Lived Birth Experiences of African American Women and Impact of Mother's Perceptions, Locus of Control and Culturally Responsive Care: A Qualitative Pilot Study

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Healthy People 2030 designated eliminating health disparities as a national priority in the United States (US), with a particular focus on the differences in outcomes for African American women and newborns during childbirth. The US is currently seeing an uptick in maternal mortality rates. Over the last 50 years, maternal mortality rates had increased from 7 deaths out of 100,000 live births to 32.9 deaths out of 100,000 live births (Hoyert, 2021). The maternal mortality rate for African American women is even more concerning, with 69.9 deaths per 100,000 live births (Hoyert, 2021). These rates were across all economic classes and education levels leading to the conclusion that race was the sole reason for this high maternal mortality rate. This disparity was due to several reasons including the lack of Black doctors, women's complaints often not being taken seriously by physicians, and a belief that Black people have a higher pain tolerance. In a 2019 survey, 17% of women felt as though they were treated differently by a healthcare professional due to their gender, compared to 6% of men (Paulsen, 2019). A Pearson nursing textbook Nursing: A Concept-Based Approach to Learning published in 2017, was found to have racist sentiment regarding Black, Muslim, Asian, and Hispanic patients, displaying that those racist medical teachings were still occurring.

Mistrust between African Americans and medical professionals has been widely discussed in the literature. One source stated that there was no difference in distrust simply based on race as white Americans, Latinx Americans, and Black Americans had similar levels of distrust. Yet, Americans in lower socioeconomic classes displayed higher levels of distrust of medical professionals. (Greene and Long, 2021).

In an analysis of global levels and causes of maternal mortality, it was found that rates were decreasing in most countries due to more access to health care and advances in maternal

care. In developed countries, the main causes of maternal mortality were “late causes” and “other direct causes” (Kassebaum et. al 2014). Although this has been useful information in comparing the statistical trends across countries, it has not provided an explanation for the maternal mortality crisis the United States, particularly the African American community is facing.

In a study comparing maternal mortality caused by medical conditions unrelated to pregnancy, and maternal mortality depending on certain social determinants such as maternal education, immigration status, marital status, geographic region, and area deprivation it was found that there was no difference in maternal mortality caused by medical conditions unrelated to pregnancy between non-Hispanic white women and non-Hispanic Black women. However, factors such as area deprivation for non-Hispanic Black women were higher than for white women, indicating that socioeconomic factors played a significant role in maternal mortality outcomes. Women with higher education levels tended to have a lower maternal mortality rate, but non-Hispanic Black women had higher maternal mortality rates than their peers with the same education levels. Similarly, while married women tended to have lower rates of maternal mortality, non-Hispanic Black women who were married had a higher maternal mortality rate of 9.9 compared to 9.71 in unmarried non-Hispanic white women (Singh and Lee, 2021).

After conducting a literature review on maternal mortality rates and race, it became apparent that few studies have explored the perspectives of Black mothers on maternal care. To fill this gap, a pilot study has been designed to gather the perspectives of African American mothers by analyzing YouTube videos they have uploaded about their birth experiences. Using content analysis, the study will identify patterns, categories, and themes to gain a better understanding of the Black birth experience in America.

The qualitative study aims to explore the perceptions of African American mothers regarding their birth experience and the care they received from the healthcare team. The researcher hopes to identify themes that reflect effective and/or ineffective healthcare practices affecting African American mothers. Therefore, the research question is: What are the perceptions and birth experiences of African American mothers in relation to the care provided by the healthcare team?

Theoretical Framework

Phenomenology is a philosophical theory developed by Edmund Husserl that emphasizes analyzing a topic on an individual basis rather than making generalizations about a group. Unlike other research methods that generalize data to draw conclusions about a social group, phenomenology holds that individuals' lived experiences have a significant impact on outcomes, rather than simply belonging to a social group. This philosophy is compatible with qualitative research because it does not rely on generalizations, which are difficult to achieve through qualitative research. To apply a phenomenological approach in this study, the literature review was conducted after the data was collected, preventing the researcher from making any prior assumptions and allowing for a less biased interpretation of the data (Husserl, 1972).

