This chapter provides a discussion of the research method utilized in the study. The research questions, research purpose, description of the research design (constructionist grounded theory methodology), sample, protocols to protect research participants, setting, procedure/general steps, and the researcher's resources and skills are also addressed.

Research Questions

The research questions for this study are:

- What are Black women's perceptions of the quality of PNC via the traditional medical model?
- What are Black women's perceptions of the quality of PNC via the midwifery model by Black midwives?
- How does the Black women's perception of the quality of care in the traditional model of PNC compare to the Black women's perception of the quality of care in a race-concordant midwifery model of PNC?

Research Purpose

The purpose of this study was to explore Black women's lived experiences with maternal healthcare, and to understand and describe the quality of maternal healthcare from their perception. This understanding could inform interventions that may help to improve the quality of PNC provided to Black women. This study also provides the foundation for future research into the issues of Black maternal health, the quality of maternal healthcare, as well as racial health disparities in maternal health.

Research Method

A Black homebirth practicing Certified Nurse Midwife and a hospital-based obstetrician was used to identify and interview 20 women patients, 10 from each medical provider, who had delivered a live newborn within a 12-month period. A semistructured interview guide informed by the Donabedian quality of care framework to elicit women's experiences with PNC and delivery, any prior delivery experiences, and recommendations to improve PNC, was used. Inductive analysis was used to compare and contract PNC processes, experiences and satisfaction between both modalities of PNC.

Research Overview

This study is a qualitative exploration of Black women's lived experiences with pregnancy and childbirth healthcare. The study intends to investigate Black women's experiences with PNC and juxtapose the perceived quality of PNC in traditional medical models of care with the perceived quality of PNC in the midwifery model of care with race-concordant Black midwives.

Research Purpose

The purpose of this qualitative research study is to understand how Black mothers perceive and describe their experiences and satisfaction with the quality of care received at from a traditional medical maternal health clinic and from a race-concordant midwifery care model. The qualitative investigation aims to develop a new theoretical model to fill the gap in the literature on the quality of PNC from the perspective of Black women and inform ways on how to improve the quality of PNC for Black women.

The goal of this research is to underscore the importance of high-quality, culturally informed, race-concordant midwifery care for Black women to ameliorate maternal health racial disparities. The research focused on the experiences of Black women and compare their

perceptions of the quality of care of traditional PNC and race-concordant midwife-led PNC. The results of this research will help to crystalize the meaning of quality of maternal care from the perspective of Black women and incentivize a paradigm shift in the American maternal healthcare system to one that is more effective, safe, people-centered, equitable, integrative, and efficient (WHO, 2022a). This research will be acutely important because of the rise in the MMR and the current Black maternal health crisis in the United States.

Research Methodology

In this section, an overview of qualitative research and grounded theory methodology is provided to lay the foundation for Kathy Charmaz's constructivist grounded theory, the research method used to guide this study. Constructivist grounded theory methodology was chosen to understand the nature of the lived experiences of Black women with PNC in the traditional medical model of care and with the race-concordant midwifery model of care. Constructivist grounded theory guides the investigation into how Black women create meaning from their experiences with PNC. Constructivist grounded theory is the most appropriate methodology to gain an interpretive understanding of Black women's lived experiences with maternal healthcare (Charmaz, 2008). The constructivist approach of grounded theory is particularly fitting to this study because it allows for the co-construction of meaning from the unique perspectives of Black mothers and a Black midwife as the research participants and the researcher (Charmaz, 2008). Racial disparity in maternal health is a complex issue requiring further investigation from those who live the experience (Canty, 2020).

Glaser and Strauss (1999) discovered grounded theory methodology in 1967 from data systematically obtained in sociology research. Grounded theory in sociology is a method for handling data in research, providing modes of conceptualization for describing and explaining.

There are four main types of grounded theory: Barney Glaser's classic grounded theory, Anselm Strauss and Juliet Corbin's basics of qualitative research, Kathy Charmaz's constructivist grounded theory, and Adele Clarke's postmodern situational analysis (Sbaraini et al., 2011, para. 3). Generally, grounded theory focuses on social processes and asks open-ended questions about what happened and how people interact to find meaning in what drives people's actions.

When Glaser and Strauss (1967) originally conceptualized grounded theory, it assumed a social constructivist approach. Due to grounded theory being fundamentally inductive, scholars commonly viewed it as a social constructivist method (Charmaz, 2008). Fundamentally, all types of grounded theory share the premise of an external reality, the discovery of provisional truths in this reality, the role of the observer, and an unproblematic representation of the research participants (Charmaz, 2008). Grounded theory became known for its realism and positivism among the modernist qualitative methods. However, grounded theory became the center of much criticism for many postmodernists as they challenged positivist assumptions in classic grounded theory statements and questioned its relevance (Charmaz, 2008). Postmodernists valued research participants' full stories, rather than excerpts from their stories as used in grounded theory to develop theoretical statements. Many critics rejected grounded theory for its emphasis on theory building rather than storytelling. However, few grounded theory studies build theory, instead, many provide an analytical handle on a specific experience (Charmaz, 2008).

Charmaz's (2008) approach to social constructivist grounded theory makes the following assumptions:

> (1) Reality is multiple, processual, and constructed—but constructed under particular conditions; (2) the research process emerges from interaction; (3) it takes into account the researcher's positionality, as well as that of the research participants; (4) the researcher

> and researched co-construct the data—data are a product of the research process, not simply observed objects of it. Researchers are part of the research situation, and their positions, privileges, perspectives, and interactions affect it. (p. 402)

Social constructivists value the role that positionality plays in the co-construction of meaning by the interaction between the researcher and research participants (Charmaz, 2008). Social constructivists negate the idea of a completely unbiased researcher without predispositions that influence data. Instead, social constructivists recognize and value the researcher's prior knowledge and theoretical preconceptions and its impact on the interpretation of the data (Charmaz, 2008). Most importantly, with constructivist grounded theory is the analysis process of the data, which is expected to be done with rigorous scrutiny (Sbaraini et al., 2011).

Charmaz (2008) posits that social construction grounded theorists adhere to the following positions:

> • Treat the research process itself as a social construction
>
> • Scrutinize research decisions and directions
>
> • Improvise methodological and analytic strategies throughout the research process
>
> • Collect sufficient data to discern and document how research participants construct their lives and worlds. (p. 403)

In summary, grounded theory sees the research as an interactive process between the data and the analysis of the data without rules on how to do it. This range of flexibility that the researcher is offered with grounded theory comes with scholarly responsibility for the researcher, who is expected to make independent decisions and detail the thought process of how and why things are done the way they are done. The meticulous observation and documentation of the

thinking process required using this methodology lead to the improvement of methods and analytical strategies in the research. Finally, it is important for researchers who use grounded theory to know the world from the research participants' perspectives to understand how they construct the meaning of their world (Charmaz, 2008).

The primary investigator of this research is a self-identified Black woman of Afro-Caribbean descent, who gave birth to her first child within one year of this study and works as a certified nurse midwife. The researcher has over 10 years of experience in maternal healthcare in under-served communities nationally and globally. Her work experience includes spending 6 years in Los Angeles, California, where she was an active member of the California Association of Nurse Midwives and the California Coalition of Reproductive Justice. During her time in California, the researcher served as a mentor with a Black, Indigenous, People of Color (BIPOC) midwifery mentorship program, where she developed relationships with a group of BIPOC midwives and BIPOC aspiring midwives.

The researcher has worked within the traditional medical model and the midwifery model of care. Most recently, the researcher relocated to the state of Florida, where she works with a hospital-based obstetrician providing maternal care and overall women's health. It is her work with certified nurse midwives in California and the obstetrician in Florida that has guided her investigation of Black women's experience with midwifery care in California as well as Black women's experience with the medical care in Florida.

There are multiple commonalities that the research participants share with the researcher. Both the research participants and the researcher are Black women who have given birth within one year, and have experienced the maternal healthcare system in Orlando, Florida, for care of their pregnancy and birth. Given these shared demographics, positionalities, and

intersectionalities, the researcher is uniquely positioned to understand the world from the research participants' point of view, which is a fundamental principle of grounded theory research methodology.

Qualitative research has become increasingly popular in health research, and grounded theory methodology is one of the most cited qualitative methodologies in the healthcare field (Sbaraini et. al., 2011). This study uses a qualitative method to investigate Black mothers' lived experiences with PNC and understand their perception of the quality of care of traditional medical PNC and the midwifery model of PNC with race-concordant midwives. A qualitative method was selected to study the human experiences of Black mothers, recipients of PNC in the U.S healthcare system, to best capture the crucial elements of this sociological phenomenon (Glaser & Strauss, 1999).

The value of using constructivist grounded theory for this research is that it places the experiences of Black women at the center. Social constructivism is a research paradigm that denies the existence of an objective reality, asserting instead that realities are social constructions of the mind (Guba & Lincoln, 1989). Social constructivism buttresses the understanding that reproductive justice exists when people have the power to create their own meaning of reproductive freedom and quality of maternal healthcare. Constructivist grounded theory acknowledges the constructed meaning to the perceived experiences of Black mothers as reality extracted from the interactive process between Black women within their social, cultural, and temporal context (Sbaraini et al., 2011). The use of constructivist grounded theory is key to better understand what Black mothers value regarding healthcare for their pregnancy and childbirth experiences.

Given the importance of the quality of PNC to the prevention of maternal mortality, the researcher finds it important to explore Black mothers' experiences with PNC to understand how they construct meaning of the quality of care. *Quality of care* is a relative concept and has different meanings that are contingent upon cultural, individual, and social variations (Grøndahl, 2012). Therefore, the methodology of grounded theory was utilized to construct a novel theory to define and elucidate the quality of PNC from the perspectives of Black mothers interpreted by a researcher, who is a Black midwife and new mother. The constructivist perspective underpins the interpretation of Black mothers' experiences, which was co-constructed with the researcher (Lassig, 2012; Mills et al., 2006).

The purpose of grounded theory is to generate a theory inductively developed from interplay with data collected through research on Black women's experience with PNC (Glaser & Strauss, 1967). Grounded theory methodology, based on a social constructivist research paradigm, was used to develop a novel theory on the healthcare delivery approach of PNC that caters to the holistic needs of Black women. Generating a theory from data means the concepts will derive from data and systematically worked out in relation to the data during the course of the investigation (Glaser & Strauss, 1999).

Epistemologically, constructivist grounded theory emphasizes the subjective interrelationship between the researcher and participants and the co-construction of meaning, where the researcher acknowledges their value as an inevitable part of the outcomes rather than being an objective observer (Mills, et al., 2006). Given that medical research has not equitably included members of racial/ethnic minority groups and females, such as Black women (Flores et al., 2021), it is appropriate to use grounded theory methodology to expand the body of knowledge about Black women's experiences with pregnancy and childbirth care. Grounded

theory methodology is appropriate when little is known about a phenomenon such as the Black maternal health experience and Black mothers' perception of the quality of care (Chun Tie et al., 2019).

Using grounded theory methodology, this research aims to produce an explanatory theory that uncovers contributing factors to the Black maternal health crisis as well as ways to improve maternal healthcare for Black mothers. It is important to generate a new theory about the quality of PNC for Black women grounded in data. An exploratory cross-sectional research design was utilized to compare the experiences of Black women who use traditional PNC with the experiences of Black women who receive care from Black midwives using the midwifery model of care. The use of constant comparative method was applied as a key component of grounded theory methodology to organize and analyze data (Chun Tie et al., 2019).

Research Design

A qualitative research design was used to collect, analyze, and interpret data on Black women's experiences with PNC to draw a conclusion that is credible, dependable, and replicable. The study used an exploratory cross-sectional research design to investigate two groups of Black women during the postpartum period, which is within one year after childbirth. One group of Black mothers had experienced PNC and childbirth using the traditional medical model of PNC with an obstetrician, and the second group of Black mothers had experienced PNC and childbirth with a Black midwife using the midwifery model of care.

The research design is exploratory and useful in answering the study's research questions (Cuthill, 2002). Twenty Black women were interviewed using semistructured interview questions. The sample size was chosen for this qualitative research project to garner an in-depth understanding of the lived experiences of Black women with contrasting maternal healthcare

services (Dworkin, 2012). This sample of about 20 people was designed to provide maximum variation in Black mothers' perception of the quality of pregnancy care (Sbaraini et al., 2011). Given how homogenous the target population being studied is, Black women who recently experienced care for pregnancy and birth by either traditional maternal healthcare or race-concordant midwifery care, the sample size is expected to generate data saturation. The semistructured interview questions were designed to answer the research questions.

