Elevating Black Pregnant Voices for Self-Advocacy

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Introduction

Research from the World Health Organization on maternal mortality in the United States notes that over 50% of maternal deaths are preventable (Agrawal, 2015). There are approximately 1,200 maternal related deaths in the United States each year and at least 60,000 serious complications due to childbirth. Black women are three to four times more likely to die in childbirth than White women (Center for Disease Control, 2017). Black women report less satisfactory experiences in their birth from their health care providers due to racism, quality of prenatal care, and implicit bias from their health care provider than any other race (Facione & Facione, 2007).

The obstacles discussed in the research that contribute to the high maternal mortality rates of Black women include a lack of education and advocacy (Ferguson, Davis, & Browne, 2013; Brashers, Haas, & Neidig, 1999). Research suggests there is a significant impact on improved birth outcomes after pregnant women attend childbirth education (Ferguson et al., 2013). Additionally, when patients feel confident in their ability to self-advocate with their provider, there is a significant increase of participation in healthcare decisions and assertiveness in their care (Brashers, Haas, Klingle, & Neidig, 2000). In the work that follows, the evaluation of a childbirth and advocacy education course was explored.

Review of the Literature

Maternal mortality is an issue facing Black women in the United States more than any other ethnicity (Center for Disease Control, 2017). Although the average number of maternal deaths per 100,000 births is 23.8, the average number of maternal deaths per year for Black women is 40.0 as compared to 12.3 for White and 17.6 for women of other races (Harvard Public Health, 2019). Many factors contribute to maternal mortality, four prominent factors for Black women are (a) systemic racism, (b) access to health care, (c) quality health care providers, and (d) lack of reproductive and childbirth education (Ronsmans et al., 2006).

In Fair Park, located in South Dallas, pregnant women face multiple obstacles that can hinder prenatal care and impact childbirth. These obstacles include accessing health insurance and quality providers and include lack of transportation (City of Dallas, 2018). These barriers may lead to a difficulty in accessing childbirth and advocacy education. There is a need to evaluate possible interventions for the issue of maternal mortality for Black pregnant women in

South Dallas.

Contributing Factors

There are four consistent factors from the research that can impact maternal mortality. Foremost is the racial discrimination that women endure throughout their lifetime (Nuru-Jeter et al., 2009). Systemic racism, political and social systems designed to discriminate against people of color, significantly impact a Black woman's experience during childbirth. The interpersonal experiences of racism may have a lasting affect and can create stress on an expectant mother. Access to healthcare is another important factor in maternal mortality (Center for Disease Control, 2019). In neighborhoods with a high minority demographic, there is less access to hospitals and medical clinics resulting in decreased doctor visits and preventative care. (Center for Disease Control, 2019). Next are the socioeconomic disparities among Black women. There are lower rates of insured patients in urban areas of poverty, significantly impacting affordability of medical services (Morello-Frosch & Shenassa, 2006). Finally, minimal sexual and reproductive education is accessible to Black women, including medical rights in childbirth (Davis, 1982). The disparity in education, as Davis noted, is about contraception, abortion, sexual diseases, and childbirth, all of which can contribute to higher risk of maternal mortality. These research-based factors contribute to higher maternal mortality rates among Black women as compared to any other race.

Factor 1: Racism

Racism has existed since the founding of the United States and has infiltrated laws, education, health care, and interpersonal interactions (Feagin & Ducey, 2019). Both systemic and interpersonal racism significantly raise stress levels and impact the health of Black women during pregnancy and childbirth (Rich-Edwards et al., 2001). The Systemic Racism Theory (Feagin, 2010) defines five dimensions of national racism: (1) dominant racial structures, (2) comprehensive framing benefitting White culture, (3) individual and collective discrimination, (4) social production of material inequalities regarding race, and (5) racial institutions exerting power over minority Americans. The Systemic Racism theory provides a review of the history of systems of racial oppression and evaluates current structures in the United States that exhibit White dominance and discrimination.

Black women have suffered from White framing in relation to their health care (Roberts, 1996). The medical field is one of the institutions wherein 75% of the providers are White as

well as the majority of hospital governing boards are populated with White people (Castillo-Page, 2010). When White culture makes decisions from a monocultural lens based on the represented decision makers. This is referred to as White framing. In the 21st century, Black women are still dismissed when presenting real symptoms of health issues, and given poorer quality health care than White women (Chin, Walters, Cook, & Huang, 2007). The problematic health care for Black women not only impacts health treatment and their comfortability to receive treatment, but there is a significant impact on stress levels in pregnant women giving birth (Rich-Edwards et al., 2001).