Literature review

After conducting an initial review of the problem, the researcher determined that additional data needed to be collected through further searches. The literature review was then focused on four key aspects: gender and racial disparities in the United States, social determinants of health, maternal mortality in the United States, and the effects of childbirth trauma. Additionally, the researcher explored previous research on birth from a phenomenological perspective.

To commence the analysis of gender inequality in the United States, the researcher examined the gender inequality index, which is an annual report completed by the United Nations Development Program. The index measures various factors, including the maternal mortality ratio, adolescent birth rate, percentage of parliament seats held by women, secondary education rate, and labor force participation rate. According to the 2019 report, the United States ranked 46th out of 128 countries, indicating that women are still not regarded as equals to men in the country (Human Development Reports, 2019). This lack of importance can have an impact on the perceived value of women's lives, opinions, and feelings, both emotional and physical, and lead to high maternal mortality rates and other death rates related to medical care.

Gendered social determinants of health are also a crucial aspect to consider. As noted by Heise et al. (2019), laws, policies, market forces, and corporate interests shape where people live and what resources they have access to, thus influencing health outcomes. Laws and policies that entrench gender inequalities or lack a progressive stance can negatively affect women's health and wellbeing. These findings align with the results stated in the Human Development Report, which indicated that less than 24% of parliamentary seats in the United States were held by women in 2019, despite women making up approximately 50% of the country's population (Human Development Reports, 2019). This underrepresentation of women in government positions suggests that laws are not focused on improving gender equality, and progress is slow.

Furthermore, a 2017 study found that states with a higher percentage of women in government positions had better birth outcomes:

> “This study is the first to identify a strong negative relationship between the political representation of women in state governments and state infant mortality rates in the United States. This relationship is evident both within individual states as the

> representation of women changes across time, and between states with high vs. low levels of women's representation. The fact that consistent findings were observed in both the random-effect and fixed-effects models indicates that the relationship between women's political representation and IMRs cannot be attributed solely to differences in unobserved time-invariant characteristics of U.S. states" (Homan 2019, p.130).

This study specifically focused on infant mortality rates instead of maternal mortality rates, but both are closely related. According to the CDC, "Pregnancy-related complications are closely tied to infant deaths as well. Nearly two-thirds of infant deaths occur during the first month after birth, often from congenital abnormalities and complications from preterm births." Although healthcare and the government are not deeply connected in the United States, due to a lack of socialized health care and an abundance of private hospitals, it is clear that women's presence in government had an influence on social ideas surrounding women and influenced women equality in all facets of life and that a lack of gender equality in United States culture has led to the maternal mortality issues we are seeing today.

In addition to gender inequality, several other factors contribute to the high maternal mortality rate among American women compared to other developed countries. Social determinants of health are among the primary factors that affect maternal mortality rates, as noted in a study that found that African American women were three times more likely to die during childbirth or due to complications from childbirth. The study attributes this increased risk to poor access to prenatal care, lower educational attainment, state median income, and uninsurance rates (Nelson et al., 2018, p.5).

Another study identified several risk factors that contribute to negative maternal outcomes among African American women, including trauma during delivery by c-section

(Elkafrawi et al., 2020). According to the National Center for Health Statistics, Black women were slightly more likely to undergo a Cesarean Section (C-section) than other racial groups, with 35.5% of live births from African American women being C-section compared to 31% for white women, 32.5% for Asian and Pacific Islander women, and 28.9% for Native American women (2021).

The Covid-19 pandemic has brought to light the already existing health disparities, especially among minority groups. According to Yusuf et al. (2020), African American women were going to fewer prenatal doctor visits and had higher rates of being uninsured during the pandemic. Pregnancies during the pandemic have also raised additional concerns. A study conducted in New York revealed that 15% of pregnant women with Covid-19 died after receiving treatment at a hospital (Kogutt & Satin, 2020). Overall, it is evident that the United States has a maternal mortality problem, and this issue is being further highlighted with the increased attention to social determinants of health, as well as the impact of the Covid-19 pandemic.

