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Walden University

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Abstract

The Lived Experiences of African American Women Regarding Their Prenatal Care

By

Alison Edinboro

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Health

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Abstract

The practical manifestation of health inequality can cause a severe societal problem for the African American community. African American women are at risk of their lives and often live in abject poverty. The purpose of this qualitative hermeneutic phenomenological design study was to understand the personal viewpoint and perspective of the lived experiences of African American women regarding their prenatal care experiences. The research question will address perceptions of African American women regarding their prenatal care experience in Southern New York." The qualitative dissertation employs a researcher-designed interview protocol based on Kleinman's explanatory model of illness. After conducting semi-structured interviews to collect data, the responses of 10 African American women who had at least one pregnancy were between 18 and 50 and spoke English. They were analyzed using thematic analysis. Three themes emerged during data analysis to address this question: (a) interactions with prenatal care personnel were limited or rushed but rarely discriminatory, (b) overall experiences of prenatal care quality was mixed, and (c) racism and lack of cultural sensitivity were perceived as general problems confronting African American women in prenatal care. Research findings provide essential information regarding the experiences of African American women in prenatal care, indicating the need for enhanced diversity in the healthcare system to mitigate racism and discrimination against minority women such as African American women. The outcome of the study may help healthcare stakeholders develop essential policies and programs to enhance equity in healthcare systems.

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Dedication

I want to dedicate my dissertation to my family, friends, and "Supporters who have loved and supported me." I dedicate this study to the loving memory of my mother, Marjorie Adams, and my father, Cecil Adams. To my husband, Karifa, who has shown me unconditional love from the beginning of this journey. Moreover, to my son, Shannon, and my daughter, Tiffany, thank you for your unwavering support, encouragement, and constant love that has sustained me throughout this process. Thank you to Dr. Tubman and Dr. Wiginton for their support. I am truly grateful to you both.

A famous quote from Dr. Martin Luther King Jr: If you cannot fly, run. If you cannot run, then walk. If you cannot walk, then crawl, but whatever you do, you must keep moving.

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Chapter 1: Introduction

African American Women and Prenatal Care

African American women in the United States face significant health inequities directly correlated to maternity care. African American and low-income women are 2 to 5 times more likely to die in childbirth or experience severe maternal morbidity than their White counterparts (Creanga et al., 2017). Prenatal care is essential to reduce maternal deaths and morbidity. Nevertheless, prior work has demonstrated that African American women, particularly those with low socioeconomic status living in urban areas, face significant barriers to high-quality care, including lack of transportation, financial constraints, structural racism, and explicit discrimination. Pre-existing prenatal care delivery structures that require continual in-person contact in clinical settings can exacerbate these barriers. Thus, prenatal care in its current form may create complex challenges for African American women, particularly those with low socioeconomic status, who stand to benefit the most from receiving this vital health service.

To provide the best perinatal care, it is crucial to prioritize the patient's experience. This includes establishing trusting relationships with healthcare providers who prioritize the patient's needs and offer consistent care. To achieve this, healthcare providers should receive more training on informed consent, bodily autonomy, and communication. Maternal and birth care resources should be interactive and engaging to improve patient knowledge. Patients should be able to select a provider who understands and respects their cultural background. It is also crucial to create innovative educational tools and classes led by care providers of color, with proper representation in outreach

and educational materials. These are some recommendations from the Giving Voice to Mothers (GVtM), a U.S. study by Vedam et al. (2019).

The GVtM study explored the inequities and mistreatment encountered by pregnant women and mothers during gestation and delivery in the United States (Vedam et al., 2019). This study, led by a multi-stakeholder team of service users, nongovernmental organizations, clinicians, and researchers, aimed to grasp the lived encounters of maternity care in diverse people. The study employed an online cross-sectional survey to collect participant data, integrating patient-designed items that focused on indicators of mistreatment like oral and bodily abuse, freedom, prejudice, failure to fulfill proficient benchmarks of care, inadequate connection with providers, and insufficient circumstances in the health system. The preponderance of mistreatment was investigated regarding various aspects, comprising race, sociodemographic, mode, place of birth, and care context.

Findings from the GVtM study exemplify the degree of mistreatment women undergo during pregnancy and childbirth. Disturbingly, one in six women documented encountering one or more forms of mistreatment, for instance, loss of autonomy, verbal abuse, and being disregarded or denied help. The care context, like the mode and place of birth and contrasts of opinion, is likened to advanced reports of mistreatment. Notably, the study demonstrated substantial disparities, with women of color, especially those with low socioeconomic status, undergoing more elevated rates of abuse (Vedam et al., 2019). It is paramount to acknowledge that this study is not an isolated endeavor but part of a broader body of research addressing the perceptions and experiences of Black women

during prenatal care. For instance, Zhang et al. (2021) examined the intersection of intimate partner brutality, prenatal anxiety, and drug use among pregnant Black women. Yoder and Hardy (2018) conducted a narrative assessment on midwifery and antenatal care for Black women, highlighting the importance of culturally sensitive care. Welch et al. (2022) explored establishing Black-led birth centers to manage health inequities, while Taylor (2020) delved into the consequence of structural racism on maternal health among Black women.

The United States is one of only 13 countries in the world where the rate of maternal mortality is now higher than it was 25 years ago. Between 2018 and 2021, the number of maternal deaths in the United States increased each year from 658 to 1,205, representing a maternal mortality rate increase of 17.4 per 100,000 to 32.9 deaths per 100,000 live births (Hoyert, 2023). During the same period, the maternal mortality rate for non-Hispanic Black women increased from 37.3 to 69.9 deaths per 100,000 live births. Therefore, it is crucial to consider these issues critically and explore how socioeconomic inequalities influence maternal care (Altman et al., 2019; Salmond & Dorsen, 2022).

Among developed countries, the United States has the highest infant mortality rate (IMR), where, in 2021, the IMR was 543.6 infant deaths per 100,000 live births (Centers for Disease Control (CDC), 2022). An infant born in the United States is three times more likely to die than a baby born in Japan (World Health Organization, 2024). Although there has been a decline in the overall IMR in the United States, a disparity gap has arisen between the infants of Black/African American women and their

White/European American counterparts. The IMR in Southeast Queens communities among African American women was twice that of European American women residing in the Borough of Queens (Taylor, 2017).

There is epidemiological data on the incidence/prevalence of specific conditions that can complicate pregnancy (Hoyert, 2022). For example, African American women have higher rates of inflammation than other groups of women, which increases their risk of perinatal outcomes (Saadat et al., 2022). Inflammation during pregnancy can harm the immune system of the baby and the mother (Goldstein et al., 2020; Han, et al., 2021). When the mother's immune system is damaged, preterm birth and pre-eclampsia are often the result (Sawyer, 2021). Han, et al. (2021) found that environmental and social stressors combined with the mother's inflammation may impact the baby's developmental process, indicating neurodevelopmental disorders when the baby is older. Depression during pregnancy occurs in 12% of pregnant women, though African American women experience depression more often than other races/ethnicities National Institute of Mental Health (2021); Mukherjee et al., 2016). Stress has been connected to adverse birth outcomes in African American women, which is much higher than in White women. Stress and inflammation increase the risk of depression, which is a factor in preterm birth (Cruz et al., 2019; Saadat et al., 2022). Intimate partner violence, substance use, and cigarette smoking are related to low birth weight, preterm birth, and infant mortality, especially for African American women (Zang et al., 2021). However, more research is needed to identify the mechanisms related to fetal and maternal outcomes

(Saadat et al., 2022). Intimate partner violence is a form of stress; if experienced before a woman becomes pregnant, the risk of depression is higher (Saadat et al., 2022).

Stressors such as perceived racism by Black pregnant women impact their immune system negatively and can result in infection and, in turn, low weight at birth for babies (Chambers et al., 2020). Racism is a chronic stressor related to both low birth rate of the baby and preterm birth (Braveman et al., 2017; Dominguez, 2011; Dominguez et al., 2008). The definition of racism is a perceived threat formed on an immutable characteristic often central to a person's identity, resulting in unfair treatment based on a person's physical attributes, including skin color (Shiao & Woody, 2020). Stress from racism involves worry, denigration, discrimination, and racism in which a person internalizes the messages therein. Racism can occur at work, home, school, and community (Braveman et al., 2017; Earnshaw et al., 2013; Wallace et al., 2015). According to Chambers et al. (2020), "It is well known that Black women report higher levels of stressors at multiple time points across pregnancy compared to women of all other racial and ethnic groups" (para. 1). High levels of racism that Black women experience may impact maternal outcomes negatively. Furthermore, stress stemming from racism is related to the onset of early labor and preterm births (Braveman et al., 2017; Earnshaw et al., 2013; Nuru-Jeter et al., 2009).

Structural racism in the United States involves practices such as redlining, thus limiting access to quality education and housing and disparities in incarceration, wealth, and employment (Bailey et al., 2017; Mehra et al., 2017; Ncube et al., 2016). Research has continually shown that when Black pregnant women experience structural racism,

adverse birth outcomes are related (Chambers et al., 2018; Mehra et al., 2017; Ncube et al., 2016). Stress in the form of microaggressions often experienced by African American and Latino women has been documented in healthcare environments that have a detrimental impact, especially in the form of barriers and well-being due to the correlation with anxiety and depression (Cruz et al., 2019).