Factor 2: Access to Health Care

There are racial barriers in access to healthcare (Brown, Ojeda, Wyn, & Levan, 2000). The type of insurance and lack of reliable transportation play a significant role in health outcomes (Lillie-Blanton & Hoffman, 2005; Syed, Gerber, & Sharp, 2013). The critical issue finding and obtaining resources for health care have important implications for the maternal health of Black women. Care for women who are pregnant is a gateway for health care beyond childbirth and for the next generation (Facione & Facione, 2007). Health care experiences are important for prenatal women and impact comfortability with their health care provider and the women’s knowledge about birth. In a review of published research pertaining to women’s prenatal experiences, participation and processes of prenatal care and perceptions of prenatal care were measured (Novick, 2009). The researchers used qualitative analysis to evaluate 22 studies, from the United States, England, Australia, Canada, Scotland, and New Zealand. Several results emerged from the review of the studies.

The first theme, benefits and barriers, revealed that the barriers to prenatal care included transportation, lack of insurance, substance abuse, and lack of childcare. The second theme, the prenatal care setting, showed that cleanliness and play areas for children were important factors in respondents’ satisfaction with prenatal care. The third emergent theme was time spent in the waiting area and time spent with providers. The fourth theme, continuity and comprehensive care, showed that many (the number was not specified) women did not often see the same provider throughout prenatal care. The women in the reviewed studies generally did not feel they had much control over their prenatal care. In theme five, relationships with providers, many women reported they felt dismissed by rude providers and felt as if providers stereotyped them and treated them with less respect because of their race. In the sixth theme, patients sought

prenatal care information outside of their providers and the medical setting (i.e. doctor's office, hospital, clinic) and looked to midwives and nurse case managers for continued care. From the analysis of qualitative studies, the authors saw a need for personalized care and more training for healthcare professionals to create healthier social and emotional environments for minority pregnant women. The barriers to health care are compounded by the issue of quality insurance based on job status and socioeconomic level of family income.

Factor 3: Quality of Health Care

Birth outcomes and quality of health care between of Black and Hispanic women is frequently reported lower as compared to White women (Saha et al. 2003). A study was conducted to understand the disparities in quality of care among various racial groups. Researchers analyzed the data from a phone survey conducted by the Commonwealth Fund's Quality Health Care Survey (Betancourt, Green, & Carillo, 2002) between April and November of 2001. The phone survey randomly called households across the United States. Numbers located in largely Hispanic and Black neighborhoods were called over 20 times per household to ensure a higher chance of participation. A total of 6,722 people participated. The three factors analyzed from the survey about health care providers and quality of care included: (a) quality of patient-provider relationships, (b) provider cultural sensitivity, and (c) provider racial similarity. Results indicated that 25% of Black and Hispanic participants and 50% of Asian participants had a provider of the same race. Additionally, Asian, Hispanic, and Black participants reported lower levels of satisfaction with their providers while approximately half of minority (i.e. Black, Asian, and Hispanic) populations surveyed felt their provider was appropriately, culturally sensitive during their health care. The authors reported overall lower levels of patient-provider quality of care for non-White populations (Saha et al., 2003). The quality of care that patients receive can impact their emotional well-being and physical health. In prenatal care, this quality of care could impact birth outcomes. The stress from lack of care or negative experiences in pregnancy can add to the physical health of the mother, which can contribute to health risk factors in birth.

Factor 4: Childbirth Education

Childbirth education classes are programs for birthing families that address various types of childbirth, labor interventions, and pain management techniques, which are important for informing birth plans and improving birth outcomes (Nolan, 1997). There are physical and emotional benefits to childbirth education. Australian researchers Ferguson et al. (2013)

conducted a systematic review and meta-analysis of research studies that evaluated the physical, emotional, and psychological benefits of childbirth education. Over 3286 research articles, originating across the world, including countries such as Spain, Sweden, Canada, Australia, United States, Iran, United Kingdom, and Thailand, were related to the topic of childbirth; but only ten articles met the criteria correlating antenatal (childbirth) education and labor and birth. Four studies reported lower rates of women arriving at the hospital in false labor when participants had attended a childbirth education class. One of the studies conducted in Iran reported higher rates of vaginal labor without labor interventions when pregnant women attended classes before labor. The meta-analysis also examined emotional effects as well. Sixty-five percent of women who had attended classes reported decreased rates of anxiety compared to 45% of women who had not attended classes. A study in the United Kingdom found that partners were more involved in supporting the laboring mother if they had also attended the childbirth classes. The researchers reviewing the studies talk about the possible significant physical and emotional effects as a result of attending childbirth education. Although this review focused on biopsychosocial factors, there is a need to understand birth outcomes for pregnant women who attend childbirth education.