It is clear that maternal satisfaction with the childbirth experience is an important aspect of maternal health that should not be overlooked. One study found that personal control in the childbirth experience played an important role in how satisfied the woman is with her birth experience (Goodman et.al 2004). Tabaghdehi et.al, 2021, further explored birth satisfaction in a separate study, *Prevalence and factors affecting the negative childbirth experiences: a systematic review.* The study attempted to analyze what causes a bad birth experience but determined that it is hard to generalize on the subject of birth and suggested a qualitative study be done instead. Tabaghdehi (2020) completed another study on the topic qualitatively and determined that "providing positive experience factors of childbirth plays an important role in women's

self-efficacy and self-esteem, which requires cooperation and effort at the level of the individual, family, education system and healthcare system" (Tabaghdehi, 2020 p.1). The findings were reinforced with another study that stated that previous negative birth experiences cause trauma within mothers and can potentially lead to self-doubt in their ability to give birth in the future. The main factors in causing this birth trauma were determined to be pain and negative experiences with staff (Nilsson and Lundgren, 2007). The World Health Organization stated that making childbirth a positive experience for mothers is important and created new guidelines for intrapartum care. The nine guidelines created were: respectful labor and childbirth care, emotional support from a companion of choice, effective communication by staff, pain relief strategies, regular labor monitoring, documentation, audit, and feedback, oral fluid and food intake, mobility in labor and birth position of choice, pre-establish referral plan, and continuity of care (WHO, 2018).

During the analysis of previous phenomenological studies on the birth experience, little information on Black mothers was found. Other studies focused on fathers' experiences, C-sections, mothers of babies with down syndrome, mothers who gave birth at home, and many more experiences. Commonly found across these studies were the small participant size and the creation of themes and subthemes. Generally, studies had eight to twenty people but one had as many as 53 participants and created general themes and specific subthemes to analyze the data that was gathered.

Research on birth and maternal mortality has been relatively common in a quantitative sense, but there has been little research done qualitatively which would provide a unique perspective that strays away from statistics and focuses on a human perspective. Additionally, work focusing solely on Black or African American mothers giving birth in American hospitals

was rare. The trauma of the birth experience has been an established problem validated by the National Institute of Health as well as the World Health Organization and has been explored vaguely over the past few years. This pilot study further explored the issue through a phenomenological lens on Black women's stories and started to fill the gap of understanding surrounding the Black birth experience in America.

Methods

Phenomenology was used in this pilot study to gather an understanding of the Black birth experience in America. Due to the personal nature of childbirth, phenomenology was determined to be the appropriate way to analyze the experience on a person-to-person basis. A qualitative approach was used to analyze the text transcriptions of the Youtube videos that were selected for analysis.

Materials needed to replicate this study are a device that allows access to Youtube and a digital document service such as Microsoft Word or Google Docs. For this study, a computer was used to access Youtube and both Microsoft Word and Google Docs were used for the collection of data.

The procedure for the study began with the selection of videos that were uploaded to the world wide web by African American mothers. The inclusion criteria for a video was being a birth story uploaded by a woman identifying as Black or African American who gave birth in an American hospital. Videos from women who did not identify as Black or African American were not included. Videos from Black or African American women who had home births were also not included.

The researcher used the video-sharing platform Youtube to find videos. Through the site, the researcher searched "Black Birth Storytime" to find videos relating to the topic of interest.

The videos were then watched one time to determine if they fit the criteria necessary to be analyzed. The videos were then rewatched and transcribed by the researcher. To ensure no transcription mistakes were made the videos were also transcribed by Youtube's closed captioning service. Both transcriptions were then compared and edited for mistakes. The transcriptions were then reviewed by the researcher for categories, patterns, and themes.