A study of the mental health of African American women during pregnancy revealed an ardent desire for more access to healthcare professionals who are aware of white supremacy, racially conscious, and understand racial issues about health equality (Kemet et al., 2022). A randomized control study found that cognitive behavior therapy groups that utilized the Mastery Lifestyle Intervention with African American and Latino prenatal pregnant women were influential and ought to be included as a routine adjunct (Ruiz-Morris, 2022).

The use of labor neuraxial analgesia for vaginal delivery was found to decrease the risk of severe maternal morbidity (Guglielminotti et al., 2022). The findings suggested that increasing access to higher utilization of labor neuraxial analgesia might help decrease severe maternal morbidity and improve maternal health outcomes in the United States (Guglielminotti et al., 2022). Lower labor neuraxial analgesia use has been continually reported among racial and ethnic minorities, the uninsured, and low-income obstetric women (Butwick et al., 2018). While an estimated 80% of White women get labor neuraxial analgesia nationwide, only 70% of African American women get labor neuraxial analgesia compared to 65% of Latino women. Furthermore, an estimated 75% of pregnant women of all races and ethnicities who have health insurance get labor

neuraxial analgesia, while only 50% of uninsured pregnant women receive the analgesia (Butwick et al., 2018).

The CDC (2020) reported that African American women tend to have higher rates of several chronic conditions and, therefore, are at a higher risk for maternal mortality and morbidity. The leading causes are hemorrhage, sepsis, hypertensive disorders associated with pregnancy, thrombotic pulmonary, and other types of embolism (CDC, 2020). Despite that, these risk factors do not account for severe maternal morbidity entirely (Leonard et al., 2019).

Many women do not go to even one postpartum visit, which has the potential to contribute to maternal morbidity, and this can be a factor in preventing a smooth transition to their well-being in the future (Attanasio et al., 2020). The Presidential Task Force on Redefining the Postpartum Visit and Committee on Obstetric Practices (The American College of Obstetricians and Gynecologists, 2018) explained that the second gynecology appointment after giving birth should occur in 12 weeks and include an evaluation of the women's physical, social, and psychological well-being. Research has shown that women attend postpartum appointments based on insurance, sociodemographic, and clinical characteristics (Campbell et al., 2022). Research also showed that African American and Latinx women versus White women and those who have Medicaid versus those who have private insurance are less likely to receive sufficient and well-timed preventive care in general (Taylor et al., 2020). Moreover, postpartum studies conducted in the United States have shown that inequities regarding postpartum care content were widespread across all states, which poses a severe

disadvantage to women. Nonetheless, examinations based on only one identity dimension may understate the scope of disparities (Wouk et al., 2020).

Furthermore, racial differences in minority rates among women of color can be traced back to healthcare inequality in the United States. Segal et al. (2022) investigated growing healthcare inequalities in America and examined the fundamental community, medical, and system-wide causes. According to the results, eradicating health inequality will necessitate shifting the primary objective of studies beyond health inequalities and onto achieving racial justice through the elimination of structural discrimination. Racism is one of the most significant contributing factors that need to be evaluated and accounted for to ensure comprehensive healthcare coverage for African American women (Chinn et al., 2021). Black women face more preventable deaths when compared to White women. Studying this in other ways shows that pregnancy rate, the death span, and income also vary and are co-related with education (Bodeker et al., 2020).

African American women also experience a higher rate of problems during childbirth compared to White women (Vedam et al., 2019). African American women's pregnancy difficulties are not a passing issue; they stay with them throughout their lives. Even though persons of color and low-income individuals are disproportionately affected by care inequities, their experiences have been largely ignored in research on the delivery of prenatal care (Hunt, 2021). So, clinicians and healthcare executives lack the vital information necessary to adapt prenatal care to the needs of underprivileged communities. According to Bartlett (2022), Human-centered design (HCD), an approach to reimagining processes from the perspective of the end user, has led to the development

of new prenatal care models that are more practical for patients and health care workers. While HCD shows promise as a strategy for reimagining prenatal care for low-income and African American patients' specific needs, the vast majority of HCD work to date has been conducted with White, high-income populations in privileged academic care settings.

African American women face severe reproductive healthcare issues that include a higher rate of unintended pregnancies. As of June 2022, abortion is no longer legal in the United States. However, some states have passed legislation to keep abortion available (Messerly, 2022). A study in southern New York found that African American women were less likely to receive contraceptives than Latino and White women. Access to abortion is limited for African American women, and they are more likely to experience the effect of abortion at various stages of pregnancy due to stigma (Biggs et al., 2020; Moseson et al., 2019).

Discrimination and implicit bias were found to be a shared experience of Black women, often manifesting in healthcare workers not believing the severity of symptoms, so treatment was not sufficient (Saluja & Bryant, 2021; Hatton, 2022). Obstetric care standards were often not adhered to even though they were central to the incidence of preventable deaths. Williams (2019) mentioned the need for a greater understanding of racism in healthcare and the need to address racism as vital to the improvement of maternal healthcare. Both Alio et al. (2022) and Clay (2022) stated that understanding the experiences of pregnant Black women is needed to develop better practices and interventions to serve this population better.

Background

The New York State Department of Health (2024) reported that New York State faces a challenge with higher maternal mortality rates, ranking 23rd in the country. In 2014-2016, the NYS maternal mortality rate was 18.9 deaths/100,000 live births, 1.7 times the Healthy People 2020 target of 11.4/100,000 (The New York Department of Health, 2024). The mortality gap disproportionately impacting African American women only gets larger when looking at the NY-specific rate where African American women experience 51.6 mortalities per 100,000 live births compared to 15.9 mortalities per 100,000 live births among white women in 2014-2016 (New York State Expert Panel on Postpartum Care, 2021). Although rates have decreased, the racial disparity persists, with recent maternal mortality rates at 40.2 deaths per 100,000 for African American women compared to 12.7 deaths per 100,000 for White women (Crandall, 2021).

Among the most recent cohort of pregnancy-related and pregnancy-associated deaths (New York Department of Health, 2024), over half of the pregnancy deaths occurred within a week of the end of pregnancy (66.7%). The most significant proportion of fatalities occurred the day after the end of pregnancy (45.5%) (New York State Expert Panel on Postpartum Care, 2021). The top six causes of pregnancy-related deaths, regardless of timing, identified during the most recent cohort reviewed (2012-2014) included embolism (not cerebral) 23%, hemorrhage 17%, infection 17%, cardiomyopathy 11%, cardiovascular problems 7%, and hypertensive disorders 6% (New York State Expert Panel on Postpartum Care, 2021). Therefore, a cause for concern for many

postpartum individuals is the significant barriers to obtaining and maintaining health insurance coverage, especially postpartum.

While this creates a substantial barrier in many other states, New York has an extensive collection of insurance options that ensure most birthing individuals can maintain coverage after their pregnancy. Among those individuals who gave birth in 2018 and received NYS Medicaid Coverage based on pregnancy eligibility, 90% of enrollees maintained public insurance coverage for six months postpartum (New York State Expert Panel on Postpartum Care, 2021). Of those who maintained enrollment in public insurance plans, 73% of enrollees maintained Medicaid coverage. Of the 27% who lost Medicaid coverage, 62.5% moved into a public insurance option (i.e., Essential Plan or Child Health Plus), 2% enrolled in Qualified Health Plans, and the remaining 36% (approx. 9,000 individuals) lost coverage. Almost two-thirds, or 62% of those enrolled in Medicaid based on pregnancy Medicaid coverage for 12 months after the end of their pregnancy. Of the consumers who lost Medicaid coverage in the 7-12 months postpartum, 36% moved into another public health option.

Problem Statement

There is a problem in the healthcare of African American women. African American women are three times more likely to die during pregnancy and childbirth than non-Hispanic White women (Chalhoub & Rimar, 2018). Another study found that prenatal healthcare African American women participants received did not meet their needs based on their perceptions (Peahl et al., 2022). Supportive collaboration with other

team members from the community was recommended. Healthcare should also be tailored to the individual and be offered in more convenient locations (Peahl et al., 2022).

A possible cause of this problem is racial inequities in the healthcare of African American women during pregnancy (Clay, 2022; Pabayo et al., 2019; Ramraj et al., 2019; Salahuddin et al., 2022). Further, studies on the topic of racist experiences in maternal healthcare are needed (Mehra et al., 2020). This study seeks to expand on the quantitative findings of the GVtM study and others like it by engaging participants in a qualitative hermeneutic phenomenological study to fill the gaps in perceptions of maternal care.

Purpose

The purpose of this qualitative hermeneutic phenomenological design study is to understand the personal viewpoint and perspective of the lived experiences of African American women regarding their prenatal care experiences. This research aims to provide context for interpreting the research findings concerning racial and cultural differences in pregnancy. I am also aiming to understand better the psychological and social phenomena of African American Women's perspective of their prenatal care experiences who have received prenatal care in Southern New York. The study population is all African American women from Southern Queens, New York.

The theory guiding this study is the critical race theory (Bell, 1992; Delgado & Stefancic, 2017) as this study is about African American women's perspective of their prenatal care experiences. Data were collected through individual interviews to be analyzed thematically.