Research Setting

The research sample was drawn from two different locations in the United States, San Francisco, California and Orlando, Florida. California is of particular interest to this study because of its progress in improving maternal health outcomes and achieving an MMR that is lower than the national average. California went from an average of 13 maternal deaths per 100,000 live births during 2005–2009, to an average of 7 maternal deaths per 100,000 live births during 2011–2013 (Main et al., 2018). Since 2006, California's MMR has decreased by 65%, but despite the decline, Black women in California experience three to six times the rate of maternal mortality (California Maternal Quality Care Collaborative, n.d.).

Florida's MMR is 13.4 maternal deaths per 100,000 live births, but the MMR for Black women in Florida is 37 maternal deaths per 100,000 live births (Florida Department of Health, 2018). The Black MMR is higher than the White MMR in the state of Florida and both MMRs have increased from the year 2001 to 2014 (Bernet et al., 2020). From 2001 to 2014, the average MMR in Florida was about 19 per 100,000 live births, with the MMR almost three-times higher among Black mothers than among White mothers (about 40.6 and 15.7, respectively; Bernet et al., 2020). The problem of racial inequality in maternal mortality is consistent in both California and Florida, which makes both states appropriate settings to investigate Black women's

experience with the quality of maternal healthcare. This study was conducted using samples from two regions of the United States, San Francisco, California and Orlando, Florida.

An obstetrician's medical office in Orlando, Florida was used to purposefully select patients who have received care from the hospital-based medical doctor for their pregnancy and childbirth. The reason why this particular medical office was used for this study is because the principal investigator has a working relationship with the medical practice and access to patients at this facility. The medical doctor referred interested patients who meet the criteria of the study, so the investigator can consider them as potential research participants.

The second location, San Francisco, California, is where the principal investigator has a relationship with a Black Certified Nurse midwife who practices home births with a Black doula, who is a mentee of the principal investigator. Since this study focuses on race-concordant care and the promotion of Black midwifery care, it is significant that one of the settings for the research sample to be taken from patients of a Black-owned midwifery homebirth practice.

The two settings allowed a contrasting view of patient perceptions of the quality of care of traditional medical PNC service and the quality of care from a race-concordant midwifery model. This exploration looks to highlight the importance of race-concordant care, and the importance of a diverse midwifery workforce to help improve the quality of maternal care and health outcomes for Black women. This exploratory cross-sectional research project took place during the COVID-19 global pandemic. Of note, the number of women in the United States who died during pregnancy or shortly after giving birth increased sharply during the first year of the coronavirus pandemic (Rabin, 2022).

Participant Selection

In consultation with local health professionals in Orlando, Florida and San Francisco, California and colleagues at each site, the medical office and midwifery homebirth practice that best reflect service quality and challenges of the medical model and midwifery model of care were purposely identified and selected to achieve variation in birth experiences. These two maternal care settings were used to purposely sample 10 Black mothers per facility. The purposive sample frame was theoretically derived to maximize participant variation by parity, age, ethnicity, marital status, occupation, education and type of maternal care received (race-concordant midwifery care and traditional medical model of care), which are factors that may influence a woman's experience.

Participants were purposely selected from two distinctive health practices within 12 months of giving birth. Using purposeful sampling, 20 self identified Black women patient participants were selected, including 10 recipients of care from a medical doctor in a traditional medical office and 10 recipients of care from a certified nurse midwife in the homebirth practice. The criteria for participation include those over the age of 18, not currently pregnant, not under arrest, mentally sound and physically able to provide informed consent, and recent experience with PNC and childbirth within 1 year. The two distinct maternal healthcare providers, medical doctor and certified nurse midwife, referred interested and qualified patients from their respective practice to the researcher for possible participation in the study. Women who agreed to be interviewed signed an informed consent and return it to the study investigator. After consent is received, participants were telephoned by the researcher to schedule an interview via audio-visual communication.

Data Collection

Grounded theory methodology informs the process of data collection via individual semistructured interviews. Data were collected from responses to semistructured interviews with 20 Black women who experienced maternal care for their pregnancy and childbirth within 12 months via a traditional medical office and a midwifery homebirth practice. Sixty-minute, pilot-tested, verbal semistructured interviews were administered via in-person or audio-visual communication to 10 patient informants from a traditional maternal health office and 10 patient informants from a midwifery practice. A total of 22 patient interviews were completed from August to November 2022, which included two pilot interviews with a patient from each location. Semistructured interviews allow the researcher to explore participants' perceptions of their experiences (Evans & Lewis, 2018). The interview process provided the opportunity for individuals to tell stories about their lived experiences with contextual meaning that elicits interpretation by the researcher (Denzin, 2001; Dillard, 1982).

Semistructured interview questions are designed to explore patients' experience with PNC and their perception of the quality of care they received. The interview questions originate from a recent similar qualitative study on mothers' experience with facility-based maternal healthcare in Ethiopia (Hagaman et al., 2022; see Appendix B). Semistructured interview questions aim to elicit information about mothers' experiences of their most recent pregnancy and delivery, focusing on various domains of healthcare satisfaction including staff interactions (communication, skill, trust), services (type, quality, privacy), and facility (cleanliness, equipment, distance; Hagaman et al., 2022). The Donabedian (1966) Framework on the patients' perspective of the quality of care informs the research questions. To contextualize expectations for healthcare services and subsequently, healthcare satisfaction, the interview questions are designed to explore women's past delivery experiences, their recommendations for service

quality improvement, and influences in their social and community network that shaped their use of their chosen maternal care modality (Hagaman et al., 2022). Perceived satisfaction with quality of care was assessed by asking participants if they would use their maternal care facility in the future and/or recommend maternal care services to women they knew.

Interview Protocol

The interview introductory protocol is adapted from a student toolkit from the National Center for Postsecondary Improvement (NCPI, 2003):

> To facilitate our note-taking, we would like to audio record our conversations today. Please sign the release form. For your information, only researchers on the project will be privy to the tapes, which will eventually be destroyed after they are transcribed. In addition, you must sign a form devised to meet our human subject requirements. Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary and you may stop at any time if you feel uncomfortable, and (3) we do not intend to inflict any harm. Thank you for agreeing to participate.
>
> We have planned this interview to last no longer than one hour. During this time, we have several questions that we would like to cover. If time begins to run short, it may be necessary to interrupt you in order to push ahead and complete this line of questioning.
>
> You have been selected to speak with us today because you have been identified as someone who has valuable information to share about your experience with maternal healthcare. Our research project focuses on the improvement of the quality of maternal healthcare, with particular interest in understanding what is important to women about maternal healthcare. We are trying to learn more about the quality of maternal healthcare

for Black women, and hopefully learn about healthcare practices that help improve the quality of maternal healthcare for Black women. (p. 1)

Data Analysis

This qualitative grounded theory research data analysis was completed using thematic analysis of data extracts from semistructured interviews. Thematic analysis is an appropriate method of analysis for seeking to understand experiences (Kiger & Varpio, 2020). An inductive approach was used to generate themes from the data to understand Black women's perspective of the quality of PNC. Themes were co-constructed meanings derived from the data to answer the research questions about Black mothers' perceptions of the quality of care (Kiger & Varpio, 2020). The benefit of using thematic analysis in this study was that it allowed the researcher, from a constructionist perspective, to explore and co-construct meanings that Black women create from their experience with PNC (Evans & Lewis, 2018). A combination of semantic and latent coding was used in the thematic analysis through an iterative and recursive process.

The process of thematic analysis began with data collection and continue through the transcription of voice recorded interviews, where codes, meanings, and themes were identified and threaded through the reading and rereading of the transcription and interpretation of the data (Evans & Lewis, 2018). The widely accepted six-step process for conducting thematic analysis was utilized: to become familiar with data, generate initial codes, search for themes, review themes, define and name themes, and produce a report (Kiger & Varpio, 2020).

Chapter 4: Results

Chapter four includes a presentation and discussion of the study findings. The study aims to explore Black women's experiences with maternal healthcare. More specifically, the study highlights Black women's *experiences* with two modalities of maternal healthcare, the traditional medical model of care and the race-concordant midwifery care model. Amidst the increasing maternal mortality rate in the United States that disproportionately affects Black women, there is a continued need to better understand Black women's experiences with maternal healthcare. Therefore, this study aims to grapple with the contextual experiences and expectations that shape Black women's perception of the quality of care they receive from two different models of care.

A total of 22 Black mothers were interviewed for this study. Ten interviews came from mothers who received maternal healthcare from a medical doctor and had a hospital birth. Ten interviews came from mothers who received maternal healthcare care from a Black Certified Nurse Midwife and had a home birth. One pilot interview from each group was included in the total number of interviews. All the interviews were conducted via Zoom. Women shared stories that provided insight into their experiences with two types of maternal healthcare practices and their perception of the quality of care they received. Each participant shared 30- and 60-minute narratives about their experiences with their pregnancy and childbirth care, occurring between 12 months to 6 years ago. Half of the women who experienced a hospital birth were first-time mothers. Most women who had home births had one hospital birth before their home birth. The average age of the women interviewed is 33. All women interviewed have college-level education.

First, this chapter presents women's descriptions of their maternal healthcare experiences. It then describes the complex array of experiences that form women's perception of the quality

of maternal health they received. It was found that a woman's overall satisfaction with care received is mainly contingent on birth outcomes, interpersonal experiences with healthcare providers, and women's expectations of birth. For women who had hospital births, experiences may have been perpetuated by tolerance for lower quality care, which seems to be a result of women not adequately engaged with their healthcare providers. For women who had home births, women's experiences were overwhelmingly satisfactory, which matched their expectations of birth and more sophisticated standards of care.

Semistructured interviews (see Appendix) were used to elicit mothers' experiences with their most recent pregnancy and birth, focusing on various domains of healthcare satisfaction, including staff interactions (communications, skill, trust), services (type, quality, privacy), and facility (cleanliness, equipment, distance) informed by the quality-of-care framework by Donabedian (1966). Research findings generated themes that describe the in-depth experiences of Black women during pregnancy, birth, and the type of maternal healthcare they received.

Constructivist grounded theory (Charmaz, 2008) is the methodology used to inform the exploration of the data and understand Black women's perception of quality of care from their lived experiences with maternal healthcare. Given the interpretivist nature of constructivism and its theoretical underpinnings of symbolic interactionism and constructivism (Gardner et al., 2012), this approach provided an appropriate way to reflect, understand and extrapolate knowledge about maternal healthcare from the experiences and perspective of Black women.

Research findings are presented in two groups, themes from the experiences of Black mothers who had a hospital birth and themes from the experiences of Black mothers who had a home birth with a race-concordant certified nurse midwife. Themes from each group were organized into four sections that tie in with the interview question purposes to learn about:

1. Mother's experience with pregnancy

2. What led the mother to utilize maternal healthcare at her facility (why, where, who)

3. How mother experienced maternal health services (access, space, staff, beliefs about care)

4. Mother's satisfaction with her maternal healthcare and future use

Themes for Mothers who had a Home Birth

1. Mother's experience with pregnancy:

    a. Pregnancy Challenges

    b. Healthy Habits

    c. Social Birth

    d. Home birth Suspicions

    e. Uneventful

2. What led the mother to utilize maternal healthcare at her facility (why, where, who)

    a. Repeat the Experience

    b. Social Media Influence

    c. Accessibility

    d. Personal Connection

    e. Bad Experience with Hospital Birth

    f. Mother's Research

    g. Freedom to have the Birth of Their Choice

3. How mother experienced maternal health services (access, space, staff, beliefs about care)

    a. Availability & Access

b. Mother Led Care

c. Normalization of Birth at Home

d. Consistent Care

e. Encouraging & Supportive Care

f. Good Quality Healthcare

g. Family Involvement

h. Preparation for Birth

i. Emotionally Fulfilling & Peaceful Birth

j. Personalized Care

k. Race-concordant Care

l. Positive Impact & Better Health Outcomes

4. Mother's satisfaction with her maternal healthcare and future use

    a. Exceedingly Satisfactory Midwifery Care

Themes for Mothers Who Had a Hospital Birth

1. Mother's experience with pregnancy

    a. Pregnancy as a Limitation

    b. Excitement about Pregnancy and Baby

    c. Fear, Worry, and Doubt

    d. Doctor's Directions

    e. Husband and Mother's Support

2. What led the mother to utilize maternal healthcare at her facility (why, where, who)

    a. Insurance, Good Reviews, and Word of Mouth Recommendation

3. How mother experienced maternal health services (access, space, staff, beliefs about care)

    a. Self-Advocacy and Resistance
    b. Fast Appointments and Limited Knowledge
    c. No Birth Plan
    d. Complications with Medication
    e. Great Doctors and Nurses
    f. The hospital was Full
    g. Nurse Hostility
    h. Out-of-Control Labor
    i. Negative Impacts of Care
    j. "I cannot complain; we both came back alive."