The researcher completed the HHS certification for human subjects (appendix 1). The study met exemption criteria for human subject research since the videos were uploaded by the women to the Youtube public platform on the world wide web accessible to everyone. No identifiers were included, and the informants remained anonymous and listed numerically. There were no benefits or risks involved for study informants included in the study.

Findings

The sample of informants were ten African American or Black women living in America. No additional demographic information was shared in the videos uploaded. All the women were of childbearing age, resided in the United States, had male partners, and had recently given birth in a hospital.

After author analysis of the video transcriptions nine common categories were found: Expectations, Sorrow, Pain management, Disparities in treatment, Perceived quality of care, Communicating value, Feelings of empowerment, Personal control over childbirth, and Storytelling. The expectations category contains content that focused on what the mother wanted for her birth story and ideas she gathered from previous experiences and research. The pain management category focused on how the mother describes her experience with pain during her labor and how staff then assisted her in pain relief. The disparities category focused on what the mothers describe as potentially race-related mistreatment. The perceived quality of care category

focused on how the woman describes her healthcare professional's treatment of her. Communicating value focused on how the health care professionals communicated the procedures with the mother. Feelings of empowerment focused on moments the mother felt empowered by her birth or by staff. Personal control focused on the mother's involvement in decision-making during her childbirth. Storytelling focused on the general detailing of the mother's birth story. Table 1 lists each category and narrative exemplar from informants.

Table 1: Categories and Narrative Exemplars

Category	**Exemplar**
Expectations	"Basically made me feel stupid for even wanting to have a VBAC that's how I felt at the time I mean I wasn't communicating this with him obviously because of people in the room a lot of the times but at that point, I was just feeling like wow maybe it was really stupid of me to think that I could get make it through I could have a successful VBAC I should have just stuck to having a repeat c-section when in reality I could have had a VBAC. I was a great candidate I didn't have gestational diabetes or anything that could have caused my doctors to be concerned and say I need to have a repeat c-section"-Informant 3
Sorrow	"It completely broke me and that was very hard to hear that was it was just very hard because I went through my whole pregnancy without any type of issues and then all this was happening and you know by that time I was fine I got discharged and I got to see him one more time before I had to head home. And I feel like that was my complete breaking point because coming home to all this baby stuff and no baby, he's not in my stomach it was like this is awful."- Informant 4

Pain management	“They gave me the chart 1 being you’re not in pain and 10 being you’re having surgery with no anesthesia and I was at a freakin ten like I was freakin dying. And since the boosters were not working they had to call another anesthesiologist to give me another epidural and they kept checking to see how much I was dilating and I never progressed past an 8 and I would dilate a little and I would go back a little and that’s because I was in so much pain that every time I would have a contraction I would tense up and regress and also because I was tensing up I started to feel extreme pain in my neck and shoulders so I was like tensing my whole body during the whole contraction and I got to the point where I couldn’t move anymore. I couldn’t sit up. I was like paralyzed because my neck and shoulders were just like gave out because I was tensing up so badly so nobody knew why the epidural was not working on me.” -Informant 1
Disparities in treatment	“Because I don't believe I was in the correct state of mind to be answering certain questions and there I was answering whether or not I am in pain even though they have a monitor that shows them every time that I have a contraction and how strong the contractions are and the nurses’ staff prior probably already told them that my epidural wasn’t taking bitch do you think that I’m lying so you guys can give me another epidural like I’m not lying. Prior to going into labor and prior to having a baby I read that sometimes doctors or nurses are less empathetic toward people or toward black women or toward black families and afterward now I am starting to wonder did that happen to me because I feel like I had to convince a lot of people that I was in as much pain as I was”- Informant 1
Perceived quality of care	“This midwife who was unfavorable to me, in my opinion, was very dismissive of me because even after