Summary

Racism, both systemic and interpersonal experiences, negatively impact the emotional well-being and stress level of Black pregnant women in terms of premature birth, difficulty in labor, and low birth weight babies (Dominguez et al., 2008). The high number of uninsured minority patients are correlated with high maternal morbidity rates (Howell et al., 2016). Additionally, transportation is a major obstacle in accessing consistent medical care and receiving complete prenatal care for the recommended number of appointments, which impacts the health of the mother and the baby (Lia-Hoagberg et al., 1990). Issues such as community support and a quality health care provider directly impact the mother during birth (Gruber et al., 2013). Health care providers who have indicated implicit bias against Black patients explicitly impact the quality of care for birthing mothers and their families. The Black patients of the providers with implicit bias have higher reported rates of the risk of maternal mortality (Hall et al., 2015). Childbirth education can be effective in helping pregnant women physically and emotionally in labor and influence vaginal, unmedicated labor and delivery rates and birth weight of the baby (Hetherington, 1990). All these factors can critically affect maternal mortality

of Black women. Therefore, the issue of maternal mortality needs to be addressed through intervention, using childbirth and advocacy education to positively impact confidence of pregnant Black women to improve their birth outcomes.

Overview of Methodology

The purpose of the study was to explore the outcomes of a childbirth and advocacy education course on pregnant women's ability to self-advocate. The education courses served as an intervention to inform women about their patient rights and how to advocate for themselves during birth. The study used qualitative methods through a descriptive single case study with embedded units. In this study, childbirth and advocacy education was delivered to participants that met the criteria as pregnant Black women. The qualitative data were collected in focus group and postpartum interviews of the participants after the education.

Abide Women's Health Services provided the venue for the study to host the childbirth along with advocacy education course to align with their mission of serving pregnant women in South Dallas. The childbirth education course was created and delivered by childbirth educator. The researcher designed the advocacy session of the course and served in the role of researcher as insider participant. After the delivery of the course, participants were asked to volunteer to engage in a focus group and will be offered the opportunity to be interviewed after they give birth. Data collected from the education and advocacy course was in the form of focus groups, field notes, and qualitative interviews. The study data was analyzed using a thematic analysis coding process. The expectation of the study was that the childbirth and advocacy education course would positively influence the birth experiences of pregnant women in South Dallas to advocate for themselves during their hospital birth.

Research Questions

The research questions addressed in this study are as follows.

1. How do Black pregnant women in Dallas experience the childbirth and advocacy education course?
2. How do Black pregnant women in Dallas perceive their ability to self-advocate, if any, during delivery after they attend a childbirth education class?
3. To what do Black women who self-advocated attribute how and why they advocated?
4. To what extent did the childbirth and advocacy education program contribute to their ability to advocate for themselves during childbirth?

Rationale and Significance

Researchers discuss the importance of training health care professionals to be culturally sensitive toward patients. Additionally, it is important to educate pregnant women about all the aspects of childbirth to prepare them emotionally and physically (Ferguson et al., 2013). In 2014, The Center for Reproductive Rights and Sister Song Women of Color Reproductive Justice Collective (Sister Song) interviewed 25 Black women about their sexual and reproductive health (Center for Reproductive Rights, 2014). This was not an official study but a collaborative effort to engage Black women in conversation to learn the reasons of disparities in maternal outcomes by race. The issue was not only views of sex education within the community but a lack of access to reproductive health care. The interviewed women did not know of their rights to birth control or how to advocate for their medical rights at local hospitals. Additionally, childbirth and postpartum care was a difficult experience for some of the women interviewed. Interviewees felt discriminated against due to age and race, factors that may contribute to the risk of maternal mortality. The Center for Reproductive Rights and Sister Song discussed the need for better access to health care, the reduction of racial discrimination from health care providers, affordability of health care services, and increased education for Black women on sexual education and reproductive rights.

For the purposes of this study, the focus was on childbirth education. Education during childbirth can lead to lower rates of emergency medical intervention, reduced rates of anesthesia, increased rates of confidence during birth, and lower rates of premature birth (Ferguson et al., 2013). In the study described earlier, childbirth along with advocacy education was delivered to participants to evaluate the effectiveness of the education course on each participant's birth.

Data Collection

The researcher collected date in the role as an insider participant (Labaree, 2002). This was conducted through field notes during the delivery of the childbirth and advocacy education sessions. During the sessions, participants were encouraged to place their questions in the chat box provided on Zoom.