According to Wilkins (2012), research that captures the experiences and ideas shared by African American women provides a unique insight into the lives and the communities in which they live. Self-definition, self-evaluation, and self-identification through voice have been themes for the African American community since the 1890s. The voices of this community provide insight into the interrelatedness of their health, education, social opportunities, moral character, cultural values, and general social betterment (Hogue, Hoffman, & Hetch, 2001). Until recently, the literature did not contain basic descriptive information about the self-defined experiences of pregnancy among African American women and their families (Taylor, 2017).

Collins (2000) noted that by placing African American women, their voices, and their thoughts in the research center, researchers can move beyond the traditional epidemiologic reductionist framework and take a Black feminist approach. Black Feminist thought allows African American women to have a voice in organizations from their own experiences (Collins, 1986).

Framework Theoretical

The study was conducted with two theoretical approaches that explore African Americans' lived experience with prenatal healthcare of women. The theoretical approach defined the various factors and philosophical approaches to the issue. The underpinning of the theoretical approaches discussed with women's healthcare includes social and cultural experiences. Kleinman's explanatory model of illness and CRT, explained in the sections below, provided a framework that supports the current research.

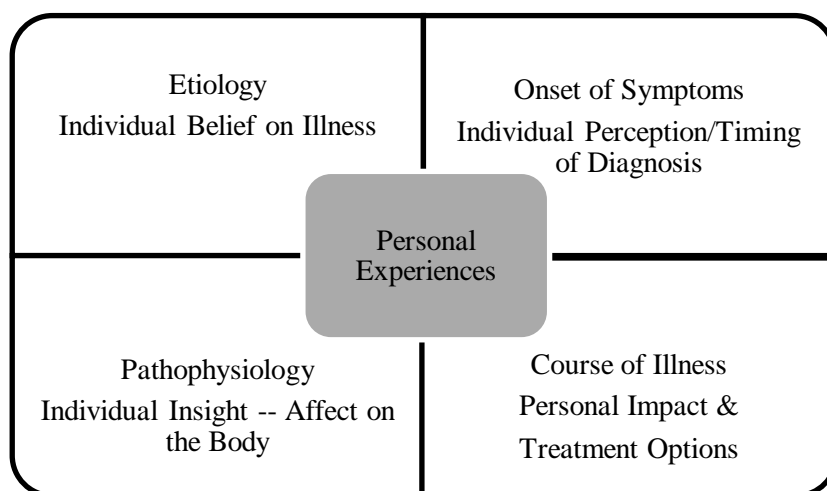
Kleinman's Explanatory Model of Illness

According to the theoretical approach study under Kleinman's explanatory model shows the model of illness. This model emerged in the 1970s and allowed scholars to be medical and experience different diseases patients face (Kleinman, 1978). These factors show that the model provided is used to explore the patient's experience, which has better access to healthcare differently. Patients provide some foundations that explore the patient experience with healthcare patient satisfaction. The cultural perspective tells us that patients must be provided with clinicians and treated from different perspectives. Kleinman's explanatory model of illness is used for development to help healthcare providers recognize cultural factors. These issues explain the complete healthcare model in some dimensions. The impacts of the healthcare department recognize the social and cultural effects on the patient's condition.

Figure 1 shows that observation and experiences are based on the personal condition of illness. Women face specific issues during pregnancy, and the explanatory model explains this better. African American women have severe illnesses during pregnancy that view how diseases are dangerous for long-term health conditions.

Figure 1

Kleinman's Explanatory Model of Illness: Individual Perceptions



This study used the hermeneutic phenomenological method research design based on individual reality and the interconnectedness of social and cultural dimensions. Using Kleinman's theoretical model, this study explored how African American women suffer from barriers to prenatal healthcare.

Critical Race Theory

CRT recognizes that racism is not biological but socially constructed, permanent, and regular and is institutionalized in policy, societal, and educational systems (Bell, 1992; Delgado & Stefancic, 2017). Because people of color are marginalized, CRT users employ counter-storytelling to empower them (Bell, 1992; Delgado & Stefancic, 2017). CRT can address the combination of racism and power while empowering employees to examine structures conducive to racial healthcare disparities that include mental healthcare (DeNard et al., 2017). CRT can often be used to challenge attitudes about race within a person and systems of society (Harris et al., 2020).

Exploring African American women's experiences related to the issue of prenatal healthcare due to racism, discrimination, and inequalities is the aim of the study. A

systematic approach is needed to assess the problems that have created the conditions under which pregnancy of African American women has become a severe health crisis. CRT provided a foundation to understand why this is much more prominent in African American women compared to other segments of society.

Racism is directly linked to society as certain factors under which the health system works. These issues must be addressed to address particular topics under a health program developed for all rather than only some specific people. African American women face health issues because of the fractured health system, as there are higher death rates in African American women than in White women, yet that is only one of the reasons for the disparity.

In the study, CRT provided a theoretical lens to understand approaches that can challenge bias, privilege, and positionality in the analytical process of contextualizing and addressing the lived experiences of the barriers faced by African American women during prenatal healthcare in Southern New York.

Research Questions

The purpose of the research is to examine the lived experiences of African American women regarding their prenatal care. Thus, the following qualitative research question was addressed in this study: What are the perceptions of African American women regarding their prenatal care experience in Southern New York?

Nature of the Study

This dissertation is a qualitative study that aims to explore the prenatal care experiences of African American women in Southern New York. I used a general

qualitative design and open-ended interview questions as the primary data collection method. Through thematic analysis, the study identified social barriers to access to care and potential solutions to mitigate these barriers.

Qualitative research is an inquiry that enables researchers to uncover and chronicle specific population perceptions and actions by representing or signifying them in richly descriptive written forms. Qualitative research allows one to describe how and why people feel, think, act, or react in a specific setting, such as time, place, or circumstances that may not seem apparent or they may not be aware of.

Definitions

Bias is a preference or inclination that restricts impartial judgment and is the same as prejudice (Sue et al., 2007).

Discrimination is based on prejudice that can be either conscious or unconscious, that a person prefers one group over another regarding services, goods, or opportunities (Sue et al., 2007).

Healthcare disparities refer to the differences in the distribution of health determinants or health status between groups of people (World Health Organization [WHO], 2018). Health disparities are well-documented and costly (CDC, 2020).

People of Color refers collectively to people from Africa, Asia, Native America, and Latinx countries.

Pregnancy-related deaths mean the woman died while pregnant or within one year of the end of pregnancy from a pregnancy complication. It is a chain of events that originated from pregnancy or a condition unrelated to aggravation by the physiologic

effects of being pregnant. The death may have a temporal relationship to pregnancy, which is causally related to pregnancy or the management of pregnancy (Davis et al., 2019).

Prejudice is a preconceived judgment about a group of people or an individual that denotes negative bias.

Preterm birth (PTB) refers to a woman giving birth earlier than 37 weeks of gestation (Ely & Driscoll, 2020).

Preventable death: A death is deemed preventable if there is at least some chance of the death being avoided by one or more reasonable changes to the patient, community, provider, facility, and systems connected to the death (Davis et al., 2019).

Racialization refers to the process of marginalizing and categorizing people based on their race. Race is a social construction concept and thus depends on social dominion and the power of the dominant group in society (Smedly & Smedley, 2008).

Stereotype refers to blanket expectations and beliefs about those belonging to a particular group with an oversimplified opinion, uncritical judgment, or prejudiced attitude that is typically negative and based on little information (Sue et al., 2007).

Assumptions

The fundamental assumption of hermeneutic phenomenological research is that there are several perspectives or interpretations. Van-Manen (2014) argued that hermeneutic phenomenology is focused on several perspectives of the participants or the research subjects. Therefore, I assumed that those with vastly different backgrounds and cultures would have varying experiences. I also assumed that participants related to my

study would be easy to locate and willing to participate. This assumption was directly related to obtaining data for this study. Another assumption was that the participants would respond truthfully and honestly.

Scope and Delimitation

The participants were African American women who had gone through at least one pregnancy, were between the ages of 18 and 50, and received their prenatal healthcare from one hospital in Southern New York. This study did not include participants who have received healthcare from other facilities in Southern New York, as it is not feasible. Utilizing a case study methodology means other possibilities concerning the findings. The researcher has also limited this study to answering the research questions with two adopted theoretical perspectives: the choice of participants and the theoretical framework.

Limitations

One of the limitations of the study is that it relies on the perspective and lived experiences of pregnant and postpartum mothers. While the study's objective is to capture their subjective understanding of the services offered, emotions rather than the reason might influence the reliability of the data. Recruiting enough respondents was challenging as some mothers may have been unwilling to participate in the study. Potential participants were assured of confidentiality, and interviews were scheduled based on their availability and convenience to encourage many to participate. There are also some limitations of this study related to prenatal care of African American women who received healthcare from one hospital in Southern New York. Only one group of

women was included: African American women between the ages of 18 and 50. There may be other women, or even other African American women older or younger, or others who received prenatal healthcare at other similar facilities who have not been included; due to this being a qualitative case study, inferences cannot be made, nor can correlations, so there may be alternative explanations that could be valid. Furthermore, case study findings are only suggestive and cannot be generalized elsewhere.

Significance for Social Change

This study is significant because knowing the perceptions and experiences of postpartum mothers using pre-pregnancy and prenatal services may help in creating knowledge that informs appropriate interventions to improve utilization and pregnancy outcomes among African American women. The healthcare experiences faced by African American women during pregnancy is an important topic. Sharp racial discrimination and disparities in treatment, even in the health sector, is an issue African American women frequently deal with. This service crisis further enlarges the interdisciplinary approach that the importance of healthcare for all is a genuine issue.