	we got admitted it just wasn't a great experience anyway this midwife checked me told me that I was five statements dilated that they recommended that I go back home”- Informant 3
Communicating value	“Understood I felt like nothing was explained to me and I was just told that oh you need to go into c-section you need to sign papers and I was crying but you know that was my own traumatic experience in its own way” -Informant 3
Feelings of empowerment	“All my experience that I had with the nurses at that hospital were amazing they just make you feel so at ease and comfortable even when you just feel all alone you're in so much pain they just, they just make the situation better so shout out to all the nurses you guys are amazing if nobody tells you I just want to let you know that we appreciate you because you make the experience so much more pleasant the nurse was just holding my hand and she was just talking me through my contractions and everything” -Informant 10
Personal control over childbirth	“She was like okay we're gonna just slow things down I was like okay so I just started breathing and the anesthesiologist and y'all just took a couple steps back and they weren't asking me like cuz they were literally can you feel this even list this one felt like I'm sure they weren't like this but it felt like that and I just had to take deep breaths and I had to take those deep breaths the entire rest of the way so after like a minute or two we were able to like resume the surgery”- Informant 8
Storytelling	“We get up to the hospital that night it's 11:30 and I wobble up to the desk and I had told the woman I said I had come up here already today I sat up here till 4:00 contracting all day I said somebody needs to help me I said I'm in labor and she was like this was a whole different staff from the staff that morning and she was like okay I need you to fill out this paperwork or

	whatever the same paperwork I filled out it was the same process over again so they got me hooked up to IVs or whatever like I'm dehydrated I was like I can't keep anything down I was throwing up I forgot that part I was throwing up at home throwing up my stomach you know when your stomach when you haven't even anything and you just have green it's just like green stuff or lime green stuff throwing up but they were like okay we're hooking her up to IV we're getting her seeing where her contractions are at when they hooked me up when they put the thing on my stomach"- Informant 5

The nine categories were further examined for patterns. Three patterns emerged: a pattern of birth impacting the mother's health and well-being, a pattern of mothers' perspectives about birth, and a pattern of interpersonal experiences affecting birth. The first pattern of birth impacting the mother's health and well-being, includes the physical impact of birth, the mental impact of the birth, and how it affected decisions for future children. The second pattern of mothers' perspectives about birth includes any detail about how the mother perceived the birth and her role in it. Finally, the third pattern of Interpersonal experience affecting birth includes any details the mother gave on how caregivers treated her both positively and negatively as well as how family aided her birth process. Table 2 lists the patterns and narrative exemplars from informants.

Table 2: Patterns and Narrative Exemplars

Patterns	**Exemplars**
The impact of birth on women's health and well-being	"I'm gonna pass out like why would you traumatize me like that like if I wasn't in the strong person that I am if I was really weak if I had a weak stomach anything like you don't

	why would you do that like I could not get over what I was seeing I looked away so fast and I'm just like why the hell would you do that like this is my blood that's all over you all over your gloves all over your I don't know your hospital gear I'm just like what the hell so that Happened all I can hear was like blah blah blah blah because I'm feeling myself like getting dizzy I'm feeling queasy then they take down like all the stuff and they're like getting ready to put me on the other table like off the operating table on to like my bed and I look over to the right and there's literally like a metal pan with like rags in it with my blood all over it like everywhere I looked around here's my blood I'm just like what the hell like I'm not supposed to be seeing this right now I did not see this I did not experience this with my first day section I don't know what the hell what's happening and that house a little but it was not okay like I was not mentally okay after that" -Informant 6
Mother's perspective	"It's just me all over again so the entire time nobody's talking to me and I really did not like that at all I'm just like I felt like a guinea pig almost like they were dissecting a frog and you don't talk to the frog like I didn't like that at all it was not personable at all they're all in there just talking about their own lives and like yeah so about the quarantine and like talking about everything that's going on right now and like oh yes I have to go grocery shop it was just like almost like being inside of like their break room or something and I'm just like I'm hello like you know I am down here." -Informant 6
Interpersonal experience	"The first nurse when I checked in she was so I freakin loved her, her name was Michaela, she was like so professional. For each day I was in the hospital I had a morning nurse and a night nurse and I was in the hospital for a