Data analysis

Thematic analysis was used to organize data according to patterns and themes (Clarke & Braun, 2013). I created codes from direct quotes from the transcripts of the focus groups and the postpartum interviews to make meaning across multiple data sets through a six-step deductive

coding approach as described by Clarke and Braun (2013) to analyze the data.

Structure of the Intervention

The intervention in this study study was comprised of childbirth and advocacy education. The childbirth education combined aspects of the foundational childbirth education curriculums including Bradley (Bradley Birth, 2020), Lamaze (Riedmann, 2008), ICEA (ICEA, 2020) and DONA. The advocacy education component was informed by the Birth Rights Bar Association (2020) and *Black Bill of Rights* from the NAABB (2020). Since the study participants are Black pregnant women, the development of an intervention included cultural competency components such as CRT for Black pregnant women and is described in the following paragraphs.

Discussion

Self-advocacy before, during, and after birth can be a critical tool for Black pregnant women (Center for Reproductive Rights, 2014). Several key points resulted from the data in this study. Participants who attended the advocacy education affirmed their rights of refusal and were more confident to advocate for themselves. Additionally, participants' relationships with their providers greatly influenced their birth experience and comfortability to ask for what they needed. From this study, participants also discussed the importance of a support team in the advocacy process. The key points, limitations, and future research will be discussed in this chapter.

Knowing Patient Rights

Each of the six participants from the focus groups spoke of one aspect of their rights they learned from the education session. One participant stated that she realized she doesn't have to trust that everything that happens is in her best interest. Other participants engaged in conversation about learning they can refuse care or leave the hospital if they feel their rights are being violated. The participants related their confidence from learning how to refuse care or ask questions from the Black Birthing Bill of Rights (Birth Rights Bar Association, 2020).

The value of using rights became clear in the postpartum interviews when participants talked about reminding herself that she could leave if she wanted. Participants indicated that they did not want doctors to dictate their birth, but they can be heard for what they want and need. One participant used her rights to ensure she was being heard when she expressed that she did not want to be induced. These examples echo what research says about targeted advocacy for

Black pregnant women (Baffour et al., 2006). The implementation of advocacy programs involving rights followed with focus groups for discussion can lead to Black women feeling decreased stress and increased confidence about birth and postpartum (Baffour et al., 2006).

During the interviews, each participant reported that they advocated or asked questions to their provider during birth. Each woman indicated some level of confidence to advocate for their needs. What was indicated in the postpartum interviews showed that provider response played a large role in the continuance of self-advocacy. This aligned with the research from the Brashers et al. (2000) study; participants advocated more when providers engaged in collaborative decision-making for patient medical treatments. Facione and Facione (2007) discuss the emotionally and physical impact of stress that providers can have on Black pregnant women. This stress comes from a strained patient-provider relationship. Although there may be an increased confidence in self-advocacy after learning and affirming patient rights, support and communication from the provider can influence how pregnant women continue to advocate during their birth.

Patient-Provider Relationship

During the focus groups, participants discussed the process of selecting their providers for several different reasons. These reasons include changing birth outcomes from a previous birth, comfortability during prenatal appointments, or choosing a Black provider for racial representation. The research on prenatal care for Black women found that the quality of care is often lower than prenatal care for White women (Saha et al., 2003). The choice of a provider can significantly impact birth outcomes (Facione & Facione, 2007). During a postpartum interview, one participant stated that she felt comfortable asking questions to her provider and verbalizing her concerns. Although she had a positive experience, another participant's careful choice to have a Black provider still did not lead to an ideal experience before and during birth. She consistently stated she did not want be induced, and she repeatedly had to ask for pain management during labor. This patient-provider relationship was described as disappointing.

The issue of cultural knowledge and sensitivity is prevalent in the patient-provider relationship (Betancourt et al., 2002). Although participants did not indicate an instance of bias during their birth, participants expressed the need to know what they wanted to say if they felt violated in birth or not heard from a White provider. Black women have historically been dismissed when bringing up health concerns to their providers (Chin et al., 2007). This can play

a role in stress during pregnancy and birth, which not only contributes to birth outcomes but the bigger issue of maternal mortality (Rich-Edwards et al., 2001).