4. Mother's satisfaction with her maternal healthcare and future use

    a. Good overall care with areas that need improvement

Home Birth Mother's Experience with Pregnancy

Pregnancy Challenges

Many women who had home births reported having a difficult pregnancy. Although all women who had home births expressed overwhelmingly positive experiences with their care, it did not necessarily mean that their pregnancy was absent from illness, stress, health challenges, and pain. Mothers had a range of illnesses and stressors, including COVID-19, symphysis pubis dysfunction, hyperemesis, gestational diabetes, signs of preterm labor, insomnia, childcare, work, and relationship problems. This was an interesting observation because it speaks to the

feasibility of women still having a desirable experience of maternal healthcare and birth, despite having risk factors in pregnancy.

One mother described her pregnancy challenges: "Having COVID while pregnant was isolating and emotionally challenging." A second mother reported, "My pregnancy was difficult. I had SPD (symphysis pubis dysfunction), and it was getting worse, but I continued to dance and yoga throughout the pregnancy." A third mother described her pregnancy experience: "I was busy with three other children and working while pregnant."

Healthy Habits

Findings show that mothers who received care from a midwife used pregnancy as a time to start healthy practices and traditions. For example, one mother said, "I was diagnosed with gestational diabetes, so I had to prick myself daily and exercise. I started swimming every week at the YMCA." Other women reported starting a healthy diet and doing regular exercises, like dancing, walking, and yoga. They also reported engaging in mindfulness traditions during pregnancy, like planting a tree and incorporating holistic measures to treat discomfort in pregnancy rather than using medicine. Another healthy practice that women who used midwives started during pregnancy was mental health therapy, which was encouraged by the midwife. One mother said:

> When I met with my midwife, we talked about more than just my pregnancy. Talking to my midwife was like talking to family. We talked about my personal life, and whatever was going on in my life at the moment. I was going through difficult times in my personal life, and she told me to see a therapist, and I did.

Social Birth

Women who used a midwife and had a home birth felt very strongly about the importance of having family and friends involved with their pregnancy and birth experience. Some women reported wanting a home birth because they wanted their family to be present for the birth. All women with home birth reported that family members, friends, and significant others accompanied them to their prenatal visits at least once. Most women involved their husbands and children in their prenatal appointments and birth. Mothers expressed a deep appreciation for family involvement in pregnancy and birth care. Many reported their desire to experience birth as a collective celebration. Multiple mothers planned a birthday party in the same house where they also planned to give birth while having family witness the birth. One mother described her birth plan as an open invitation to all her friends and relatives. These mothers reported being happy to have shared their birth experiences with their families.

Home birth mothers reported that they did not feel pressured by family and friends to use the hospital for the birth. They reported that they felt their birth desires were respected by their family and friends. Home-birthing mothers described their pregnancy experience as feeling reassured, supported, and affirmed by their friends and family for their birth choices. One mother said, “Birth was a meaningfully profound experience for the women in my family.” Another mother detailed, “There were tears in everyone's eyes to see a birth happen so close.” A third mother described, “Birth was a bonding experience for my family.”

Home Birth Suspicions

Mothers who received midwifery care reported having experienced some level of curiosity from family and friends about their decision to have a home birth. Some mothers reported that their family and friends felt apprehensive and questioned their choice to have a home birth. One mother reported receiving a lot of negative feedback from the public on social

media after posting a video of her home birth with hip-hop music. Another mother reported, "I was happy to answer questions and inform others about home birth." Notably, most home-birth mothers reported feeling supported by their family and friends for planning a home birth.

Uneventful

Pregnancy was uneventful, healthy, and comfortable for several mothers who had a home birth. One mother reported, "I was excited to be pregnant because I love giving birth." Another mother said, "I was working from home while pregnant, which was nice. It was comfortable to be home." Most mothers reported being healthy and able to continue their regular activities, such as caring for other children, working, exercising, and taking care of the household while pregnant. One mother reported, "I danced and did yoga throughout my pregnancy. I also had to take care of three other children."

What Led Mother to Utilize Maternal Healthcare at her Facility (why, where, who)

Repeat the Experience

Mothers who chose midwifery care and home birth reported doing so mainly because they had used a midwife and had previously had a home birth. These mothers reported being happy with the care they experienced and thus wanted to repeat the experience with the same healthcare provider. Some mothers expressed their desire to continue to use midwifery services for healthcare needs beyond pregnancy and birth. One mother stated, "I used the same midwife for my previous birth." Another mother said, "After having an unassisted birth at home, I never wanted to go back to a hospital." A third mother stated, "I was happy with the care I received from the midwife."

Social Media Influence

When asked about what led mothers to choose midwifery care, several mothers stated that their midwife influenced them on a social media platform. One mother reported:

> I followed my midwife on Instagram before becoming pregnant. After becoming pregnant, I found out that she was in my area, so I reached out to her about pregnancy care. We had an interview first, and I loved her immediately.

Another mother reported having felt a connection to the midwife's Instagram page as the impetus to soliciting care from her.

Accessibility

Mothers who had a home birth reported that a reason for choosing midwifery care was the accessibility of midwifery care and home birth. Mothers reported that they chose their midwife because the midwife was close. In addition to being local, another aspect of accessibility that played a role in why mothers had chosen their midwife was affordability. Several mothers reported that having a home birth was more affordable than having a baby in a hospital. One mother stated, "Having a baby at home was more affordable than having a baby in a hospital."

Personal Connection

The more significant part of mothers who utilized midwifery care reported a personal connection with their midwife. One mother expressed, "I felt that meeting my midwife was divine placement." Another mother stated, "When I met her, I loved her midwife immediately." All mothers reported that the care they received from their midwife was personal. Having a race-concordant midwife added to the personal connection mothers reported with their midwife. One mother stated, "I immediately felt drawn to a Black midwife."

Bad Experience with Hospital Birth

A history of poor hospital birth experience was why most mothers sought an alternative option in maternal healthcare with midwifery care and home birth. Mothers reported that a previous bad experience with medical care and hospital birth was the driving force in their desire for a different birth experience. Mothers chose midwifery care and home birth to have a better birth experience. The single most prominent reason mothers choose midwifery care, and home birth was their bad experience with a hospital birth.

The disappointment with medical doctors and hospital birth stemmed from the mother's previous negative experiences. Some negative experiences include inconsistent care when under the care of multiple doctors and hospital restrictions with family at birth. Mothers reported other negative experiences as having a traumatic birth, not feeling heard by their doctor, having a long wait time, and receiving impersonal care. Mothers also reported feeling rushed and pressured by their medical doctors while in the hospital.

One mother who reported having had a traumatic hospitalized birth with her first child described being overly medicated, feeling drunk, and not understanding what was happening during her hospital birth. She stated that she felt driven to have a cesarean section and that she could not hold her baby after her child's birth. This mother stated, "I felt rushed and pushed to have a c-section because I couldn't push fast enough with the epidural. I felt I could not do it, so I had to have a c-section." After having a traumatic birth experience, she knew that she wanted to have a different birth experience, which is how she came to midwifery care and home birth.

Mother's Research

Mothers who experienced midwifery care and home birth reported choosing this type of healthcare due to doing their research while searching for different birth options. They reported that after researching different ways to give birth, they realized they wanted a water birth. One

mother reported that she was introduced to the idea of home birth by the doula she utilized for the previous hospital birth. Another mother verbalized that after researching alternative birth options, she found a midwife who led her to the home birth option. In general, most mothers researched different options for maternal care and birth experience, and their research led them to midwifery care and, subsequently, a home birth.

Freedom to Have the Birth of Their Choice

The final theme that stemmed from interview questions to understand what led Black mothers to midwifery care and home birth was the freedom to have the type of birth experience of their choice without restrictions. Mothers who had a home birth expressed that they knew what they wanted their birth experience to be like and chose a midwife to fulfill their birth plans without limitations. One example is a mother who stated, "I liked that the midwife had a hands-off approach. With no disrespect to my midwife, actually, with all respect to my midwife, she wasn't a big part of my birth story, and that's exactly what I wanted." This statement highlights this mother's desire to have complete autonomy and control of her birth while having herself, her baby, and her family at the center of her birth experience. Another mother stated that she wanted her friends and family involved in her birth, and having a home birth allowed her to have anyone she wanted present at birth. A third mother reported that she always wanted a home birth.

Mothers who chose midwifery care expressed intentionality about creating the birth experience they wanted. These mothers had set expectations of what they wanted for their pregnancy and birth experience. In other words, these mothers identified what they valued. They desired their pregnancy and birth experience, such as having family involved, birthing at home, having a water birth, and wanting a different experience from hospital birth. Within these

established values was having a race-concordant midwife. One mother shared that having a midwife of color was of great importance to her and her family.

How Mothers Experienced Maternal Health Services

Availability and Access

Mothers who utilized midwifery care reported having direct access to their midwife through telephone calls and text messaging. They reported that their midwife was always available and quickly responded to answer their questions, listen to them and offer help at any time and day. When mothers needed a midwife because they saw signs of labor, the midwife's response time and arrival were quick and intuitive. One mother reported that her midwife had already been parked outside her house waiting for the call. Some mothers reported that the midwife responded quickly to their call and arrived just in time for the birth. One mother said her midwife had been waiting for her call all night. Another mother reported that she did not need much from her midwife but knew that her midwife was always available and easily accessible within close distance when needed for labor and birth.

Examples of the ease of access to midwives were depicted in mothers' statements in this study. One mother said, "The midwife arrived within an hour after starting active labor." Another mother stated, "Once I called to tell her that I was in labor, she was on her way." A third mother said, "Appointments with my midwife were like a regular doctor's office without waiting in the lobby. When I came in for my appointment, I had the whole office to myself, and the midwife was waiting on me." A fourth mother stated, "I can call or text anytime, and my midwife will listen."

Mother Led Care

Findings show that midwifery care is mother-led and mother-focused. Midwives honor the mother's birth choices without being subjected to the same restrictions they previously experienced when birthing in the hospital. Mothers felt that with midwifery care, they did not feel forced or pressured into anything. One mother reported that her midwife supported her desire to be induced naturally. Another mother said she loved that her midwife allowed her to have the birth of her choice. Most mothers reported that they felt encouraged by their midwife to make their own choices in their care and birth plan. All mothers reported that their midwives allowed them to labor wherever they wanted, like in the toilet, tub, shower, kitchen, and bedroom.

Midwives also supported mothers' choice to have family and friends present and involved with pregnancy care and birth. One mother reported that she did not like much attention and wanted to labor and birth primarily on her own. As a result, the midwife was mainly hands-off and quiet, only doing the necessary checks. Many mothers stated that they felt autonomous and able to direct their care and the level of interaction they wanted with their midwife. One mother stated, "It was good to have control over my birthing experience." Midwives asked mothers to direct when they felt ready to push, and mothers felt they transitioned through the processes of labor and birth when they felt ready. One mother stated, "Everything with the birth was going with the flow."

Normalization of Birth at Home

Testimonies from mothers who had a birth at home revealed that receiving maternal healthcare at home normalizes pregnancy and birth experiences. Mothers described the space they received to care for their pregnancy and birth at home as comfortable, familiar, safe, free from hospital restrictions and rules and a place where they felt free to move around. They also

reported that laboring at home allowed them to stay occupied and distracted with activities of daily living like cooking and taking care of their children. Mothers expressed how much they loved birthing in their tubs, being surrounded by family, and moving freely while in labor in the safety of their homes.

Mothers detailed how they created their therapeutic milieu to prepare for birth at home. One mother lit candles around her tub, and another posted words of affirmation in her shower. Other mothers played the music of their choice to make birth fun or relax. One mother stated that being at home during birth offered distraction with things to do during labor. Multiple mothers reported receiving care at home surrounded by family normalized the experience. Mothers expressed that when birthing at home, they had no fears or worries and felt safe and secure because the people who joined them at their home birth were trusted and had their best interest in mind.

In addition to a safe and comfortable place to give birth, part of the normalization of birth during a home birth is that it provides an easy transition for mothers to return to regular life activities after giving birth. Mothers reported that after giving birth, their midwife helped them move from the place of birth, such as the tub, to their bedroom. Midwives also assisted with feeding the family and ensuring the house was clean. Mothers reported that the comfort and security they felt at home facilitated their body's ability to release and do what it had to do without pressure.

Mothers had the freedom to birth how they wanted to at home. Some mothers wanted an intimate birth experience, while others wanted a birth celebration involving many friends and family. While every birth experience was unique, most mothers reported that their midwife played a role in making them feel supported, safe and comfortable. Mothers who sometimes had

to visit the midwife's office for pregnancy care reported feeling comfortable and inspired in her office space. One mother reported that she looked forward to going to her midwife's office because it was amazing, filled with beautiful Black art, and felt like a getaway.