	total of six days. I was not expecting to be there that long so that first nurse I had I loved her and you know when you're in an environment and get someone who is aggressive not in a bad way but someone who is aggressive when it comes to their job that's how it felt with that nurse. So the nurse that I hated left and I got another nurse who was a freakin angel. Yes the next nurse I got came into the room and was taking charge and blah blah blah and she was like going out of her way to make me feel comfortable and she talking to me and my husband and also she made me feel like I got this and I'm going to be able to birth this baby and I am going to live and everything is going to be ok."-Informant 1 "Reality we live in racism is real I'm not going to sit here and sugarcoat things so racism is pretty real in health care as well which is why my husband and I made it a point when we were getting ready for labor though the months coming up to labor and delivery we made it a point to educate ourselves my husband needed to educate himself as much as i needed to educate myself so that if I'm out of it he sticks to our plan he sticks to our rights we don't get you know run over or get our rights taken away from us and we would know all right so anyway the entire team I just wanted to put that out there it was not a single black person except for the anesthesia nurse" -Informant 3

Lastly, the patterns were examined for common themes. One theme emerged: The childbirth experience, locus of control, and culturally responsive care during births impacts the

mother's perceptions, health, wellbeing, and birth outcomes. This would include physical and mental aspects as well as how childbirth has affected her outlook on the healthcare system, her relationship with her body and herself, her relationship with the baby, and with her support system. Table 3 lists the theme and narrative exemplars.

Table 3: Theme and Narrative Exemplars

Theme	**Exemplar**
The childbirth experience, locus of control, and culturally responsive care during births impacts the mother's perceptions, health, wellbeing, and birth outcomes.	"Even if I want to have more children I think twice about it."- Informant 2 "I was so scared because I've never had surgery so it was really scary um I was just oh it was just so scary I didn't see my mom I didn't see anybody so I'm sitting in this bed and I'm just like I hope we make it you know me and the baby and I that's just the last thing I remember like I was just begging God in my head like I don't want to die like it was just it was really scary it was just really scary you guys um then I was I woke up and I was getting wheeled to a room and I just remember I was like I hope my baby's alive all right I'm like I should have been able to see him right away but once I held him and did sort of like a skin-to-skin thing"- Informant 7

Discussion

The first hand accounts of the women's birthing experiences offered a distinctive viewpoint that differs from statistical analysis. Throughout their narratives the women discussed trauma surrounding the birth experience and how a lack of control was the cause of said trauma which aligns with previous studies' claims of a locus of control leading to more satisfaction with

birth outcomes as well as the World Health Organization's guide for making childbirth a positive experience.

What is truly interesting about this study is each woman had a different experience, while many of the women discussed feeling disempowered by the healthcare team, others reported a mixed bag with some team members having a positive impact on the patient experience while others were completely invalidating or demeaning. This leads to the question: would employee training allow for more consistent positive treatment of patients and lead to better birth outcomes? There was little direct discussion on what employees need to do differently in order to make the birth experience better but from listening to the stories and understanding the underlying message the main issues were a lack of control and feeling invalidated.

Currently, the best solution provided for these issues is the World Health Organizations nine guidelines, respectful labor and childbirth care, emotional support from a companion of choice, effective communication by staff, pain relief strategies, regular labor monitoring, documentation, audit, and feedback, oral fluid and food intake, mobility in labor and birth position of choice, pre-establish referral plan, and continuity of care. The issue with this solution is that many of the guidelines were followed but there were still negative outcomes. For example, many of the women had done previous research on childbirth and had birth plans but once they began labor, they perceived that the healthcare team providing care for them ignored their requests. It seems that the problem isn't on the mothers to solve but on hospitals to provide training so all staff can be on the same page as well as creating a positive relationship of trust and respect between the mother and her doctor in order to ensure a positive birth experience.