Participants expressed the advocacy education as positive prevention for combatting maternal mortality and violations experienced in birth. Participants talked about their appreciation for learning more about their patient rights, so they know how to identify a violation, especially when labor requires focus on their body and bringing their baby into the world. There is a chance implicit bias may be missed in some instances when a patient's attention is diverted; but rights such as consent, collaborative decision-making, and respect can be identified and reported when they do not occur (BRBA, 2020). Because of the need to identify and self-advocate when provider bias is experienced, the support team of a Black pregnant woman can serve as an influential role in ensuring equitable care in birth.

Support Team

A support team can significantly decrease stress during birth and depression during the postpartum period (Collins et al., 1993). One participant communicated to her husband her needs and how she wanted to be supported in advocacy in pregnancy. She discussed that they had consistent communication about decision making at each stage of labor and how to speak up if they did not feel heard. In the postpartum interview she explained that her husband spoke up for her when she was not being respected by the nurse. She continued to say that they kept talking throughout birth about what she needed so he could be her voice when needed. For another participant, her husband helped her advocate postpartum when she felt ignored to receive a meal after the delivery. Because he spoke up for her, she was able to get her basic needs met. A support team helping in the advocacy process has been found to give strength to a pregnant patient (Morton & Clift, 2014).

The use of doulas was another component of support that was mentioned in the focus groups and interviews. A doula's role in birth is an integral part to the labor and birthing process (Gruber et al. 2013). Doulas can provide emotional, physical, and educational support during pregnancy and birth that allows a pregnant woman to make informed decisions about her care. One participant had minimal medical intervention, but received comfort measures from her doula to manage the pain surges during labor. The use of a doula on the support team may provide

stress relief in the process of advocacy as a knowledgeable third party for the pregnant woman (Gruber et al. 2013).

Limitations

In any research there can be limitations and that was true in this study. One of the most challenging limitations was brought on by the Coronavirus pandemic and the health risk to conduct an in-person study. Therefore, the childbirth and advocacy education were held online. This did not impact the recruitment process of the study, but the restrictions did impact the recruitment of participants from the target study area. The original intent was for participants in the study to be from South Dallas. However, all participants from various parts of the Dallas area and learned about the study from social media posts and contacts that they directly knew. There is a need to find better participant recruitment for South Dallas residents to attend the advocacy education in future deliveries of the course.

Another limitation of the study was the online format. The original plan for the study did not require participants to bring any materials or have any technological equipment. The researcher and childbirth educator planned to display all visuals and videos on our set of equipment. It was also planned to distribute informed consent and handouts. butWith the changes to the study, participants needed to have a computer, internet access, and access to email to attend the study and receive the informed consent. This may have affected the number and demographics of participants due to access of a computer and internet. This can create a barrier for lower socioeconomic status families, which aligns with the statistics and disparities of the population who resides in South Dallas (City of Dallas, 2018).

Environment is important for the optimal learning environment (Banks & Banks, 2007). Because the education courses were online, all participants stated they were sitting in their home environment. There were distractions at home during a four-hour course such as children, partners, and pets. For example, a participant attended the first part of the childbirth education but had to leave after an hour because her husband left for work and she had to watch her children. The in-person education and advocacy course would have provided childcare and been accessible to attendees from South Dallas.

Implications for Future Research

There are several indicators for future research that pertain to the issue of patient advocacy in birth. The influence doulas have on patient’s ability and frequency to self-advocate

in labor and birth. During the focus groups, the topic of having a doula as part of the support team was discussed by the participants. The focus of the post-partum interview was to collect data on the participants' birthing experience. The questions were designed to answer the research questions and not specifically the role of the doula. Participants who used a doula talked about how their doula helped them plan their birth, changed providers if necessary, and supported them to have the birth they wanted to have. It may be of benefit to further explore the role of the doula as it pertains to aiding in Black patients self-advocating and their confidence to self-advocate.

The difference of care and support provided by obstetricians versus midwives is another consideration for future research. One participant's disappointment with her provider, who is Black, is a result that differs from the research. Research studies state that the psychological and physical stress of Black pregnant women is higher when there is perceived implicit bias by providers or providers are of a different race than the patient (Betancourt et al., 2002). In this case, a Black obstetrician questioned the decisions and requests of her patient, resulting in a disappointing provider experience. One participant's experience with her midwives, however, was supportive and positive even though her providers were White. Because of these results from the data, more research may be needed about provider support. It is worth exploring the differences in level of support and comfortability in provider-patient relationship for Black women who choose obstetricians and those who choose midwives.

Another topic of future research is implicit bias, which was not prominently addressed from the study. However, the issue of racism and implicit bias was highlighted in the research literature. Because there were not clearly stated experiences of implicit bias or racism during the births of the participants, it may be beneficial to explore the impact of implicit bias training on provider practice.

References