Consistent Care

With midwifery care, mothers appreciated the benefits of having a consistent maternal healthcare provider. One mother stated, "I saw the same midwife and midwife-partner through my pregnancy and birth." All mothers shared this same sentiment and expressed that they had a good rapport with their midwives. Mothers felt familiar with their midwife, and most reported that their midwife was as close to them as family. The midwife provided the full range of care for pregnancy and birth. All mothers reported receiving care from a personal care team that consisted of their midwife, some had a birth assistant or a second midwife, and others had a doula. Mothers who had a doula reported that doulas also provided consistent care throughout the pregnancy and birth, enhancing the birth experience.

Encouraging and Supportive Care

A salient theme about the care from midwives has to do with how encouraging midwives were for mothers. Mothers reported feeling encouraged by their midwives throughout their pregnancy care, especially during labor. Several mothers reported a similar sentiment to a mother who said, "She never told me how dilated I was, but I appreciated that because it kept me encouraged." Mothers consistently reported feeling that their midwife's approach of not informing them about how dilated they were during labor helped keep them encouraged.

Another mother stated, "She gave me all the information I needed but never decided for me. When I asked her what to do, she always wanted me to make my own decisions." Midwives encouraged the mothers to take charge of decisions about their care. Midwives also encouraged

mothers to form healthy habits and care for their mental health. Mothers felt continuously encouraged and reassured by their midwife during pregnancy and birth. One mother said, “I felt I could give birth alone even if the midwife did not arrive on time.”

One mother reported that her midwife helped prevent her from giving up during labor. Another mother stated that although she was without a significant other, her midwife supported her. A third mother shared, “I felt seen, heard, and supported by my midwife. After every visit, I felt that my midwife helped me.” A fourth mother stated, “The care from my midwife was different from a doctor where I felt judged and unsupported.”

Good Quality Healthcare

In general, mothers reported having received quality medical care from their midwives. Mothers trusted their midwife’s knowledge, skill, and competence. Mothers stated that their midwife had all the necessary tools and equipment for pregnancy care and birth. One mother shared that her midwife was very resourceful and always had a remedy available to give her. Mothers reported having been well taken care of by their midwives. One mother stated, “My midwife would check on my baby and me frequently and did not leave the house until we were both stable.”

A mother stated that with midwifery care, she self-directed her care, and the level of interaction with her midwife made her feel well cared for. Another mother expressed that she did not feel that midwifery care was subpar to doctor's care. She felt that her midwife had everything needed for care at home, just like a doctor’s office. Mothers completely trusted that their midwife would inform them if there were anything unsafe about the pregnancy or birth at home. All midwifery care recipients felt they received overall good quality care from their midwife during their pregnancy and home birth.

Family Involvement

With their midwives' support, mothers had their families involved in their prenatal and birth care. They were having families involved in the care provided mothers with added encouragement and support. Mothers reported that families ensured that they received good care from their midwives. For example, one mother reported, “My mother is top tier, and she made sure I had everything I needed during my birth.” Another mother stated that it was nice not to be alone. A third mother expressed gratitude for having her support system present: "I was so thankful to have my family at my birth because they did not let me give up.” Multiple mothers reported being intentional about having their children witness and participate in their birth.

Prepared for Birth

Feeling prepared for birth was a theme connected to mothers who gave birth at home. Mothers reported that their midwife prepared them for their home birth. When family members were involved in maternal care, everyone was comfortable and prepared for the home birth. Mothers reported that the home birth did not come as a surprise even for children because everything had been explained to them with anticipatory guidance. Mothers reported they felt reassured if they happened to give birth before the midwife’s arrival because midwives had prepared them for such a scenario. One mother stated that having their family involved with pregnancy care gave them a better understanding of what would happen during birth.

Communication with the midwife helped mothers and their families learn, stay informed, and ultimately prepare for birth. One mother expressed that communication with the midwife was kind, honest, informative, and not pushy. Most mothers stated that their midwife gave them all the information and answers to their questions. One mother stated, “I felt fully informed by

my midwife about the risk of having a home birth. She did not sugarcoat anything. I know that giving birth is dangerous."

Emotionally Fulfilling and Peaceful Birth

One of the hallmarks of midwifery care and home birth is the overwhelming amount of positive emotions that the experience cultivates. All mothers reported that the birth experience at home was emotionally fulfilling and self-actualizing. Most mothers described their home birth as peaceful and surrounded by love. One mother recalled that her maternal health care felt great, and she had an amazing birth experience. Another mother described the atmosphere during her birth as, "Had no fighting, no arguments, no bad energy." Several mothers felt a sense of accomplishment after having a home birth.

Personalized Care

The most salient theme about midwifery care and home birth is the mothers' experiences of personalized care. According to mothers who experienced a home birth, midwifery care is personal. Mothers felt seen, heard, and understood by their midwives. Most mothers reported that visits with the midwife were lengthy and the care was holistic, meaning that the midwife cared for their mental, emotional and physical health. Mothers reported that they felt their midwife knew them personally, making the mother and their families comfortable with the midwife. Mothers reported that they felt helped by the midwife after consultations.

One mother reported that she felt seen by the midwife as an individual outside of pregnancy. Consultations with the midwife involved conversations about other topics, needs, and concerns beyond pregnancy. One mother stated that the midwife talked about things going on in her life. A second mother reported that her midwife helped her on a personal level. Midwives

encouraged therapy, and mothers felt their midwives imparted valuable information during their appointments.

Mothers experienced personalized care from midwives and described having aligned values with their midwives. Mothers believed that their midwife had their best interest in mind. A mother stated that with midwifery care, "I never felt like a patient. Calling the midwife felt like calling my own mother." Mothers felt a personal connection to their midwives and felt their care was personalized. One mother stated, "my appointments never felt scripted, like doctor's appointments. I never felt rushed. The appointments lasted about an hour, sometimes 30 minutes, and sometimes longer and always ended organically." Mothers felt free to discuss whatever they wanted, including life stressors and emotional needs.

Race-concordant Care

All mothers reported having felt more comfortable because their midwife was race-concordant. Mothers expressed their importance in receiving care from a midwife who shared their same racial identity. One woman stated, "I felt she cared and meant no harm because she was African American, and that was important for me." Another mother reported that reading stories about women of color still not being heard in hospital settings made it vital for her as a woman of color to be heard and feel safe with her maternal healthcare. A third mother shared, "I felt way more comfortable because my midwife was African American."

Positive Impact and Better Outcomes

All mothers reported that midwifery care positively impacted their birth experience. Mothers reported that having a home birth made their birth quick, easy, organic (going with the flow), peaceful, and enjoyable. Most mothers felt encouraged and prepared for their birth.

Midwifery care involves learning for everyone involved in the care. In summary, women reported that midwifery care was excellent.

Some mothers reported that their home birth was their easiest and quickest labor. One mother stated, “My birth was hilarious and memorable for all.” A second mother reported that she enjoyed her birth with her family, celebrating a birthday while listening to the music of her choice. A third mother stated, “My birth was a blast and fun for everyone involved.” All mothers reported having had a pleasant experience with their home birth. While some described their home birth as fun, others described it as peaceful, but all reported that giving birth at home met their birth expectations.

Some positive impacts midwifery care had on mothers were giving birth to a baby with a healthier birth weight and having no vaginal lacerations. One mother stated, “My midwife recommended that I increase the protein in my diet because with my first birth in the hospital, I had a vaginal laceration. And with my home birth, even though I had a heavier baby, I did not tear.” Mothers reported feeling confident in their body’s natural ability to give birth due to midwifery care. Midwifery care helped mothers feel empowered and inspired to help other mothers have a better birth experience. Some mothers reported, “I even had a better breastfeeding experience after having a home birth.” In all, midwives helped women fortify trust in their bodies and improve their health outcomes and birth experience.

Mother’s Satisfaction With Her Maternal Healthcare and Future Use Exceedingly Satisfactory Midwifery Care

All mothers who received midwifery care reported complete satisfaction with the care they received and recommended midwifery care to others. One mother stated that she recommends a midwife to anyone who wants a homebirth. A second mother stated that every woman deserves her experience. All women in this study highly recommended midwifery care.

No identified areas of improvement were reported by mothers who used midwifery care. One mother stated that she would not change anything about the care she received. Many mothers reported that there was no way their care could have been made better. Some mothers reported that their midwife exceeded every expectation.

All mothers in this group reported that they would use their midwife again for future births. Some mothers expressed their desire to continue to utilize midwifery care for healthcare needs outside of pregnancy. Most mothers reported staying connected with their midwife even after birth and postpartum care. Some women stated they still have access to their midwife for health questions beyond pregnancy.

All mothers reported complete satisfaction with midwifery care. Mothers expressed how much they loved the care they received. One mother stated that she never doubted her decision to have a midwife. Many mothers reported that their midwife is the best and that because they received the best care, they had the best experience with pregnancy and birth. One mother stated that midwifery care was what she needed. A second mother wrote that she wanted a home birth and her midwife helped her have it. Findings from this study show that midwifery care met the needs and expectations of all mothers.

Most mothers verbalized their appreciation for having a race-concordant midwife. One mother stated that she would appreciate it if the backup midwife was also a Black woman if her midwife had not been present for her birth. This statement highlights how important it was for this mother to have race-concordant care. Many other mothers shared this sentiment about their value and appreciation for their race-concordant midwife.

Hospital Birth Mothers' Experience with Pregnancy

Pregnancy as a Limitation

Pregnancy was described as painful, uncomfortable, and a limitation for some mothers who had a hospital birth. When asked about her pregnancy experience, one mother stated, “Horrible! I cried all day; I had terrible nausea.” Multiple mothers described their pregnancy as a hindrance to their normal body functioning. One mother reported that her pregnancy was a limitation and wanted her body back. Another mother stated that she felt restricted because of her religious beliefs about pregnancy. This mother stated that if it were not for religion, she would have had an abortion. A third mother reported feeling restricted in her activities and diet due to pregnancy. A fourth mother reported that she felt restricted in her ability to receive care due to feeling rushed and not having her symptoms and questions adequately addressed.

Excitement about Pregnancy and Baby

Pregnancy was described as good, happy, and uneventful for most mothers who had a hospital birth. Mothers reported feeling excited that everything was going well and that it was absent from adverse health events. Many mothers also reported excitement about finding out the baby’s gender and wondering about the baby’s appearance. One mother reported that doing a general reveal was her way of incorporating tradition into her pregnancy. Another mother described her pregnancy traditions involved taking pictures and belly painting.

Worry, Fear, and Doubt

Mothers reported having had doubts about their medical doctor’s diagnosis and fear surrounding their pregnancy. One mother reported being worried about her elevated blood pressure. Another mother reported doubt about her doctor’s diagnosis of her baby’s gender. Multiple mothers reported anxiety about returning home following birth because they felt rushed. One mother stated, “I was also nervous because it would be a totally different hospital. I had never been to this hospital to give birth.”

Fear was a salient theme from mothers who had hospital births. Mothers reported being afraid and worried about the outcome of their pregnancy. One mother stated, “I spent a lot of time during my pregnancy listening to OBGYN tv shows discussing rare conditions in labor and delivery and rare disabilities that affect children at birth, so I feared those things might happen to me and my child.” Mothers reported being afraid of going to the hospital and not knowing what to expect. One mother vividly depicted her fear while in the hospital with the following statements:

> While I was there I remember my chest feeling heavy like I couldn't breathe, and I was already so scared. But I was trying not to be scared. I was trying to relax in my mind, so I didn't even want to say anything about the fact that I was feeling like I couldn't breathe.

Doctor’s Directions

When asked about traditions and practices adopted during pregnancy, most mothers who had hospital births reported that they did whatever the doctor told them to do. When asked about her practices or restrictions during pregnancy, one mother stated, “I felt good. The doctor didn’t give me any restrictions so I didn’t give myself any restrictions.” Two mothers reported making healthy diet changes because of pregnancy. One mother reported being a smoker and stopped smoking once she found out she was pregnant. One mother reported that she started pregnancy yoga.

Husband and Mother’s Support

Most mothers who had a hospital birth reported that most of their support came from their husbands and mothers. Hospital birth mothers felt supported by their mothers, who took care of the cooking and cleaning of the house after they gave birth. Most mothers reported feeling supported during pregnancy and birth by their husbands, who accompanied them to their

prenatal care appointments and cared for other children after birth. One mother reported that because of her husband and mother's help, she was given the space needed to be the sole caretaker of the newborn baby.

What Led Mother to Utilize Maternal Healthcare at her Facility

Insurance, Good Reviews, and Word of Mouth Recommendation. For almost all mothers with hospital birth, insurance was the determining factor for choosing the maternal healthcare facility they utilized. This quote from one mother depicts what many other women also shared, "So being in a new city, I didn't know like where to go or who was a good doctor, so I basically just picked one who was compatible with my insurance and thankfully it ended up being a good doctor as far as the weekly appointments that I would go to." For most women, there were no additional factors that went into selecting maternal healthcare besides being in network with their health insurance. Insurance dictated what medical facility and hospital all mothers utilized for pregnancy and birth care.