One common point found in the videos was the lack of diversity in the health care team. Many of the women discussed a lack of African American health care professionals in their

delivery room and a few of them stated that having a female doctor probably would have led to a better birth experience. One woman believed that if her doctor was a mother, it would have been a more understanding environment but instead, she had a male doctor who invalidated her pain. There is a common issue with healthcare professionals believing that women may be over-exaggerating their pain. Additionally, there are issues with Black patients not being valued the same as white patients. Negative health care experiences of women and of Black people intersect with the discussion of African American maternal mortality. A probable solution for solving a lot of the issues in healthcare is increasing the diversity of the healthcare team. Increasing the diversity on any team allows for more productivity due to a multitude of experiences coming together. This idea is reinforced by the study mentioned in the literature review that showed states with higher women in government positions had lower rates of maternal mortality in their states. A change in the culture and leadership of an organization has a trickle-down effect leading to meaningful change in the lives of everyday people, in this case, the mothers. For these mothers their perceptions were their truth. Their aim to communicate these perceptions to other mothers led them to post the intimate details of their birth stories to inform and prepare other mothers for this meaningful life event. A perception that flowed through the stories is that perhaps their race as Black women had been a factor that had impacted their experiences.

Conclusion and Future Directions

Broader issues of social determinants of health were not analyzed in this study due to the lack of knowledge of the demographics of the sample (other than race). Gathering more information on the women in the videos would have led to a more complex analysis of the Black birth experience and how outside factors play a role in the hospital. This study was also

completed with a small sample size. Having a larger sample size would add to the breadth of knowledge in the analysis and add more insight into the Black birth experience. Using direct interviews may also allow for a narrower look at the birth experience with the story being guided through the questions rather than being a general story of the birth. The use of interviews looking at one specific area in the United States (ie. the south, the northeast, California) may allow for more definite results that were not able to be obtained through this pilot study due to the origin of the videos being from across the United States. Using a mixed-method study with stories from women in a specific hospital or area and the maternal mortality rates of that same hospital or area would be an interesting intersection of phenomenology and quantitative data and would probably lead to greater insights on what needs to change as patterns are found in the data.

The contents of the Youtube videos analyzed to provide greater insight on the realities of the birth experience for African American women but it is important to remember that these few videos do not allow for a generalization of the African American birth experience. The phenomenological approach does not allow for generalizations as is the aim of quantitative research, but it does provide more personal information which was necessary for the goals of this pilot study. Intentional focus by the healthcare team on the mother's birth experience, locus of control and satisfaction with care received is a priority. Healthcare providers should aim to provide culturally responsive care with awareness that gender, race, ethnicity, and many other factors intersect to create a unique individual. Showing respect and value for persons of color has become a priority in the US national dialogue on race and the experiences of Black people as they perceive being devalued by others, especially those in positions of authority. Further study is needed to discover the strategies needed to reduce healthcare disparities impacting childbearing African American women in the US to improve health outcomes.

References

Centers for Disease Control and Prevention. (2021, March 2). *FastStats - births - method of delivery*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/delivery.htm.

Declercq, E., & Zephyrin, L. (2020). *Maternal mortality in the United states: A primer*. Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer.

Elkafrawi, D., Sisti, G., Araji, S., Khoury, A., Miller, J., & Rodriguez Echevarria, B. (2020). Risk factors for neonatal/maternal morbidity and mortality in african american women with placental abruption. *Medicina*, *56*(4), 174. https://doi.org/10.3390/medicina56040174

Goodman, P., Mackey, M. C., & Tavakoli, A. S. (2004). Factors related to childbirth satisfaction. *Journal of advanced nursing*, *46*(2), 212–219. https://doi.org/10.1111/j.1365-2648.2003.02981.x

Greene, J., & Long, S. (2021). Racial, Ethnic, and Income-Based Disparities in Health Care–Related Trust. *Journal Of General Internal Medicine*. https://doi.org/10.1007/s11606-020-06568-6