This study may have particular significance for African American women who are pregnant and seeking prenatal healthcare. Healthcare professionals could use the information from the findings to provide better healthcare for African American women so outcomes can improve. African American women believe that their health and the health of their babies are affected by the disrespect and discrimination they experience in interactions with healthcare professionals (McLemore, 2018). The information shared or withheld by healthcare professionals influences issues such as the power dynamic

between the professional and patient (Altman et al., 2019). In addition, contextual factors such as judgment toward the patient and bias can also impact the interactions between healthcare professionals and patients (Altman et al., 2019).

Summary

There are multifaceted issues regarding the pregnancies of African American women and the worsening IMR (Altman et al., 2019; Howell & Zeitlin, 2017). African American women are more likely to be at risk of death during pregnancy problem because of the weak socioeconomics and lack of quality healthcare (Creanga et al., 2017).

The practical manifestation of health inequality can cause a severe societal problem for the African American community. African American women are at risk of their lives and often live in abject poverty (Howell & Zeitlin, 2017). Health, medical facilities, and health insurance can play a vital role in preventing complications during pregnancy (Hall, 2015). The lack of mental healthcare can also play an important role in redressing the deteriorating condition of healthcare for mothers in the African American community.

Chapter 2 is a literature review of relevant prior research to the study. Prenatal care is mainly focused on since it is the closest related. However, other aspects of African American women's pregnancy are also included to provide a wide-ranging understanding of the problems.

Chapter 2: Literature Review

Introduction

Pre-pregnancy and prenatal care can help women avoid difficulties and learn about crucial steps to safeguard their babies and have a successful pregnancy. Disparities in healthcare outcomes between ethnic, cultural, and socioeconomic classes are exacerbated by disparities in prenatal care access and utilization (Okeh et al., 2015). Prenatal care research typically looks at the relationship between the frequency and timing of prenatal visits and demographic parameters, including the woman's age, schooling, race, socioeconomic background, financial status, or geographic location. While usage statistics can be used to determine when women began their healthcare and whether they attended appointments regularly once they started, these studies do not evaluate the quality or substance of prenatal care, nor do they illustrate why women do not use the treatments that are provided to them (Okeh et al., 2015). Use cannot be equated with access due to the lack of accessibility to available services. Low-income women may live in areas needing healthcare or public transit. Only if women are asked is it troublesome to tell which elements have the most significant impact on them or how they interact. The woman's experience obtaining treatment, such as personal hurdles, wait times for consultations, or other explanations for why they do not initiate or sustain care cannot be revealed by utilization data (Coll et al., 2017).

The inequity of healthcare for minority women who were pregnant was so appalling that the Biden-Harris Administration specifically highlighted the situation as part of the first national gender strategy in the history of the United States (The White

House, 2021). Noting that Native American and Black women are disproportionately impacted, the administration called for unprecedented investments in healthcare (The White House, 2021). In addition, the CDC found that two-thirds of the deaths that were related to pregnancy in the United States are preventable and said they require immediate action (Davis et al., 2019).

Based on research published in 2013, this literature review investigates African American women's perceptions of pre-pregnancy prenatal care. A review of the research on prenatal care access is offered to help physicians and other healthcare professionals better understand the process, including women's perspectives on prenatal care access.

Galvan's method was employed to frame the subject and conduct the literature study. The keywords "prenatal care," "pre-pregnancy care," and "access" were used to search the PubMed, ERIC, ProQuest, and CINHAL databases. Only studies from the United States were included in the review due to disparities in healthcare systems between nations. Initially, only sources published after 2013 were examined. A review of procedures for integrity and appropriateness was included in the analysis. Research that derived findings regarding access to prenatal care usage data was separated from the literature, and studies that surveyed women about their perceptions of access were included.

Theoretical Foundations

The aim of this qualitative hermeneutic phenomenological design study was to understand better the psychological and social phenomena of African American

Women's perspective of their prenatal care experiences who have received prenatal care in Southern New York. The theoretical underpinning for this study will be based on CRT.

CRT was founded in the United States in the 1970s and 1980s (Bell, 1995). At that time, the pioneers of CRT sought to use the framework to target oppressive laws by exposing different incidences of racial inequalities embedded in U.S. policies. Derrick Bell, Kimberlé Williams Crenshaw, Richard Delgado, Lani Guinier, Mari Matsuda, and Patricia Williams were the foundational scholars of CRT.

The theory evolved and has been used in different settings to understand the influence of the intersectionality of race and gender and the representation of women in different fields, such as education, business, and other social institutions. CRT offers a theoretical lens for examining how deeply entrenched racism has become the fabric and identity of the culture of people of Color in the United States. Bell (1995), Crenshaw (1995), Delgado and Stefanic (1993), and Ladson-Billings (1995, 2021) agreed that there are five significant constructs of CRT:

1. Racism is an ordinary and regular phenomenon in society.
2. Race is a social construct.
3. Interest convergence promotes self-interest.
4. Narratives and storytelling can express or challenge Eurocentric ideologies.
5. The notion that Whites have been recipients of civil rights legislation.

Whiteness as owners of property is based on the historical enslavement of Black people who were considered human capital and property (Harris, 1993). Enslavement included extreme abuse, exploitation, rape, as well as psychological warfare to build the

wealth of White Americans (Harris, 1993). Whites were considered superior in every way and could not be enslaved (Harris, 1993). The White supremacist ideology still provides White people systematic advantages in employment, housing, health, education, and healthcare even though race is socially constructed speciously (Ratner, 2022).

CRT, as utilized by Ladson-Billings (1998), was aimed at education, yet some of the same points apply to healthcare. Ladson-Billings's CRT emphasized cultural relevance, and the objective was to liberate Black people's educational environments that were systematically racist. The study also highlighted culture and the five central tenets of CRT.

There has been much criticism recently about CRT (Kaplan & Owings, 2021). "Conservative activists are believed to be distorting this theory to ban it" (Morgan, 2022, p. 35). At least 28 states, as of July 2021, have passed legislation restricting what teachers can teach about race (Schwartz, 2024). The fact is, CRT is not taught in K-12 schools at all, yet it has caused controversy because there are programs that may be dropped wherever CRT is banned. For example, teachers can be fined \$5,000 for students being taught to feel guilty about their race in Arizona (Pitzl, 2021). Some teachers and other school personnel have resigned (Kaplin et al., 2021). Those who stay and teach the "honest history" of the United States have been promised they will be defended in court if they are punished for their teaching practices by the American Federation of Teachers (Binkley, 2021). However, teachers do not feel safe, even though they want to do the right thing for the best learning of their students (Kaplin et al., 2021). However, they do not want to upset students or parents (Kaplin et al., 2021). American history can be taught

balanced and inclusively while incorporating accurate facts about the past and socializing children into loyal, proud American citizens (Kaplin et al., 2021). However, CRT has become a substitution for “state-sanctioned racism” (Kaplan & Owings, 2021).

CRT has become the latest boogeyman they can use to scare people into thinking America’s children are being ‘indoctrinated’ by leftist teachers (Ray & Gibbons, 2021). Some Republican state legislators have even succeeded in banning the teaching of CRT (Morgan, 2022). An illusion is being spun that CRT is being taught in K-12 schools, but it is not (Morgan, 2022). Fox News has exaggerated the lie that CRT teaches that one race is “inherently superior to another,” but that is not what it (Gillborn, 2024). Examples of what guests on Fox News have said about CRT have crossed over into the absurd. Newt Gingrich said the people behind CRT “want to brainwash your child,” Tucker Carlson called it “a cult.” In contrast, Miranda Devine said it would “warp the minds of American children” and “is a recipe for social upheaval and mental illness”. Understanding how White supremacy is maintained will help in the dismantling procedure. Contrary to some people’s belief, CRT is not taught in K-12 schools, although conservative activists have successfully banned it in many states by misrepresenting the meaning (Morgan, 2022).

CRT provided a foundation and theoretical lens to explore the prenatal care experiences of African American women in Southern New York. In the study, CRT is especially applicable through the five constructs, mainly that racism is an ordinary and regular social phenomenon, race is a social construct, and narratives and storytelling can express or challenge Eurocentric ideologies. The study process is expected to allow

African American women to tell their stories in their voices. The findings can be used to challenge bias, privilege, and positionality in the analytical process of contextualizing and addressing the lived experiences of the barriers faced by African American women during prenatal healthcare in Southern New York.

Review of the Literature

Quality of Pre-Pregnancy and Prenatal Care for African American Women

In the United States, Black women have poor pre-pregnancy and prenatal health outcomes. Access to health insurance is another factor causing the disparities in the quality of care received by African Americans and their European American counterparts. According to Oribhabor et al. (2020), the Affordable Care Act significantly increased the number of people with healthcare insurance, as more than 20 million people have gotten insurance since the law was passed. Taylor (2020) explained that the Affordable Care Act helped millions of African Americans get access to improved healthcare, but it did not eradicate mother and newborn mortality disparities. African American women still have limited access to quality healthcare because their socioeconomic situations restrict their ability to afford insurance (Williams & Cooper, 2019). Even with the insurance, the researchers noted that those in rural and other underserved areas lack physical proximity to specialized prenatal caregivers, which continues to put them at risk. In such places, access to maternity wards, OB-GYNs, and other related professionals is limited, which means the women cannot access regular pre-pregnancy and prenatal care when they need it. However, women, there are also other

factors impacting the disparities that African American women experience during pregnancy.