Some mothers chose their maternal healthcare provider solely because they had previous children with the doctor. A few mothers wanted consistent medical providers for their pregnancies and birth care. However, even for mothers who expressed they wanted consistency with medical providers, their doctors were also covered by their health insurance. No mothers with hospital birth chose a medical doctor or hospital not covered by their health insurance.

Besides being covered by insurance, many mothers also reported that having good reviews supported their choice of doctor. When asked about what led them to choose the maternal healthcare facility they utilized, almost half of the mothers reported that they saw their doctor had good reviews. Having good reviews validated their choice of a healthcare facility.

Two mothers reported that besides being covered by health insurance and having good reviews, they knew someone who had used the doctor and received a word-of-mouth recommendation.

How Mothers Experienced Maternal Health Services

Self Advocacy and Resistance. An important theme from the experiences of mothers who utilized medical doctors and had a hospital birth was the need to advocate for themselves. In both the medical office facility and the hospital setting, most mothers expressed situations where they had to speak up for themselves, defend themselves, repeat themselves and demand the care they needed. The need for self-advocacy was a theme that threaded through most of the experiences shared by mothers who had hospital births.

One mother reported that because her doctor was not engaging, she needed to take the lead in her care and always ask questions during her appointment; otherwise, she would not be informed. Another mother shared that her doctor appointments were so fast that she learned to adapt by writing her questions down and asking them quickly. A third mother reported having had to ask again and strongly requested an appointment to be seen by her doctor while pregnant.

Many mothers reported experiencing resistance and disbelief by hospital nurses, which required mothers to further self-advocate. Mothers reported they had to continuously explain themselves to nurses in the hospital, ask questions, and demand to be heard. One mother stated that hospital nurses gave her medication without informing her, and thus she had to continuously ask the nurses to explain what they were doing to her. Another mother said she demanded to be listened to about her birth plan. A third mother reported requesting the nurse to call her doctor for intense labor pain.

One mother illustrated an example of the resistance she experienced from hospital nurses and how she responded to it emotionally with self-advocacy:

> And I asked her. I said, you know, instead of doing that, why don't you just bring me a pump for me to pump the milk and show you that I'm producing the milk that she's drinking? Why don't you do that? Eventually, after all the fighting, because I was so angry, and I was trying to hold myself back. And you know I was crying because I was so mad, so mad because I started even thinking about how many women they must have done that to. They discourage them from breastfeeding, you know, like telling them, you know you can't produce, like so quick to do that, right? And they never even brought in a lactation specialist. But you're quick to tell me, give her a formula.

Fast Appointments and Limited Knowledge. Many mothers reported that their prenatal appointments were quick. Mothers described her pregnancy care doctor appointments as fast, in and out, mechanical, scripted, and the same thing at every visit, which did not feel personal. One mother stated that she felt her doctors only addressed the concerns of the moment that she brought and nothing further. Mothers who reported their appointments were fast did not see this as a negative but instead learned to adapt to it. One mother stated, “His appointments are fast, but I appreciate less wait time than in other doctors' offices.” On the contrary, another mother stated that she wished her appointments were an hour duration and received more validation from her doctors.

Perhaps as a result of speedy medical consultations, many mothers also reported not feeling prepared for birth. One mother reported not feeling well informed, educated, or prepared because, although it was her third pregnancy, it all felt new. Another mother stated that she was prepared for a vaginal birth but did not feel prepared for a cesarean section. A third mother stated, “I did not expect all the swelling I had; I was not educated about that.”

No Birth Plan. Most mothers who had a hospital birth did not have a birth plan. The only mother who did have a birth plan stated that it was fluid and open to whatever may come. For almost all women who had a hospital birth, their experience was inconsistent with what they expected for their birth. Although most mothers did not have a formally established birth plan, most mothers had expectations of what they envisioned their birth to be. However, many mothers' hospital experiences differed from what they expected, and some expressed disappointment. This mother's quote is an excellent example of what she envisioned for her birth was not what she experienced:

> I wasn't planning to take any painkillers or medication for it, but because I was already feeling discouraged and not able to move from the bed, and not let my body go into natural labor. They induced me, so at that point, I just went with the epidural. Yup, I went with the medicated route, so my plans just fell through because I guess my birth plan wasn't really considered.

Complications with Medication. Several mothers reported experiencing some type of complication due to the medication they received during their hospital birth. One mother reported that she suffered complications due to her intravenous line not being able to be started or maintained correctly. Another mother shared that the medication she was given in the hospital caused her baby's heart rate to drop. A third mother reported that she suffered complications from a bad reaction to the epidural that caused her panic attack.

Great Doctors and Nurses. All mothers, except for one, reported that they had great doctors. Most mothers reported confidence in their doctors and believed they were knowledgeable. Mothers reported that they appreciated their doctors' quick responses. They appreciated being able to call their doctors with questions and receive answers. One mother

stated that she preferred that her doctor used analogies to explain things in the simplest form. Another mother stated that she liked that her doctor's office was organized, appointments were made in advance, and the doctor had multiple office locations.

Regarding the hospital experience, all mothers reported that most nurses and doctors were great. One mother detailed her experience with the doctor on call for her birth stating, "The doctor on call happened to be very calm, didn't say much, and went with the flow. She seemed at peace with anything and everything, which worked to my advantage."

One mother shared that she had one lovely hospital nurse who listened to her birth plan and was engaging. Another mother stated that she had one outstanding nurse who made her feel comfortable and at ease and reassured her. A third mother shared that it was good to have the same nurse for 12 hours, for labor, delivery, and postpartum care. A fourth mother stated, "The check-in process at the hospital was smooth and fast, faster than I thought. Everyone was so nice."

The Hospital was Full. A common theme from mothers who had a hospital birth was that the hospital was full. Mothers said they were made to wait for a bed to become available after birth. One mother stated that she was in the hospital but wanted to go home. Another mother shared that she was not allowed to walk around. Several mothers reported that there were no rooms in the hospital, space was unavailable for them to transition from labor and delivery to postpartum, and thus had to wait an extended amount of time. One mother stated, "In the hospital, they did everything they were supposed to do, but they couldn't move me to go where I was supposed to go in postpartum because there was no space."

Nurse Hostility. About half of the mothers who had a hospital birth reported hostility from nurses. Mothers reported hostility in the form of poor service, lack of service, inappropriate

comments, and microaggressions. One mother stated that her husband felt he was treated differently by a nurse. This same mother also reported receiving unwelcoming comments and remarks about her body type, which may have been microaggression. Another mother stated that she felt a hospital nurse lacked empathy and humanity and did not assist a first-time mother. A third mother reported disappointment because a nurse could not remember her baby’s name.

A mother reported her experience with subpar care from a nurse in the hospital in her statements below:

> I felt like it was negative about breastfeeding, and I felt so, like, disappointed because I felt like you should push more from breastfeeding, but they were so quick they wheeled in a bottle of formula, and I'm like, where are you going with that?

Out-of-Control Labor. Several mothers described their labor experience in the hospital as painful and out of control. One mother stated, “Aside from the screaming and squirming and kind of the desperation I felt in the moment that it was time for the baby to be born, most of it was, I guess, uneventful.” Another mother reported that she felt horrible contractions and was out of control. The most poignant description of the intensity of labor pains and the helplessness experienced by mothers who gave birth in the hospital was given by this mother. She stated, “I just remember thinking in my head there is no way my body could go through this and survive it. The pain was unbearable.”

Negative Impacts of Care. When asked how the care they received impacted them or their baby, several mothers detailed adverse sequelae from medical care and hospital birth. One mother reported that as a result of her overly medicated hospital birth her baby was born stressed with meconium staining and decelerations in her heart rate. Another mother stated that she

started to scream and cry after she was told that she had no choice but to have a cesarean section. When asked about her experience with maternal care at the hospital, one mother stated:

> I thought it would be a little bit different. I was a little in shock and disappointed because I thought, even though I was in the hospital, I thought it was going to be more of a natural labor, or at least being able to be more mobile and move around my room. But as soon as I got there, they pretty much wired me up, put an IV on, I had to stay in the bed, and I had the monitor on my belly. I was just in bed for over 24 hours until I gave birth.

"I Cannot Complain; We Both Came Back Alive." A more salient theme about the impact of care received by mothers who had a hospital birth was a sense of complacency. Most mothers reported positive impacts of care such as surviving the hospital and surgical birth. Having a live birth was the ultimate marker of satisfaction with healthcare outcomes for mothers with a hospital birth. As long as the baby was alive and well, that is what most mothers valued. One mother stated that she was comfortable with the cesarean section if that was what she needed. Another mother said she was relieved to give birth because her pregnancy was causing severe pain. Lastly, a mother said she could not complain about her experience because she and her baby both came back alive.

Mother's Satisfaction With Her Maternal Healthcare and Future Use

Good Overall Care With Areas That Need Improvement. Most mothers who received medical care and had a hospital birth reported good overall care. All mothers, except for two, stated that they would use the same doctor in the future. Two mothers reported dissatisfaction with their doctor's care and thus would not utilize their service in the future. One of those mothers stated that she would not use the same doctor because the doctor functioned with an anxious mindset, was reactive, and would have rushed her into a cesarean section. The other

mother said she would choose a Black doctor for her subsequent pregnancy. All mothers reported that they would recommend their doctors to others.

Although all mothers reported having received overall good care from their doctors, several mothers described areas of needed improvement. When asked about her overall care, one mother responded, “I liked them. They weren’t like over the top, like yay, I love this place, but it was not like, oh my God, I hate going there.”

Some of the improvements described by the mothers include having less wait time, allowing mothers to move around in labor, providing personalized care, more engaging doctor appointments, and explaining what would happen at the hospital. Several mothers wished they were more educated about their birth experience. A couple of mothers said they wished for more diversity in their healthcare staff. One mother reported wishing her birth experience was more of a bonding experience with her husband.

Increasing availability was an area of improvement passively suggested by a mother with this statement, “It was scary not to be able to schedule an appointment soon, but it didn't feel terrible or irresponsible.” Another area of improvement was to increase the availability of female medical providers, which was passively suggested by a mother who made this statement, “I only wanted a female doctor, but was willing to tolerate a male doctor.” Finally, a mother reported wishing her prenatal appointments were longer and engaging with her doctor.

Chapter 5: Discussion, Application, and Conclusions

Chapter 5 contains a discussion of the research findings on the perceptions of the quality of maternal healthcare of Black mothers. Discussions of the findings are divided into three parts that address each research question. The clinical practice implications of the study are examined. Limitations of this study, suggestions for future research, and contributions are also discussed.

Black Mothers' Experiences of Maternal Healthcare

The purpose of this study was to describe the experience of Black women who experienced maternal care from the traditional model of PNC and the experience of Black women who experienced maternal care from the midwifery model of PNC with a race-concordant midwife. The women in this study experienced maternal care from two models of care, traditional medicine, and midwifery care. All women in this study reported overall good quality care. For women who had a hospital birth, despite describing negative experiences, they were satisfied with the care mainly because of the survival of the mother and baby. Mothers who had midwifery care reported excellent quality of care with no reported areas of improvement. The findings from this study demonstrate the complexity of Black women's experiences and perceptions of the quality of care. Findings have significant implications for clinical practice and future research.

Constructivist grounded theory, the methodology for this study, provided an approach to understanding and exploring the meaning of quality of care through the perspective of Black mothers. Grounded theory guided this investigation of the human experience of maternal healthcare from the perspective of Black women. This study provides a deeper understanding of what it was like to experience obstetrical and race-concordant midwifery care for Black mothers.

Many themes emerged from the narratives about the lived experience of Black women with maternal healthcare.

For Black mothers who experienced race-concordant midwifery care, themes were: Availability and Access, Mother Led Care, Normalization of Birth at Home, Consistent Care, Encouraging and Supportive Care, Good Quality Healthcare, Family Involvement, Preparation for Birth, Emotionally Fulfilling and Peaceful Birth, Personalized Care, Race-concordant Care, Positive Impact and Better Health Outcomes.

For Black mothers who experienced traditional medical care, themes were: Self Advocacy and Resistance, Fast Appointments and Limited Knowledge, No Birth Plan, Complications with Medication, Great Doctors and Nurses, Hospital was Full, Nurse Hostility, Out-of-Control Labor, Negative Impacts of Care and "I cannot complain; we both came back alive."

This study elicited birth narratives and perceptions of quality of care from 20 Black women who gave birth at home or in a hospital. Women who gave birth at home received pregnancy and birth care from a Black Certified Nurse Midwife using the midwifery model of care. Women who gave birth in the hospital received care from an obstetrician using the traditional medical model of care. For women in this study who had a hospital birth, the survival of the mother and baby was the most prominent factor in their evaluation of the quality of care. For women in this study who had a home birth, having personalized care, autonomy, and family involvement was vital for positive birth experiences and quality of care.