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., . . . Geeta, R. G. (2019). Gender inequality and restrictive gender norms: Framing the challenges to

health. *The Lancet, 393*(10189), 2440-2454. doi:http://ezproxy.queens.edu:2480/10.1016/S0140-6736(19)30652-X

Homan P. (2017). Political gender inequality and infant mortality in the United States, 1990-2012. *Social science & medicine (1982)*, *182*, 127–135. https://doi.org/10.1016/j.socscimed.2017.04.024

Hosseini Tabaghdehi, M., Keramat, A., Kolahdozan, S., Shahhosseini, Z., Moosazadeh, M., & Motaghi, Z. (2020). Positive childbirth experience: A qualitative study. *Nursing open*, *7*(4), 1233–1238. https://doi.org/10.1002/nop2.499

Hosseini Tabaghdehi, M., Kolahdozan, S., Keramat, A., Shahhossein, Z., Moosazadeh, M., & Motaghi, Z. (2020). Prevalence and factors affecting the negative childbirth experiences: a systematic review. *The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians*, *33*(22), 3849–3856. https://doi.org/10.1080/14767058.2019.1583740

Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023. DOI: https://dx.doi.org/10.15620/cdc:124678.

Husserl, E., & Boyce, G. W. R. (1972). *Ideas: General introduction to pure phenomenology*. Collier-Macmillan.

Kassebaum, N. J., Bertozzi-Villa, A., Coggeshall, M. S., Heuton, K. R., Gonzalez-Medina, D., Barber, R., Huynh, C., Dicker, D., Templin, T., Wolock, T. M., Ozgoren, A. A., Abd-Allah, F., Abera, S. F., Abubakar, I., Achoki, T., Adelekan, A., Ademi, Z., Adou, A. K., Adsuar, J. C., … Lozano, R. (2014). Global, regional, and national levels and causes

of maternal mortality during 1990–2013: A systematic analysis for the Global burden of Disease Study 2013. *The Lancet*, *384*(9947), 980–1004. https://doi.org/10.1016/s0140-6736(14)60696-6

Kogutt, B. K., & Satin, A. J. (2020). Obstetric innovation. *American Journal of Obstetrics and Gynecology*, *223*(4). https://doi.org/10.1016/j.ajog.2020.05.047

Nelson, D., Honiz, M., & Davis, M. (2018). Population-level factors associated with maternal mortality in the United States, 1997–2012. *BMC Public Health*.

Nilsson, C., & Lundgren, I. (2009). Women's lived experience of fear of childbirth. *Midwifery*, *25*(2), e1–e9. https://doi.org/10.1016/j.midw.2007.01.017

Paulsen, E. (2020). *Recognizing, addressing unintended gender bias in patient care*. Duke Health Referring Physicians. https://physicians.dukehealth.org/articles/recognizing-addressing-unintended-gender-bias-patient-care.

Singh, G. K., & Lee, H. (2021). Trends and Racial/Ethnic, Socioeconomic, and Geographic Disparities in Maternal Mortality from Indirect Obstetric Causes in the United States, 1999-2017. *International journal of MCH and AIDS*, *10*(1), 43–54. https://doi.org/10.21106/ijma.448

World Health Organization. (2018, March 27). *Making childbirth a positive experience*. World Health Organization. https://www.who.int/reproductivehealth/intrapartum-care/en/.

Yusuf, K. K., Dongarwar, D., Ibrahimi, S., Ikedionwu, C., Maiyegun, S. O., & Salihu, H. M. (2020). Expected Surge in Maternal Mortality and Severe Morbidity among African-Americans in the Era of COVID-19 Pandemic. *International journal of MCH and AIDS*, *9*(3), 386–389. https://doi.org/10.21106/ijma.405

Appendix 1

Congratulations!

You have completed OHRP's learning module:

Lesson 2: What is Human Subjects Research?

OHRP does not collect information about who completes this training. Please fill out the information below and print this page for your records.

Name: Sydney Lash

Date: July 5 2021