Patients and providers must establish relationships to ensure effective prenatal and postnatal care outcomes. Ineffective communication and interaction between pregnant women and healthcare providers has harmed pregnancy outcomes in the United States (Bush et al., 2017). This issue could lead to misdiagnosis or delayed diagnosis of pregnancy problems. As a result, timely reporting or referral of high-risk cases to professionals or high-level healthcare professionals to take the necessary actions needs to be improved.

Shahin et al. (2020) posited that despite the advances in maternal health promotion technologies over the last decade, the maternal mortality rate in the United States has steadily increased. The authors noted that pregnancy is a unique and essential time for most women, but they face that period of their lives with a lot of fear and uncertainty. This is supported by Herring et al. (2016), who claimed that there are many unknowns regarding labor and delivery. Still, non-White women's perspectives on preparing for the prenatal journey to the end are typically overlooked. The marginalization, stigmatization, and stereotypes they face in this regard are caused by the racism they must endure in American society. The differences between the life experiences of pregnant European American and African American women merit renewed interest in the cause of the differences so that a solution can be found to address them.

Preparation for motherhood is a crucial step for women during the pre-pregnancy and prenatal stages. Szumilewicz et al. (2013) provided essential insights into the experiences of these women before and during pregnancy. Women look for role models to guide them through the process from their older female relatives or, in places where they had none, someone who could hold the place of a mother to them, such as an older female neighbor; similarly, Barimani et al. (2017) noted that role models are in charge of supporting women through the pregnancy process as well as teaching them how to be good mothers. In this regard, role models support women through pregnancy and teach them to be good mothers (Leech et al., 2014). The women even reported feeling safe and comfortable under the care of their spouse, mother, sister, or any female relative (Leech et al., 2014). Notably, this is very different from the experience of White women at the time, as many had access to the services of professionals in the field, which gave them better chances of a successful or at least less problematic pregnancy experience (Barimani et al., 2017).

Physical activity is also essential during pregnancy, especially while preparing for natural childbirth, was the focus of a study by Szumilewicz et al. (2013). Insights were provided by the participants about their experiences during delivery and the course of labor. The findings showed that healthcare providers must give detailed instructions during appointments as individual issues may need to be considered. Intervention research trials are required globally to establish guidelines about physical activity (Lewis et al., 2016). This topic is also important during breastfeeding because if there is not enough calcium for both mother and baby, bone resorption and infant growth can impede

breastfeeding, as can the amount of physical activity. There are also times during and after pregnancy when physical activity is recommended to be adjusted. These have been established by the Society of Obstetricians and Gynecologists of Canada (SOGO) Clinical Practice Obstetrics Committee, the Executive and Council of SOGO, and the Board of Directors of the Canadian Society for Exercise Physiology (Barakat et al., 2020).

It is essential to understand if pre-pregnancy and prenatal care quality has changed for African American women. According to Chalhoub and Rimar (2018), the situation has not changed since studies by the Center for American Progress showed that African American women are thrice as likely to die during pregnancy and childbirth as non-Hispanic White women. The authors attributed this to the continuous refusal by the American healthcare system to listen to the health concerns of African American women. In the United States, racial inequities continue to raise risk factors for Black women since they are more likely to suffer from hypertension, anemia, and gestational diabetes (Leonard et al., 2019). These illnesses require special care but are often not addressed in African American women and may result in high maternal mortality (Chalhoub & Rimar, 2018). Chalhoub and Rimar's study refuted other factors, such as smoking and drug abuse, that have previously been attributed to high maternal mortality among African American women. This shows that the problem lies in the whole American social system that makes African Americans predisposed to specific health conditions and a healthcare system that does not consider the implications of these conditions on the pregnancy journey (Chalhoub & Rirma, 2018).

There are also severe consequences for the infant when women do receive qualitative healthcare during pregnancy. Clay (2021) explored the trends in Black/White IMR in the United States between 2007 and 2016 based on maternal age, marital status, education, and access to prenatal care. Secondary data from the CDC and descriptive statistics were used in the study. The results showed that IMRs for non-Hispanic Blacks had declined faster (15.8%) than non-Hispanic whites (13.5%). Even though non-Hispanic Blacks have registered better rates in terms of IMRs, racial disparities persist, with Black people lagging (Clay, 2022). Other research has found similar results (Pabayao et al., 2019; Ramraj et al., 2019; Salahuddin et al., 2022).

Factors Affecting Perceptions and Experiences of African Americans' Pre-pregnancy and Prenatal Care

Various factors influence the perceptions and expectations of African American women regarding pre-pregnancy and prenatal care. These include low income, family and friends, discontinuity of care, delay in seeking care, racial microaggressions, and other barriers. These factors were discussed in this section as they are relevant to the study.

Low Income

Low income is a leading factor influencing these perceptions of African American women. Edmonds et al. (2015) found that income level influenced African American women's perceptions of the care they needed. Such women from low economic backgrounds have low expectations of the quality of care they need to ensure their safety and that of their children. Many low-income women, especially first-time mothers, do not see a professional before becoming pregnant (Copeland & Harbaugh, 2016). Those who

see a professional and those who experienced complications in a previous pregnancy want to know if it is safe to be pregnant again (Ross et al., 2019). Minimal prenatal care is also the norm in communities where they feel they do not need to visit the clinic more regularly than peers and family advise. The services are expensive, so they must minimize the expenses as much as possible.

Family and Friends

Edmonds et al. (2015) added that the study participants mentioned their family and friends as the primary motivation for seeking prenatal care. Factors like the well-being of the baby and their health come second. Despite their fears that missing prenatal care appointments may cause complications for the baby, parents must consider other factors, such as insurance and transportation, before selecting whether to use the services (Davis-Floyd et al., 2020). According to the scholars, the visits to the clinic involve being instructed and critiqued by the providers on what they are doing wrong but never taking time to listen to the needs of the pregnant mothers. African American women wish they were treated more humanely during such visits (Attanasio & Hardeman, 2019). With the right motivation and support, many of these mothers can do what is required for their well-being and that of the baby.

Discontinuity of Care

Healthcare workers who provide care during pregnancy should be aware of health disparities and how to address them. According to Scott et al. (2019), these guidelines are equally relevant to newborn and perinatal health practitioners and public health professionals, as neonatal and prenatal health discrepancies may result from maternal

health inequities. In their research, Sommers et al. (2016) mention that discontinuity of care is a significant reason why African American women from low-income families do not seek prenatal care. Some of the respondents in this study claimed that the provided only followed the chart and asked repeated questions during every visit, which they did not deem the most effective approach.

While providers may view this as an essential routine important for measuring progress, more is needed to help connect with the patients and understand their specific needs (Yoder & Hardy, 2018). Patients claimed this approach made them feel like "paper patients," as the providers cared about the records, not the actual patients. Other patients in this study cited negative experiences with trainees. While they agreed on the importance of the trainees' learning, some were concerned about redundancies and errors in the provision of care by trainees. The mistakes by trainees give patients a bad experience as they must be checked multiple times for the same issue.

Delay in Seeking Care

Delay in seeking care is another persistent factor affecting prenatal care among African American women. Research by Warri and George (2020) sought to understand why they initiate antenatal care late. African American women lowly value early antenatal care because, for them, pregnancy is a regular health condition that does not have to be regularly checked (Herring et al., 2016). Such mothers do not even seek pre-pregnancy care and preparation unless they have had a complication in their previous pregnancy. They are less motivated to start prenatal care early because of positive experiences with earlier pregnancies or with other women in their families (Tekelab &

Berhanu, 2014). This was combined with other factors such as the high cost of services, distance to health centers, and poor road networks, making it difficult for them to start prenatal care early. There is also a perception of a lack of support from relatives and friends who do not believe it is essential to seek antenatal care early.

Racial Microaggressions

African American women face discrimination when seeking pre-pregnancy and prenatal care. Often, discrimination takes the form of microaggression. Microaggressions were defined by Sue et al. (2007) as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group” (p. 273). However, microaggressions in the environment impact minorities and their identity, so a strong connection to one’s ethnic group and, thereby, a sense of belonging can act as a buffer against racism (Wong, 2003; Sue, 2003; Sue et al., 2019). For example, excluding decorations in the office of a person’s racial identity will minimize that person’s cultural connections with their community.

Vedam et al. (2019) conducted a cross-sectional survey on the experiences of diverse populations in maternity care. The researchers sought to understand issues such as verbal and physical abuse, autonomy, discrimination, poor relationships with providers, and poor environmental conditions in the hospitals as a source of inadequate services. When assessing interactions between patients and caregivers of different races, there were more cases of abuse of women of color seeking prenatal care (Attanasio & Hardeman, 2019). For instance, it was revealed that 27.2% of women of low

socioeconomic status reported being mistreated compared to 18.7% of White women of low socioeconomic status. Additionally, the research found that regardless of the mother's race, if the partner was Black, it increased the chances of being mistreated. Marti (2018) established that discrimination and abuse of women of color in American hospitals has harmed their pre-pregnancy and prenatal care experiences, as well as their perceptions of the same. These women would rather wait until the pregnancy is several months old before seeking prenatal care to avoid being mistreated for as long as possible.