The women in this study did not experience difficulty in accessing prenatal care as they all were covered by health insurance. For women who experienced the traditional medical model of PNC, the selection of healthcare providers mainly dictated their health insurance. They

believed that they received good care for their pregnancies and births even though they expressed concerning experiences during their hospitalization and prenatal care. Some mothers experienced distrust and disengagement with their health providers. They also experienced hostility and disappointment in the hospital. Their PNC appointments were fast and many omitted the education that women needed to be prepared for birth. The findings of this study suggest that Black women within the traditional medical healthcare system are still at risk for poor quality maternal healthcare experiences.

Women who experienced race-concordant midwifery care did not express any concerns with their PNC and home birth. They expressed complete satisfaction with care that was holistic, personal, family-centered, accessible, and efficient. Even with more sophisticated expectations of PNC and birth experience, these mothers reported complete satisfaction with no areas of improvement. The findings of this study suggest that race-concordant midwifery care can improve the quality of care for Black mothers and thus may help improve health equity and racial disparities in maternal healthcare.

Discussion of Findings for Research Question 1

The women from this study who received care via the traditional medical model described the care as overall good. However, these women also experienced provider disengagement, lack of information, decreased accessibility to their doctors, and poor quality care (e.g., knowledge deficit, no space in the hospital, medical complications, and hostile nurses). Although women express satisfaction with care, they highlight simultaneous negative experiences (e.g., disappointment, anger, mistrust, fear, and microaggressions) and empowering ones (confidence in doctors, having great doctors, good care, and family support).

Women who obtained care from medical doctors described maternal and infant survival as a priority over poor experiential care and mistreatment. Social support from family, access to healthcare, communication with doctors, comfortable healthcare facilities, and friendly nurses enhanced women's experience and subsequent evaluation of the quality of care.

For women who experienced the medical model of care, findings about their perception of the quality of care show that their appraisal benchmark is low. Their expectations of care show that as long as there were no deaths, they perceived that the care they received was acceptable. Findings show that these mothers were willing to adapt to undesirable aspects of their medical care. For example, a mother complaining that her medical appointments were fast said, "He works fast, but I appreciate less wait time than in other doctors' offices." A mother who stated that she only wanted care from a female doctor stated that she would conform with a male doctor "if it were God's will for it to happen that way." Lastly, a mother complaining that the doctor omitted information during appointments stated that she adapted by taking the lead and asking more questions during her appointments. This mother also reported that she had to diagnose herself many times by looking up her symptoms on Google.

Findings show that most women who had hospital births show up for pregnancy and birth care seemingly desultory and accepting of the care they receive with tolerance for the negative experiences. Women's feelings about their hospital birth experience include unawareness, fear, anger, overly medicated, discouragement, resistance, disappointment, and hopelessness. However, mothers mainly reported having experienced overall good care, which is conflicting. It is also conflicting that although most mothers who had a hospital birth reported that hospital nurses were friendly and took great care of them, findings show they experienced hostility from

nurses in the hospital. Half of the mothers experienced some extent of resistance, disbelief, poor care, lack of empathy, discrimination, and micro-aggression from a hospital nurse.

This study found that for mothers with low standards for quality of care, such as the mothers who had hospital births, the cultural capital given to medical doctors and hospitals strips mothers of the agency to expect more than the bare minimum. The tolerance for poor quality care seen in Black mothers' experiences in this study is consistent with findings from qualitative research on Black women's experience with maternal healthcare in Ethiopia (Hagaman et al., 2022). Hagaman et al. (2022) found that although women experienced disrespect and neglect from their maternal healthcare providers while receiving care in dilapidated facilities, they reported having a positive birth experience mainly because of maternal and infant survival and safety.

Literature on mothers' perception of the quality of maternal healthcare reveals the importance of maternal and infant survival in mothers' reports of satisfaction with maternal care (McClure et al., 2007). Mothers who survive obstetric emergencies tend to associate survival with adequate care (Cham et al., 2009). Women with low expectations of maternal healthcare experiences drive high-quality care appraisals (Roder-DeWan et al., 2019). Women tend to dismiss, excuse, or ignore disrespectful or abusive care and report satisfaction with care when birth results in a living mother and baby (Hagaman et al., 2022).

The women in this study received PNC through the entirety of their pregnancy, which reveals that Black women in this study deemed it important to seek out and obtain PNC. This is congruent with a study done by Canty (2020) that demonstrated that Black women understood the importance of PNC. This finding also stands in contrast to studies that found Black women are more likely to receive late, limited or lack PNC (Malik, 2000; Park et al., 2007). The women

in this study who had a hospital birth had health insurance and did not experience barriers to accessing healthcare, which is in line with findings by Canty (2020). This finding stands in contrast to other studies that state Black women face barriers to PNC (Fyer et al., 2020; Johnson et al., 2003; Oparah et al., 2017; Prather et al., 2018).

Clinical Practice Implications

In this study, Black mothers who experienced traditional medical care resulted with findings that align with other research studies that have demonstrated that Black women tend to receive poor-quality care for pregnancy and birth, and consequently are in need of improved quality maternal care (Howell, 2018; Oparah et al., 2017; Pranther et al., 2018; Sakala et al., 2018). Racial disparities in the quality of care can contribute to poor maternal health outcomes (Howell, 2018). The overall improvement in the quality of PNC is likely to result in improved maternal health outcomes for Black women (Howell, 2018). It is urgently vital to ensure high-quality PNC as an effort to help eliminate maternal health racial disparities (Center for Reproductive Rights, 2014).

Accounting for the perception of women is critical in the appraisal of quality of care (Redshaw, et al., 2019). Similarly, this study highlights the importance of taking heed to the perceptions of Black women to inform changes to improve the quality of care in maternal healthcare for Black women. Findings from this study are in line with other studies that have found that women want to feel respected by the healthcare staff, prefer a clean environment, and expect their medical providers to be caring, competent and accessible (Michels, 2000). In line with Hagaman et al. (2022), this study found that in order to empower Black mothers within the traditional healthcare system, healthcare providers need to improve engagement with patients

and increase the time for providing patient education and information sharing during healthcare encounters.

Findings from this study show that Black women are terrorized in the hospital. The hospital experience was described with hostility, neglect, resistance, and poor care from healthcare staff by most Black mothers who experienced a hospital birth in this study. The micro-aggressions, discrimination, neglect and poor care happening in the hospital need to be acknowledged and addressed by the healthcare system. About 176 jurisdictions in the United States (72 counties, 99 cities and townes, five states) have admitted to racism being the cause of a public health crisis (Khazanchi et. al., 2021). Hospital systems, in particular, maternity units within hospital systems in the United States ought to declare racism as a contributing factor to the maternal health crisis and develop actionable steps towards anti-Black racism. Healthcare staff need further training on quality care, identifying racial biases and exercising culturally informed care.

During the COVID-19 pandemic, doctors nationwide were seen taking a knee in solidarity with racial justice as they held up posters that read, “White coats for Black lives” (WhiteCoats4BlackLives, 2022). However, since the pandemic, racial disparities maternal mortality have worsened (Hart, 2022). Performative statements have proven invalid in making an actual difference in maternal healthcare outcomes and experiences of Black women. Hospital systems may need to be redesigned and restructured to produce better outcomes for all birthing people in the United States, especially Black women. This study proposes that hospitals dismantle the hierarchy that gives uncontested power to doctors, and build a healthcare system that is diverse, patient centered, empathic, holistic and culturally informed. Medical providers

within the traditional medical model of care may benefit from adopting principles of care from the midwifery model of care.

Women in this study described fear related to the hospital, which further supports the need to increase the education and empowerment of Black mothers to prepare for hospital births. In the current healthcare system, Black mothers may not be encouraged to exhibit self-advocacy in their care. The existing health system culture may reinforce disempowerment and complacency with care by Black women (Hagaman et al., 2022).

There is something to be said about the choices that women make about their PNC and birth. It is important to highlight the fact that women have a choice in their maternal healthcare experience. In other words, it is important to empower women with their right to have a say in their reproductive healthcare and the cultural capital to make decisions about their childbirth. These are fundamental principles of reproductive justice (Ross, 2017). Findings from this study support the need to advocate for the reproductive justice of Black women within the U.S healthcare system. Women's right to have control in their pregnancy care and birth experience is core to reproductive justice (Ross, 2017). The mission to protect and enforce reproductive justice in the United States as clinical practice implication is of particular importance today as the nation grapples with the newly overturned Roe vs Wade legislation. Across the country women are being revoked their rights to reproductive care. Therefore, it is of maximum importance, now more than ever, to ensure reproductive justice for all women.

In addition to survival of hospital birth, mothers reported that interpersonal communication with their doctors and nurses impacted their experience, though not necessarily overall satisfaction with care. Mothers valued having their questions answered by doctors and the access to call their doctors when they had questions. Mothers also reported having appreciated

when nurses listened to their birth plans in the hospital. Friendliness and helpfulness from nurses in the hospital also contributed to the reports of positive birth experiences. Mothers reported they wanted more information and education from doctors and nurses about what was going to happen in the hospital and their recovery process (i.e swelling after cesarean section). Mothers wished that hospital nurses were more empathic and caring. Mothers also wanted more time during their PNC appointments to engage with their doctors. Other interpersonal aspects of care, such as decision-making and active participation in childbirth, were critical determinants of the quality of care by Black mothers who had home births.

Structural elements also played a role in mothers' assessment of the quality of care received and their overall satisfaction. Mothers reported satisfaction with the medical office space, including the cleanliness of exam rooms and bathrooms. They also expressed satisfaction with being able to schedule appointments ahead of time, call the office to schedule appointments, multiple medical office locations, and have the medical office close to home. These findings are in line with other research that found that women prefer a clean environment, and expect their medical providers to be caring, competent and accessible (Michels, 2000). The positive aspects of care that Black mothers highlighted are essential contributions to the maternal care literature given the current maternal health crisis that disproportionately affects Black mothers in the United States.

All women who used the medical model of care reported satisfaction with the care and most reported that they would use the service again in the future. This finding demonstrates how women exercise their right to choose to use the medical model of care for their pregnancy and birth. This choice deserves to be respected and supported. Although the decision to divest from the traditional healthcare system and birth at home with midwives may result in improved quality

of care, the midwife model of care may not be the personal choice of all Black women. It is important to consider that some women may feel unsafe birthing at home and may believe that birthing in a hospital is more safe and comfortable than at home. Some women may feel better being taken care of by a medical doctor over a midwife. One mother reported frustration about her doctor asking for her opinion when she would rather have the doctor give her recommendations.

Discussion of Findings for Research Question 2

For mothers with home births, the most salient factors that contributed to why mothers experienced excellent care was having a personal connection with their midwife, personalized care, holistic care, autonomy in healthcare, and family involvement. Most mothers reported that having a race-concordant midwife was critical in obtaining a personal connection and personalized care from their midwife. Mothers who received care from midwives had concrete expectations about their PNC and birth experiences. A contributing factor to mothers' elevated expectations of care was the motivation to have a different experience from what they had in the hospital. After having a negative experience with a hospital birth, mothers wanted the freedom to have the birth experience of their design and desire. The study highlights that women who had home births with a race-concordant midwife described their experiences contextually with prior hospital births. This expectation benchmarking shapes their expectations for birth and constructed standards for quality care.

Interpersonal communication with midwives was a crucial component in mothers' maternal care experience and overall excellent quality of care. Mothers spoke favorably about being able to communicate with their midwife directly at any given time and day. They described communicating with their midwife as they would communicate with a family member. This

highlights the personal connection Black mothers experienced with their race-concordant midwives. Mothers trusted midwives and felt comfortable. Visits with midwives were lengthy, addressing various needs, and ended organically. This level of engagement with midwives highlights the importance of holistic care to the perception of quality of care for Black mothers. Mothers reported feeling seen, heard, understood, and well cared for by their race-concordant midwife. Consultations with midwives involved more than a focus on the care for pregnancy. Mothers felt that midwifery care was personal and personalized, attending to their unique spiritual, emotional, and physical needs.

In addition to interpersonal communication with midwives, mothers valued having an active role and being the lead decision-maker in their care. Shared decision-making and taking an active role in care were significant determinants of the quality of care for Black home-birthing mothers. Mothers valued the freedom of making decisions and orchestrating their birth experience without restrictions. Having family involved, feeling safe at home, and having the freedom to move at will were essential to building the exceptional birth experience that mothers from this study were able to have at home. Peace, love, celebration, bonding, emotional support, and encouragement were attributes of home births that certainly contributed to positive birth experiences.