Other Barriers

Women face different barriers in seeking prenatal care in the United States. Research by Meyer et al. (2016) looked at these issues in three dimensions- societal, maternal, and structural. From a societal perspective, many women may not seek prenatal care for unintended pregnancies. This is because of the stigma associated with it. While this problem affects all women across the board, women of Color are the most affected because of their background. Women from low-income homes may try to postpone their initial prenatal visit as long as possible because they believe they are burdening their families with the pregnancy (Goodman et al., 2013). At the maternal dimension, this researcher cited fear of medical procedures, depression, and the belief that prenatal care is unnecessary as significant barriers to accessing prenatal care. This is also based on their background and lack of motivation from their close family and friends to start visiting the hospital for prenatal care. The structural dimension, which includes long wait times, provider language and attitude, and a lack of proper facilities in their places of residency, also has an impact on women of color (D'Angelo et al., 2016). These

structural barriers also affect Black women disproportionately because they are a marginalized group in the United States, and even those who seek prenatal care are treated poorly by the providers.

Alio et al. (2022) focused on obtaining descriptions of experiences of the multiple factors that contribute to disparities between Black women and White women concerning maternal mortality and morbidity. The study used a community-based participatory methodology where the participants become co-researchers and collaborate to help shape the study. Black mothers met in Listening Sessions in Rochester, New York, discussing their experiences with healthcare professionals. The data was coded into themes and subthemes. The factors identified by Black women's mother participants revealed multi-level factors impacting their experiences as expected (Alio et al., 2022; Maskrey, 2019). The four levels were systematic, interpersonal, individual, and clinical/healthcare. However, the most critical factor was communication between patients and healthcare professionals. Healthcare professionals' behaviors, discriminatory attitudes, and maternal health literacy were important in the interactions. Maskrey (2019), in a similar study, found that healthcare professionals tend to overestimate their communication skills whenever patients see the interaction as inadequate. Communication breakdowns lead to poor outcomes and delays in determining medical conditions and diagnosis (Ibrahim et al., 2019). These factors are not specific to Rochester, New York; they are nationwide. Therefore, better understandings of the experiences of Black women while they are pregnant are needed to inform interventions, practice, and research (Alio et al., 2022). This is an opening in the literature to which the study can contribute.

Mehra et al. (2020) used an eco-social and intersectional framework as well as a biopsychosocial model of health to understand Black pregnant women's experiences of gender racism during pregnancy. Data was collected through semi-structured interviews with 24 Black pregnant women in New Haven, Connecticut. Women were asked about their experiences with pregnancy, experiences with gender racism, and concerns related to pregnancy and parenting Black children. Grounded theory techniques were used to analyze the data. Women experienced gender-based racism during pregnancy, racist pregnancy stigmas in the form of stereotypes that stigmatized Black motherhood and devalued Black pregnancy (Mehra et al., 2020). In addition, women reported encountering assumptions from healthcare professionals that they were low-income, single, and had multiple children, regardless of their socioeconomic status, marital status, or parity. Women encountered a racist pregnancy stigma in everyday life, healthcare, social services, and housing, making it difficult to complete tasks without an exam. Many experienced stresses stemming from the racial stigma of pregnancy (Mehra et al., 2020). To counteract these stereotypes, women used a variety of coping responses, including positive self-definition. Racialized pregnancy stigmas may contribute to poorer maternal and infant outcomes through limited access to quality healthcare and barriers to health services, resources, social support, and poorer mental health. Interventions to fight racist pregnancy stigma and its adverse consequences include antibias training for healthcare and social care professionals, screening for racial stigma in pregnancy, as well as providing evidence-based coping strategies. The creation of pregnancy support groups

and the development of a broader societal discussion that values Black pregnant women will also most likely help diminish gender racism (Mehra et al., 2020).

The COVID-19 pandemic contributed to the rise in out-of-hospital births that took place either at home or in free-standing birth centers (Davis-Floyd et al., 2020). Other changes occurred also. Davis-Floyd et al. (2020) found that doulas (support persons for pregnant persons) and the partners of the pregnant women were often excluded from the rooms where birth happened. This practice left women unsupported even though there was a lack of PPEs for hospital personnel, and the provided guidelines needed clarification. Many pregnant women made swift decisions to have out-of-hospital births at this time. Some decided out of fear, and others had been considering it, and the pandemic gave them a little push to settle. However, there was much controversy about out-of-hospital births, even though it has been debated for years.

Davis-Floyd et al. (2020) tracked some of the discussions. They presented all sides of the issue, from doctors who were definitely against out-of-hospital births to doulas and midwives who had long-standing practices of helping women give birth at home and in birthing centers. The medicalization of birthing had come to the fore when Hurricane Katrina occurred over a decade before the COVID-19 pandemic stifled everyday life worldwide. Nothing was done to prepare for the next disaster after Katrina, so the medical community was unprepared to address so many patients. Some advocated relaxed regulations to allow midwives to practice during the pandemic. In contrast, others exaggerated the risks of out-of-hospital births to women trying to decide where to give birth.

New York and some other states relaxed restrictions on practicing midwives, as they did for nurses crossing state lines, to help with the onslaught of rapidly rising hospital admissions due to the pandemic. Much of this article's information is gathered from members of the Council on Anthropology and Reproduction, REPRONETWORK, which included doulas, midwives, obstetricians, and other birth practitioners. Maternity wards were restricting who could be a support person, so women had to choose between their partner and their doula. Mistreatment and racism were reported from mothers giving birth in hospitals. Midwives were accused of not staying abreast of the latest information for safety measures and not being connected to others in the community, such as nearby universities, even though many hospital personnel lacked PPEs. One key contagion site was the hospitals.

Racism in maternity care has been documented by many researchers (Davis D.-A., 2019; Rapp, 2019; Valdez & Deomampo, 2019). Others have shown that supporting care for women of Color improves women's empowerment and agency in institutional maternity care in the United States, where hospital personnel are predominantly White (Bakal & McLemore, 2021). As stated by Davis-Floyd et al. (2020), "The unequal access to safe and high-quality maternity care within the US has only been exacerbated by the COVID-19 virus" (p. 420).

This study focused on African American women and other women who were survivors of abuse about their chosen preference to have a planned out-of-hospital (OOHB) birth or an unassisted birth (UAB) with no midwife or other healthcare professional birth attendant (Sperlich & Gabriel, 2022). Few studies have focused on

Black women who choose OOHB, and little is known about why they choose OOHB. Previous studies have demonstrated that women who have experienced childhood physical or sexual abuse may give priority to having a sense of autonomy and control while giving birth. Sperlich and Gabriel (2022) recruited 18 women who had an OOHB or UAB and who were either Black or survivors of trauma to participate in the study. Individual interviews collected data. The transcriptions of these interviews were analyzed using a grounded theory technique. The findings showed that women may choose OOHB or UAB due to experiencing prior trauma or because they feel discriminated against by healthcare professionals (Sperlich & Gabriel, 2022). The discrimination they experienced was viewed by the participants as happening due to skin color, age, pregnancy, weight, or some other health condition, and choosing OOHB or UAB allowed them to have more control during the procedure of giving birth. Understanding the role prior trauma and discrimination play in choices about giving birth may assist healthcare professionals in considering bodily autonomy, antiracism, physical and emotional safety, and independence as significant components in their interactions with women who are pregnant and giving birth (Sperlich & Gabriel, 2022). Although the study is focused on Black women's prenatal care in a hospital, they may have considered giving birth in out-of-hospital situations such as a home birth or a birth center, so understanding their choices is essential.

Perceptions of Patient-Provider Interactions

Patient-provider interactions also cause disparities in healthcare outcomes. This is a problem that mainly faces racial/ethnic minorities in the United States. Many factors are

involved in the interactions between patients and providers, but many of the issues are related to bias, prejudice, and discrimination. In general, it appears that there is evidence for racial problems to arise from many different aspects of healthcare, with prenatal care being one. Therefore, this section will first present some of the studies related to healthcare for minorities in generalized healthcare situations and then some specially tailored to focus on prenatal care.

Gollust et al. (2018) study aimed to understand healthcare professionals' points of view about the causes of disparities associated with race in a mixed-methods study. Data was collected by a survey completed by healthcare professionals from three Veterans Health Administration sites and interviews, in addition to reviewing the literature of prior studies. The findings showed that some physicians realized they were biased and reflected on it, while others did not. For example, one patient who was African American said the staff was racist, and the physician was initially annoyed by the patient. However, the physician learned about the experiences of racism this patient had endured by establishing a relationship. Another was a White physician who revealed that the relationship with an African American patient reminded him of his own biases based on race. There was also an African American physician who went to the emergency room for back pain and received racially biased treatment. Gollust et al. (2018) concluded that a multidimensional approach was needed to reduce healthcare disparities that included the patient's circumstances and the provider's circumstances, in addition to factors on a systems level.

In another study, Baciu et al. (2019) found that even though healthcare professionals had good intentions, some had a paradoxical attitude concerning mental healthcare. Some valued intersectional identity in their patients and thought professionalism and good intentions protected them against racism (Baciu et al., 2019). This study aimed to determine if healthcare professionals contributed to differences in care based on race/ethnicity, culminating in institutional discrimination. The evidence suggests that motivation and awareness are necessary to control stereotypes, but they are insufficient (Baciu et al., 2019). However, Goldberg et al. (2020) found fewer disparities when military service was noted at the beginning of mental health treatment.