Clinical Practice Implications

Findings show that Black mothers who had home births with a race-concordant midwife experienced excellent quality of care. For Black home-birthing mothers in this study, maternal care experiences encompassed family involvement, hands-off birth assistance by midwives, autonomy in care, leading decision-makers in care and the freedom to move in labor in the comfort and safety of home. Mothers who received midwifery care demonstrated clear

expectations about maternal care and desired birth experience. They demonstrated commitment to meeting their maternal care expectations by researching alternative maternal care options, vetting their midwife through a review of their social media page and establishing a birth plan. These finds show that Black mothers received higher quality care from alternative maternal healthcare providers such as midwives and doulas.

Findings from this study highlight the importance of race-concordant midwifery care for Black mothers to experience high quality care for pregnancy and birth. Black midwives in this study demonstrated the provision of high quality midwifery care to Black mothers. These findings may help inform clinical practice implications to improve maternal healthcare for Black mothers. The care provided by Black midwives to Black mothers exemplifies the philosophy of midwifery care as established by the International Confederation of Midwifery (2014):

- Midwifery care is holistic and continuous in nature, grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women.
- Midwifery care is emancipatory as it protects and enhances the health and social status of women, and builds women's self confidence in their ability to cope with childbirth.
- Midwifery care partners with women, recognizing the right to self-determination and is respectful, personalized, continuous, and non-authoritarian. (p.2)

In this study, Black mothers who received race-concordant midwifery care described their experience with maternal healthcare as holistic and personal while being autonomous, having shared decision-making with their midwife, and having family involvement. Based on the narratives from Black mothers in this study, the care from Black Certified Nurse Midwives

evidenced to be authentically aligned with the Standards of Practice as established by the American College of Nurse-Midwives (2022):

STANDARD III

Midwifery Care Supports Individual Rights and Self-Determination and Respects Human Dignity, Individuality, and Diversity.

The midwife:

1. Upholds and facilitates the autonomy of all people to make informed health care decisions.
2. Demonstrates cultural humility and understanding of cultural safety, affirming the dignity of all persons.
3. Supports self-determination and shared-decision making within the context of the family, the community, and the health care setting.
4. Practices in accord with the Philosophy of the American College of Nurse-Midwives and Code of Ethics.

STANDARD IV

Midwifery Care Occurs Within the Context of the Family, Community, History, and a System of Health Care.

The midwife:

1. Demonstrates knowledge that the individual resides within a context of health care, legal, structural, historical, psychological, economic, cultural, and family dynamics that affect health, perceptions of care, outcomes of care, and dissatisfaction with care.

2. Engages with the individual, community, and other health professionals to promote and improve health outcomes.
3. Promotes the involvement of support persons as a critical element of health care. (p. 2)

Key findings from this study can help influence necessary changes to improve the quality of maternal healthcare. Patient perception is an essential indicator for evaluating the quality of care (Michels, 2000). This study demonstrates that Black women's perceptions of the quality of care based on their experiences in the maternal healthcare system is valuable to inform change. To improve the quality of maternal care for Black women, it is important to understand how Black women interpret and conceptualize high quality care. Of critical importance to the improvement of quality care for Black women is for Black women to define what high quality of care means to them. The narratives of Black women who used midwifery care in this study can be used to extrapolate essential information about what Black women consider as valuable and necessary in high quality maternal healthcare.

The findings in this study highlight that Black mothers can experience high quality care for pregnancy and birth. Black midwives demonstrated to be exemplars in their provision of care that aligns with the ACNM standards of practice, while being uniquely positioned to provide higher quality care for Black mothers. This study finding is congruent with findings from a previous study that found that patients identified that midwives of color were uniquely positioned to provide high quality care to communities of color (Wren Serbin & Donelly, 2016). Black midwives have demonstrated to be excellent and uniquely positioned to provide the personalized care that Black women love. Simply stated, the nation needs more Black midwives.

Black midwives are needed to represent the diverse patient population they serve and to provide the benefits of race-concordant care to Black mothers.

Midwifery care, particularly Black midwifery care, is essential to the high-quality care experienced by Black mothers in this study. Race-concordance between midwife and mother facilitated the personal connection mothers felt towards their midwife. Therefore, it can be concluded that race-concordant care was critical to the experience of high-quality, personalized care that Black mothers received. The findings of this study are consistent with other study findings that highlight that race-concordant care improves Black women's experience with health care and healthcare outcomes (Greenwood et al., 2020; Jetty et al., 2022; Takeshita et al., 2020).

In this study, the term Black was used to include women of African descent, such as Afro-Latina, African American and women who identify with the Black race. Half of the research participants were Afro-Latina from the Dominican Republic and Puerto Rico. It is important to note that there may be some core cultural differences between African Americans and Afro-Latinas. However, in this study, one mother who identified as Black, Afro-Latina from the Dominican Republic received care from a midwife who is Black and from Hati. This mother boasted about the importance of having a Black midwife in her experience with the excellent care she received. This mother did not report any cultural differences in the care she received.

Although this study did not find any areas of improvement with race-concordant midwifery care, a consideration for future research would be to explore findings in the quality of care when midwife and patient share the same culture. It is also important to note that many Dominican and Puerto Rican mothers do not identify with the Black race. For this study, the principal investigator found it challenging to recruit Black mothers who used the medical model

of care because many Dominican and Puerto Rican mothers declined to participate because they did not identify as Black.

A final key finding from this study is that it is not merely enough to have written standards of practice. The issue with interventions against racial inequality in maternal healthcare is not about what is written on paper, but what is done after words are on paper. Evidence of care delivered as prescribed in the ACNM standards of practice is urgently necessary for all women. The literature has shown that Black women tend to receive poor quality care. This study emphasizes the need for equality in the delivery of high quality care. In other words, this study supports the need for all women to receive the type of high quality care that midwives are expected to provide, per their standards of practice.

Discussion of Findings for Research Question 3

Findings show that women who used medical doctors and women who used midwives shared some expectations about maternal healthcare. Both groups of women found it essential to have quick access to their medical providers. Access to medical providers was needed for urgent questions, concerns, and signs of labor. Women in both groups expressed appreciation for having access to their healthcare providers. In both study groups, women expressed the importance of feeling comfortable with the care they receive. Women in both groups reported feeling confident in their medical providers. Women who used a medical doctor reported feeling their doctors were knowledgeable and confident in their care. Women who used midwives reported the same confidence and trust in their midwife's care. Findings also show that women from both healthcare models expressed that having a quick birth is desirable.

Several women who had hospital births reported disappointment with their hospitalized birth experience, and some even detailing what they wanted in their birth plan, shows that both

women who use midwives and the medical model of care have expectations about their birth, or some extent of a birth plan. The difference noted is that women who have hospital births seem to lack the agency or cultural capital to enforce their birth plan or make the necessary efforts to actualize their expectations. The lack of effort to enforce a birth plan or to meet desired birth expectations may be due to women relinquishing their autonomy or reproductive rights as they endow their doctors with it.

Pregnancy is a challenging experience for many women, whether they receive traditional medical care or midwifery care. Several mothers in both groups reported to have experienced physical and emotional difficulties while pregnant. Regardless of the type of care received, pregnancy for about half of all women in this study presented an added stress. Even for women who reported a healthy pregnancy, they stated that pregnancy was a time of adjustment to a growing family. They also reported that the physiological changes of pregnancy made activities of daily living like working a job, taking kids to school, and contracting a viral illness more challenging.

The main difference between women who used midwifery care and women who used the medical model, is how they interpreted the challenges of pregnancy. For women who used midwifery care, the difficulties of pregnancy were perceived as manageable. For example, one mother who reported worsening symphysis pubis dysfunction stated that she continued to do yoga and dance through her pregnancy. A mother who reported being diagnosed with diabetes, having to take care of children and dealing with a recent separation from her child's father, also reported having started regular exercises, weekly swimming lessons and meeting with a mental health therapist, as advised by her midwife.

On the contrary, women who used the medical model of care expressed hopelessness when reporting their pregnancy difficulties. One mother said that her pregnancy was horrible because of the persistent nausea and vomiting. She only found relief once her baby was born. Another mother reported that she was relieved when her baby was born because it was the end of her pain. A third mother stated she was glad to give birth because she wanted to have her body back. Many women who had hospital births reported happiness to end the suffering brought on by pregnancy.

Regardless of the PNC model used, all mothers value being treated kindly. Interpersonal relationship with healthcare staff is an important element of quality of care for all mothers. This is evident in the testimonies of women who reported how friendly and helpful the healthcare personnel all were, including receptionists, medical assistants, nurses and doctors. Soft skills are an important asset for PNC healthcare professionals in all levels and in both models of care.

Women who had home and hospital births had core differences in care expectations and experiences. Women who had home births were intentional about having family involved with pregnancy and birth care. On the other hand, women who had hospital births were content with only having their husbands and mother at birth and during pregnancy care visits. Findings showed that most women who had a hospital birth had a delivery date planned by the doctor. They were told they had a specific time frame to go into labor spontaneously; otherwise, the doctor would induce. Doctors instructed mothers when to go to the hospital to give birth, while women who had home births instructed midwives when to arrive for their birth. Home birth mothers decide when to inform the midwife and direct her to show up at their home for the birth. In general, mothers who gave birth in hospitals did not show commitment to a dedicated birth plan, while home-birth mothers elaborated on their plan and successfully executed it.

Limitations

The limitations of this study are discussed in this section. Two major limitations were the location of research participants who received care from a Black Certified Nurse Midwife and the lack of home birth practicing Black Certified Nurse Midwives. Home birth participants gave birth in three different states, California, Georgia, and New York. There were limitations in the geographical location of the participants because there were not enough participants who gave birth with assistance from the Black Certified Nurse Midwife in California, as initially planned. Three home birth participants gave birth in California. The principal investigator recruited additional participants using Instagram. On Instagram, three additional home birth research participants were recruited who were located in Georgia. They were found on a Black Certified Nurse Midwife's Instagram page. Four home-birth research participants gave birth in New York. The New York based participants were referred to the principal investigator by a Black Certified Nurse Midwife who practiced homebirth in New York and is now retired. The retired midwife from New York collaborated with the principal investigator through a communication forum from the American College of Nurse-Midwives. She referred some of her previous clients to the principal investigator as potential research participants.

It was challenging for the principal investigator, who is located in Florida, to find Black women who had a home birth with a Black Certified Nurse Midwife. The challenge in finding research participants stems from the fact that there are several states in the United States where there are limited to no Black Certified Nurse Midwives who practice home birth. For example, the principal investigator used Facebook to contact a Black Mothers Home Birth group and was advised that no Black Certified Nurse Midwives were doing home births in Kentucky. The principal investigator also contacted the Florida chapter of the American College of Nurse-

Midwives. The chapter leader informed that investigator that she did not know any Black Certified Nurse Midwives who did home births in Florida. These challenges in access to Black Certified Nurse Midwives further support the need to promote diversity in the midwifery profession workforce.

Midwives have good healthcare outcomes and patient satisfaction, but the problem is that there is an insufficient number of midwives in the United States, and disproportionately less Black midwives. Black Certified Nurse Midwives only make up seven percent of the midwifery workforce (ACNM, 2022). Certified Nurse Midwives work primarily in hospitals, while certified professional midwives mainly focus on home births. According to the CDC (2022), there were more than 50,000 home births in the United States in 2021, an increase of 12% over the year before and the highest level since at least 1990. Home births increased by 21% for Black women, 15% for Hispanic women, and 10% for White women in 2021. Home births remain rare despite the rise, accounting for 1.26% of all births in the US (CDC, 2022).

Given that participants experienced home births in Georgia, California, and New York, while their counterparts experienced a hospital birth in a different state, the study's third research question about comparing the quality of care experienced by Black women who received care from a Black midwife with the quality of care experienced by Black women who received care from a medical doctor, may not elicit results that are directly comparable. In other words, the Black women in this study may not be homogeneous enough to make an equivalent comparison between the two groups of women since the participants are geographically in different places.

In the United States, states are governed by laws, policies and norms that may influence how maternal healthcare is practiced and therefore, maternal health outcomes. For instance, Black women in southern states such as Georgia, Louisiana, and Texas have disproportionately

higher rates of maternal deaths compared to White women (Moaddab et al., 2016). Women who live in rural areas, hours away from obstetrical care, may present with more concerns about adverse maternal health outcomes in labor (Canty, 2020; Platner et al., 2016). This geographical factor may influence how women experience maternal healthcare, which may be different from the experience of women who live within close proximity to maternal healthcare. Therefore, since participants of this research study did not come from all 50 states, findings may not be representative of the experiences of all Black women in the United States.

Given that research participants from Georgia were purposely selected from clients who the midwife posted on her Instagram page, the participant selection may have been biased to ones who were predisposed to report only favorable experiences about their midwife. Midwife clients who did not have an Instagram account were omitted. The same bias applies to the participants from New York. New York home birth mothers were referred to the principal investigator by the midwife who provided their care and referred her previous clients. The New York based midwife may have been biased in only referring clients who had positive experiences. Nevertheless, these findings may provide transferable insights and ideas that could inform research in other settings.