Communication is also an area that impacts interactions between women of Color. Dahlem et al. (2015) conducted a cross-sectional study to examine the perspectives of African American women on patient-provider interactions. This study measured two primary factors, communication, and perceived discrimination, during prenatal visits. A multiple regression analysis revealed that communication between the patient and provider positively impacted the patient's trust in the provider and patient satisfaction. However, while analyzing the experience of African American women seeking prenatal, Altman et al. (2019) revealed that they do not have effective communication and interaction with the providers. Moreover, McLemore et al. (2018) established that a lack of active listening skills, not asking psychological questions, and not explaining diagnoses affect the experience of Black women seeking prenatal care. These patients cited a lack of clear communication from the provider, affecting their understanding of their situation and motivation to return to the clinic.

Khemani (2020) provided essential insights on the same topic. The researcher studied racial inequality in the United States healthcare system, which has potential consequences for maternal mortality among African American women. According to the research, racial bias is experienced as soon as a woman of Color enters a healthcare facility, from how they are received to their interactions with the providers. This study was focused on the field of reproductive health, which affects African American women's mortality and morbidity rate. Through investigating the discrepancies in the overall experience of African American women seeking pre-pregnancy and prenatal care, the research is supported by Gavin et al. (2018), who found that there is implicit bias to the extent of the quality of caregivers assigned to them. According to Flanagan et al. (2018), this is common in cases where African American women are seeking specialized care and end up with unaddressed complications because of the quality of care they receive in hospitals. The author noted that women of Color have specific needs that need to be addressed by the care providers, but these are often ignored based on their color. As a result, Black women have a terrible experience seeking prenatal care, resulting in poor postpartum outcomes for women.

Interactions between minority patients and healthcare professionals were researched by Sim et al. (2021), who conducted a literature review on the topic to attain common themes and synthesize explanations and perspectives. Analysis was applied using coding of the articles and was limited to only quotes from patients and healthcare professionals to portray the minority experience regarding healthcare delivery. The findings showed that not only is racial bias still operating in healthcare facilities, but

biases are also not limited to the United States as several other countries published research included (Sim et al., 2021). Healthcare professionals often labeled minority patients as being less compliant about their treatment. These same healthcare professionals tended to blame healthcare disparities and unsuccessful treatment on the behaviors of minority patients and did not concern themselves with unequal treatment arising from racism. Healthcare professionals saw minority patients' reports about racism as misinterpretation of innocent interactions as racist due to encounters in the past that they had experienced or that they were just oversensitive. Many minority patients reported a lack of sympathy from healthcare professionals (Sim et al., 2021). There were also reports of minority patients playing the race card unnecessarily, meaning they were trying to obtain sympathy or special treatment due to their race. However, there is evidence that minorities experience microaggressions when they are in healthcare facilities (Sim et al., 2021). These perceptions by healthcare providers may stem from a lack of responsibility and their inaction to address their biases. Exclusion of minority patients from some therapies may contribute to medical treatment that is inadequate and may stem from pigeonholing by healthcare professionals (Purtzer & Thomas, 2019). Sim et al. (2021) suggested that healthcare professionals take implicit bias assessments, such as the Implicit Association Test, and self-reflect to help detect their bias behaviors as a first step. Ireland, Australia, Israel, the United Kingdom, Spain, and the United States have all developed programs to improve racial equality healthcare for minorities.

Prenatal Care for High-Risk Women

Women from ethnic and racial minority groups birth their babies in hospitals that have higher rates of severe maternal morbidity in addition to hospitals that are of lower quality (Dagher & Linares, 2022). According to the CDC (2020), Black women are nearly four times more likely to die when pregnant than their White and Latina counterparts. Black women have higher rates of chronic conditions that make them at higher risk for maternal mortality and morbidity (CDC, 2020). The leading causes are due to sepsis, hemorrhage, hypertensive disorders that are related to pregnancy, and thrombotic pulmonary or another embolism (CDC, 2020). Even so, these risk factors do not account fully for severe maternal morbidity (Leonard et al., 2019). Black women have difficulties attaining appropriate prenatal care as well as postpartum care, in addition to experiencing poor communication with their health professionals (Howell et al., 2020). If Black women gave birth to their babies in the same hospitals where White women give birth, the Black severe maternal morbidity rate would decrease by 47.7%, or from 4.2% to 2.9%.

Previous research has established that all women of Color are among high-risk populations as they have special needs not being adequately addressed in the healthcare system. According to Byerley and Haas (2017), increased satisfaction in care will lead to greater adherence from African American mothers. The inequality experienced by African American women accessing pre-pregnancy and prenatal care can be addressed through group prenatal care (GPC). Scott et al. (2019) noted that this group approach gained popularity in healthcare provision for pregnant women and showed considerably

good results. Based on the approach, McDowell (2020) substantiated improved health outcomes for women who underwent the GPC. For instance, the researchers found a reduction in preterm birth among low-income and African American women as their attendance at GPC increased.

Further, Trudnak et al. (2013) stated there was an increase in the level of satisfaction with care among this group due to increased knowledge about pregnancy and following other guidelines by the professionals. There were even improvements in different health outcomes among these women. Fewer pregnant women with diabetes require treatment with medication after undergoing GPC (Francis et al., 2019). Those who had to continue with their insulin dose took a smaller dose than before the intervention. Women who smoke weed even after knowing they are pregnant were more likely to quit the behavior through GPC (Zadzieslki et al., 2018). This showed that high-risk women got many benefits from engaging in group prenatal care. This is because the approach allows women to come together and form a support system to help each other receive prenatal care and even gain knowledge on pregnancy.

African American women have continued to experience poor prenatal healthcare due to the lack of action from those responsible. In their investigation, Pendergrass (2020) established that the result has been an increasing death rate related to pregnancy and childbirth. However, the researcher noted that proper measures can overcome this problem. Policymakers, healthcare providers, and communities can all work together to improve the quality of prenatal and postnatal care (Kearns et al., 2016). The research's first recommendation is expanding and maintaining access to healthcare coverage.

Statistics show that only the majority of Black women of reproductive health have no health insurance (Prather et al., 2018). Even those with insurance have experienced coverage gaps at different times. In this regard, policies need to seek the expansion of coverage so that more women can access prenatal care. The second recommendation that the researcher gave was the provision of patient-centered care that is responsive to Black women's needs (Pendergrass et al., 2020). In essence, Black women need to receive prenatal care that is respectful, safe, and culturally competent because they have specific problems to be addressed.

Addressing the social determinants of health is crucial for pre-pregnancy and prenatal care, especially among African American women. Yoder and Hardy (2018) discovered that these social determinants have different effects on health outcomes across races and ethnicities. One major impediment is racism, which has historically resulted in poor health outcomes for African American women seeking prenatal care (Prather et al., 2018). By addressing such issues, it will be possible to improve Black maternal health outcomes. Furthermore, Williams and Cooper (2020) posited that investing in healthcare quality improvement and safety efforts will ensure that Black women receive the care they require to live better lives. Improving safety and quality also entails enhancing communication and the patient-provider relationship. These are essential determinants of health outcomes of African American women.

The Future of Pre-pregnancy and Prenatal Care for African American Women

The United States is increasingly becoming racially diverse, and this must be reflected in the provision of healthcare. Serbin and Donnelly (2016) predicted a future

where the specific needs of women of Color in prenatal care would be adequately addressed. This prediction is based on research on the increasing diversity of healthcare professionals. It has become paramount for healthcare facilities to ensure personnel that reflect the community they serve. These researchers noted that hospitals have tried to be more diverse and achieve cultural competence. This is supported by Gadson et al. (2017), who note that the American health sector is making efforts to explore the social determinants of racial/ethnic disparities in prenatal care. While the researchers noted that there is still a long way to go before all the goals of equality in prenatal care are achieved, the steady progress noted is in the right direction. The efforts include engaging those at risk to understand their specific needs and how they can be adequately addressed in the healthcare system (Gadson et al., 2018). The essence of the changes is not only to improve experiences but also to change the perceptions of African American women regarding pre-pregnancy and prenatal care services because their participation and adherence are required.

One program that has made a difference in the birth-related death rate is named Birth Detroit (Welch et al., 2022). It is based on a model that is not only community-informed but led by African American women while utilizing evidence-based approaches to provide healthcare for pregnant women before and after birth. Birth Detroit opened to provide community midwifery prenatal care in Detroit (Welch et al., 2022). Evidence-based research does not mean using only quantitative research, a White supremacist research model, but instead, it is based on integrative processes, consciousness-raising, and lived experiences research studies. Services stem from the values of equity, love,

safety, justice, and trust. Birth Detroit is a blueprint developed by Black women to change the inequities of both mother and child in Black communities. “While every pregnancy is unique, the racialization of pregnancy for Black women has long been one of the most reliable predictors of negative maternal and infant health outcomes in the United States” (Welch et al., 2022, p. 4). Their adopted mantra is “We are no longer asking you to save our lives” (Welch et al., 2022, p. 14). This is an example of a model that could be adapted to other locations with a community of interested nurses and midwives striving to address health inequity.