Although the principal investigator took the appropriate steps to build rapport, create comfort, and ensure confidentiality, some mothers may have felt uncomfortable sharing negative experiences or expressing dissatisfaction with their health services. This could be particularly true for mothers who had hospital births because they were purposely selected from the health facility where the principal investigator is employed as a healthcare provider.

It is prudent for the principal investigator to acknowledge the plausibility of participant selection biases as a limitation in this study. Given that this study's research design is a

comparison between the quality of care by Black midwives and the quality of care by medical doctors, it is probable that the principal investigator, who is a Black midwife, to have been biased in her selection of research participants. It is reasonable to consider that the principal investigator may have selected participants that were more likely to have experienced optimal quality of care by a Black midwife, and perhaps omit the same type of prequalification in the selection of participants who received care from a medical doctor. It is important to establish the possibility of this type of selection bias occurring in this study and the impact it may have had on the results.

Selection bias is a common occurrence in qualitative comparative studies and it can produce erroneous study results. Selection bias is commonly understood as occurring when some form of selection process in the research design results in inferences that suffer from systematic error (Collier & Mahoney, 1996). Self-selection is a type of selection bias that may have also occurred in this comparative research study. In exploring the quality of care that Black women receive from Black midwives, the influence of self-selection bias arises given that the recipients of care from a home birth Black midwife resulted from self-selection. Women in this study who received midwifery care, self-selected into the category of Black women who received care from a Black midwife. This group of women made the conscious decision to obtain care from a selected home birth Black midwife. Selection bias can result from the self-selection of individuals into the categories of an explanatory variable, which can systematically distort causal inferences (Collier & Mahoney, 1996). In other words, the fact that the women who received care from a Black midwife self-selected into this category presents as a limitation on the dissemination of this study’s results and conclusions to a generalized context. It is important to understand that results about the quality of care from home birth Black midwives may differ for

Black women who are casual recipients of care for pregnancy and homebirth from a Black Certified Nurse Midwife. Given how rare home births are in the United States, it is highly unlikely that a woman would be a casual recipient of home birth care from a Black Certified Nurse Midwife.

Suggestions for Future Research

The United States is a country with a stark racial imbalance in maternal health outcomes. Therefore, further qualitative studies on the maternal healthcare experiences of Black women in the United States are necessary to understand the reasons for maternal healthcare inequalities. When addressing racial disparities in maternal mortality, it is critical to understand what factors place Black women at higher risk for receiving poor quality maternal care and adverse maternal outcomes. Studies are needed to investigate how Black women experience pregnancy, maternal healthcare and birth. Knowledge development is necessary to understand how culture influences their perception of the quality of care (Canty, 2020). Studies are needed to understand the barriers Black women are faced with in the healthcare system to improve access and quality of maternal healthcare.

Further exploration into the relationship between Black women and their healthcare providers is necessary to understand how to improve these relationships and provide better experiences for Black women. Understanding Black women's perception of the quality of care can help provide insight into the development of culturally informed interventions (Canty, 2020). Studies are needed to examine the role of implicit bias in encounters with health care professionals during childbirth from the perspective of Black women and their healthcare providers (Canty, 2020).

Results from this study showed that Black women experience unacceptable treatment from hospital staff, which proves that interpersonal relationships between healthcare providers and Black women is an area of needed improvement. Interventions are needed to develop healthy relationships between Black women and healthcare providers (Canty, 2020). Given that many of the negative experiences reported by Black women with hospital births centered on emotional distress as result of interpersonal interactions with healthcare providers, it is reasonable to consider the value of empathy and emotional intelligence in maternal healthcare providers to improve maternal healthcare. Further research on the development of leadership traits such as empathy, emotional intelligence and culturally informed care among maternal healthcare providers may be helpful in the aim to improve the quality of maternal healthcare.

Research on the awareness of maternal healthcare providers on the historical challenges Black women experience in the healthcare system may help to improve quality care for Black women. The acknowledgement that Black women are more vulnerable to medical violence and more susceptible to poor maternal health outcomes needs to be demonstrated with actionable changes in maternal healthcare. Interventions to improve maternal healthcare are urgently needed in the face of the current maternal health crisis in the United States. Research into interventions such as leadership development for maternal healthcare providers and strategies to promote diversity in the midwifery workforce may be instrumental in the improvement of the quality of maternal healthcare and the fight to end preventable maternal deaths.

Further investigation into race concordant patient-provider relationships is necessary. A specific focus on maternal healthcare outcomes from race-concordant maternal care is needed. To date, no studies have evidenced that there are improved maternal healthcare outcomes as a result of race-concordant care. Midwifery care is a vital solution to the challenges of providing

high-quality maternal care and good maternal health outcomes (Homer et al., 2014). It is important to explore if their maternal health outcomes are further improved for Black mothers with race-concordant midwifery care. This exploration into the impact of race-concordant midwifery care can provide insight into the clinical aspects of care and how race may play a role in ameliorating race disparities in maternal healthcare.

The presence of Black women in research needs to be increased. More Black women need to be involved in maternal healthcare research as investigators and participants because their perception of what places them at risk may offer valuable information that can be used to improve the quality of maternal healthcare (Canty, 2020). The current power dynamics in the healthcare system ought to be dismantled and restructured to place patients at the center. Social and cultural capital in maternal healthcare must be returned to women, including Black women. This process begins with a recognition that Black women are experts of their own bodies and health, a pillar of reproductive justice. The application of these suggestions may serve as a starting point in shifting the maternal healthcare paradigm to one that values and protects the lives of Black mothers.

Conclusion

Black women are more likely to die as a result of pregnancy and birth compared to other racial and ethnic groups. Black women also tend to receive inferior quality care. Research into the quality of maternal healthcare experienced by Black mothers may provide insight into why the disparities in maternal health outcomes. The maternal health crisis that disproportionately affects Black women in the United States is still not well understood. There is a gap in the literature on the experience of Black women with maternal healthcare. This study sought to

identify and give perspective to the unique challenges that Black women experience in the maternal healthcare system.

This study shows that Black women who received race-concordant midwifery care experienced high quality care and even improved health outcomes. The voices of Black women must be amplified to address disparities in quality of maternal healthcare. It is important to understand what Black women need to experience a safe, supportive, empowering, and stress-free childbirth experience. Advocating for Black women to receive high quality maternal care, promoting midwifery care and diversity in the midwifery workforce are essential in the fight to ameliorate racial disparities in maternal health. The clinical implications recommended by this study suggest changes to the U.S maternal healthcare system. Policies that support these recommended changes to the maternal healthcare system are needed. Policies that support further research into maternal healthcare for Black women, promote midwifery care and diversity in the midwifery workforce, like the Black Maternal Health Momnibus, are instrumental to improve maternal health outcomes for all women.

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APPENDIX A

IRB Approval

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: July 11, 2022

Protocol Investigator Name: Kimberly Navarro

Protocol #: 22-05-1857

Project Title: Black Midwives for Black Mothers: Ameliorating Racial Disparities in Maternal Mortality

School: Graduate School of Education and Psychology

Dear Kimberly Navarro:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

APPENDIX B

Interview Questions

Date: ______________________
Interviewer name: __________________________
Health facility: ________________

Age ______

How many live births have you had?: ________

How many children do you have?: ___________

How old were you when you gave birth to your first child?: _______

Marital Status: ________________ Ethnicity: _____________________

Occupation: _______________________ Religion: ________________

Number of people in household: ___________

Education (highest grade completed): ____________

How many times did you visit this clinic during your pregnancy, including delivery? : ______

Did you receive care at other health centers during your pregnancy? ____Yes ____No

If yes, which health center? _________________________________

PURPOSE: ESTABLISH RAPPORT, ALLOW MOM TO BECOME COMFORTABLE TALKING ABOUT HERSELF

1. **To begin, I would like to know more about you as a person. Tell me about a typical day in your life. From the time you wake up to the time you sleep, tell me about what you do.**

PURPOSE: UNDERSTANDING MOM'S EXPERIENCE WITH PREGNANCY

2. **I would now like to learn more about you and your experiences with your most recent pregnancy. Can you Pick one day in your pregnancy and tell me about it?**
    - How did that change later in your pregnancy?
    - What, if any, worries did you have?
    - What made you feel excited?
    - When appropriate, probe if she wanted the pregnancy at the time she got pregnant and how she found out

3. **Can you tell me about any traditions/practices that you follow during pregnancy?**
    - Are there any restrictions on what women can do when they are pregnant? (probing for how this might affect accessing care)?
    - How did these restrictions affect your ability to get care?

4. **What was it like when you returned to your home following birth?**
    - What were some of the things your family/community did? Said? How did it make you feel? .

PURPOSE: UNDERSTANDING WHAT LED MOM TO UTILIZE MATERNAL HEALTH CARE AT HER FACILITY (WHY, WHERE, WHO)

5. **I would now like to learn about your experiences getting healthcare during your last pregnancy. Can you describe how you ended up getting healthcare for your pregnancy at this clinic/facility?**
    - Tell me about why you accessed health services for delivery/during your pregnancy?
    - How did you select this clinic/facility?
    - Who, if anyone, influenced you to get care at the facility (mother, husband, women's group, etc)
    - What, if any, concerns did you have coming to this clinic/facility?

PURPOSE: LEARN HOW MOM EXPEREINCED MATERNAL HEALTH SERVICES (ACCESS, SPACE, STAFF, BELIEFS ABOUT CARE)

6. **Think about your delivery experience (the day you delivered). Can you walk me through your appointment from the moment you arrived at the clinic until you left.**

    - How long did you wait to get care from the moment you arrived?
    - What or who were you waiting for?
    - How typical are wait times for you?
    - How did that ____ make you feel? (waiting a long time, etc).

7. **ACCOMPANIMENT**: Who if anyone accompanied you to appointments?
    - Probe first for the time of delivery/birth and ANC/PNC
    - *If accompanied*: what was it like having that person there?
    - *If accompanied*: How did this person help or support you? Do you wish they could have helped in another way?
    - *If accompanied*: Who decided who would go with you?
    - Would you have liked to be accompanied by someone? Tell me more…
    - Who would you want to be there with you?

8. **SPACE: I do not know much about the clinic you attended. Can you describe the space where you received services to me?**
    - What does it look like? Feel like?
    - How do you feel at this clinic/facility?
        - (Probe: (dis)comfort, privacy, curtains, screens, others watching, overcrowding, etc.)
    - Tell me about other people that were in the room while you were delivering? Who were these people?
    - *If others were present:* Were you asked permission for others to be there?
    - How did your experience align with local practices or expectations?

9. **STAFF: Please tell me about all of the different people from the clinic/facility that you interacted with. Who were all the people who provided care to you at the clinic?**
    - What did each person do?
    - What kinds of things did you like about the staff at the clinic?
    - How were you treated by people at the clinic? (Probe: shame, respect, neglect, humiliation, physical abuse, etc.)
    - How often were you asked for your opinion or things you want at the clinic?
    - What did you not like about the staff at the clinic?
        - Probe: What happened? How did you feel?
    - How confident did you feel in the knowledge and skills of clinic staff? Tell me more…
    - Probe for non-clinicians (guards, secretaries, etc)

10. **COMMUNICATION WITH PROVIDERS: Now I would like to talk to you about the way the doctors and nurses explained things to you.**

- In general, how well did you understand what the doctor/nurse was doing during your appointments? (probe if services were explained, if she was confused)
- Were you able to ask the doctor or nurse questions? Tell me more…
- How did the doctor or nurse get permission from you to perform services? How did you feel about this?
- Tell me about how the nurses and doctors spoke to you (supportive, encouraging, harsh/strict)? How did that make you feel?

11. **How do you believe the services you received affected you?**
    - Did anything significant change?
    - How do you believe the services you received affected your child?

PURPOSE: TO UNDERSTAND HOW MOM'S SATISFACTION WITH HER MATERNAL HEALTH CARE AND FUTURE USE

12. **Tell me about your overall impressions/thoughts with the care you received at clinic/hospital.**
    - Tell me about your overall impressions with staff at the clinic/hospital.
    - Based on your experiences, would you use these services again? Tell me more about why or why not.
    - Would you recommend these services to other pregnant women? Tell me more about why or why not…

13. **How can the staff at the health facility make the experiences of childbirth better?**
    - What can the clinic do to improve care for moms?
    - What would make you feel more comfortable and want to come back to the clinic?
    - What can staff do to improve care for moms?

14. **Thank you for taking the time to share your experiences with me, I really appreciate your time and participation.**
    - Is there anything else you would like talk about more about before we end this interview?
    - Do you have any questions or comments for me?

(Hagaman et at., 2022, additional file 1)