Suarez (2020) highlighted the tremendous changes in the transition from midwifery to obstetrics, discrimination against corporate midwives, the ongoing impact of medical racism, the consequences of legislation, the marginalization of Black midwives in midwifery organizations, the proliferation and activism of radical Black Birth Organizations, Black Midwifery and Maternal Experiences, and the Improved Birth and Maternal Outcomes through Midwifery Care. Most important was that the public, politicians, and doctors needed to listen to radical Black birth attendants and mothers about their lived experiences (Suarez, 2020). The goals of the radical Black midwifery organizations include raising awareness of different birth options for Black mothers, addressing the history of medical racism, promoting and supporting Black women who become midwives, and activism for medicine and especially the state. Society can increase support for birth justice by supporting and centering radical Black birth organizations. Some ways to do this may include public pressure on the healthcare industry and the state to implement changes for greater access to care through Medicaid

and private insurance, increased funding for more Black midwives through local and state grants to Black birthing organizations, and more by and large actively calling for and working to change racism in the United States (Suarez, 2020).

There are other programs for the birthing of babies for Black women. Support has also been expressed by the American Medical Association (AMA) (2020). “The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.” The hope is that medical professionals and medical schools will embrace discourse on the topic, which would have the potential to mitigate medical racism regarding Black mothers and midwives (Suarez, 2020).

Involvement of patients and the public is now recognized as necessary to conduct good research (Frank et al., 2018). Patient and public involvement in research priority setting and funding decisions is only now being recognized as necessary, and approaches for doing so are promising. This protocol describes the Research Prioritization by Affected Communities (RPAC) protocol and the results and outcomes of adopting it with women at high sociodemographic risk for birth at preterm. The objective was to directly involve women in identifying and prioritizing questions about pregnancy, childbirth, and neonatal care, as well as treatment so that their views could be integrated into research priority setting by both funders and researchers (Frank et al., 2018). The RPAC protocol may be utilized to meaningfully involve under-represented groups at high risk for specific health problems, or those who face disproportionate disease issues, in strategy and funding priority setting for research (Frank et al., 2018).

African American women have the highest incidence of premature birth (PTB) (Berkowitz et al., 2022). Black women experience PTB 1.55 (14.39%) times higher than White women (Ely & Driscoll, 2020; Martin et al., 2019). Disparities and inequities of preterm birth have persisted for minority women for decades (Brase et al., 2021; Lonhart et al., 2019; Martin et al., 2019). Upstream factors, including neighborhood context, may contribute to this increased risk. This study examined the relationship between neighborhood quality, as defined by the Healthy Places Index, and PTB in Black women who lived in Oakland, California, and gave birth between 2007 and 2011 ($N=5418$ women, $N=107$ census tracts; Berkowitz et al., 2022). We found that women in higher-quality neighborhoods had a 20% to 38% lower risk of PTB than those in lower-quality neighborhoods, regardless of confounders. The results have implications for place-based research and interventions to address racial inequalities at PTB. The study results suggest that living in a more holistically defined, higher-quality neighborhood may help reduce the risk of Black women developing PTB (Berkowitz et al., 2022). For Oakland neighborhoods, the results identify areas for potential citywide assessment and policy intervention to address persistent racial inequalities in PTB. Our results also underscore the importance of examining and intervening on multiple intersecting dimensions of neighborhood quality.

Cities across California can access the publicly available HPI and its component domains to understand better the relationships between neighborhood quality and health outcomes such as PTB in their areas. Such efforts are necessary to advance research and practice to address health inequalities impacted by where women live (Berkowitz et al.,

2022). Other studies have also found a relationship between physical environmental factors and PRB (Braveman et al., 2021; Hawthorne, 2019). Place may also be a factor in the study.

The number of obstetricians and gynecologists in the United States is declining, so investments are necessary to expand the maternity care workforce pipeline, particularly nurse midwives, doulas, nurse practitioners, physician assistants, family physicians, and community health workers (National Academies of Sciences Engineering and Medicine, 2020). Doing so may increase maternal care's diversity, distribution, and quantity. Although midwives constitute an essential, safe, and cost-effective part of maternity care, notably in rural areas, impediments to midwifery practice endure across the country (Douthard et al., 2021).

Prenatal care is often provided by midwives (Michel & Fontenot, 2022). Craft-Blacksheare and Kahn (2022) studied the perception of the African American Maternal Mortality Crisis in the United States. They found midwives and other perinatal health workers can be leaders in ascertaining healthcare equity. To accomplish equity, suggestions were to listen more carefully to clients, use evidence-based practices, increase the number of birth centers, expand the number of multispecialty provider groups, provide racial and cultural sensitivity training, and recruit more providers of Color and midwives and other perinatal health workers have a wide-ranging understanding of the possible remedies and multidimensional causes for the high rate of Black maternal mortality (Craft-Blacksheare & Kahn, 2022).

Addressing the vast differences in regulation, certification, and licensing of maternity care professionals in the United States is critical. In addition to clinicians, increasing the quantity of community health workers, public health practitioners, and scholarly researchers in the maternal morbidity and mortality field is necessary for the expansion of functional Maternal Mortality Review Committees, community-based maternity care, and implementation of the national research agenda (Chakhtoura et al., 2019). It is vital to extend Medicaid to cover one year postpartum nationwide. Pregnant women living in high-income countries with universal insurance are not denied healthcare before, during, or after pregnancy, contributing to reducing the maternal mortality ratio in other countries (National Academies of Sciences Engineering and Medicine, 2020).

Summary

Pregnancy is unique for most women, but many face that experience with fear and uncertainty. The disparities between White and African American women deserve renewed engagement regarding the sources of the differences so that a solution can be found. Much of the fear for African American women can be attributed to the continuous refusal by professionals in healthcare to listen to their health concerns. This indicates that the problem most likely lies in the whole American social system that makes African Americans predisposed to specific health conditions and a healthcare system that does not investigate the consequences of these conditions on pregnancy. Access to health insurance is another determinant factor related to the disparities in the healthcare quality received by African American women (Davis et al., 2019). Various factors influence the

perceptions of African American women during their pre-pregnancy and prenatal healthcare. Women from low financial backgrounds tend to have low expectations of the quality of healthcare they need to ensure their well-being and that of their babies. Without good motivation and support, most of these mothers fail to do what is necessary for their well-being and that of the baby. Microaggressions, discrimination, and even abuse are everyday experiences of African American women when seeking pre-pregnancy and prenatal care (Attanasio & Hardeman, 2019; Martin et al., 2019; Valdez & Deomampo, 2019). Many studies document racism in maternity care (Davis, 2019; Rapp, 2019; Valdez & Deomampo, 2019). Martin et al. (2019) recognized that discrimination and abuse of women of Color in the hospital in the United States have harmed their pre-pregnancy and prenatal care experiences, as well as their understandings and insights of the same. Chapter 3 will explain in detail the methodology used in this study.

Chapter 3: Research Method

This study explored the prenatal care experiences of African American women, focusing on the barriers they face regarding their prenatal care experiences at one hospital in New York City. This chapter will discuss the methodology utilized, which includes several sections explaining the topic. The first section states the research question after defining the phenomenon being explored. The research tradition will be discussed next, followed by a definition of the central phenomenon of the study. The researcher's role in the study is explained, revealing professional and personal relationships with the participants. Researcher bias and how those biases were managed so as not to interfere with the research process are presented. Ethical issues applicable to the researcher and study are discussed next, and how each ethic was addressed is explained. The methodology presented includes the choice of participants, the instrument used for data collection, and the procedures for recruiting, participation, and data collection. The data analysis plan is then presented. Discussing the study's trustworthiness will include credibility, transferability, dependability, and conformability. A full presentation of the ethical procedures of the entire research will be explained in detail, as will the other sections so that another researcher can replicate the study. The chapter ends with a summary and introduction to Chapter 4, presenting the study results.

Research Design and Rationale

RQ1 – Qualitative: What are the perceptions of African American women regarding their prenatal care experience in Southern New York?

The central phenomenon in this study is that of the perceptions of African American women regarding their prenatal care experiences, especially considering factors such as discrimination from healthcare providers, discrimination, microaggressions, and abuse among those with social, economic, or health challenges and other negative experiences that have occurred when seeking prenatal healthcare. Many authors have documented these experiences (Attanasio & Hardeman, 2019; Davis, 2019; Martin et al., 2019; Rapp, 2019; Valdez & Deomampo, 2019).

This study used a qualitative method to explore the perceptions of African American women regarding their prenatal care experience in Southern New York. Using qualitative research means the researcher is interested in the participants' experiences to understand their perspective of the phenomenon (Renjith et al., 2021; Yin, 2015). Qualitative studies are exploratory and are often used in healthcare research (Renjith et al., 2021). Using a quantitative method would not answer the research question, as statistics are generated and are not needed in this study. Themes were developed from the data to answer the research question (Braun & Clarke, 2013; van Manen, 2016). No categories of codes or themes are predetermined in thematic analysis. Continually comparing data with prior data is used to search for commonalities and discover new themes from the collected data (Braun & Clarke, 2013; van Manen, 2016).

A hermeneutic phenomenological design was implemented to understand better the psychological and social phenomena of African American women's perspectives on their prenatal care experiences. Phenomenological research originated with Husserl, who lived in the 19th century, but stemmed from phenomenology philosophy (Kafle, 2011).

Essentially, phenomenology is an umbrella term comprising the philosophical movement and several research approaches (Kafle, 2011). The essence of the participants' experience is what the researcher strives for (Creswell & Poth, 2018; Moustakas, 1994). Researchers use this type of approach when they want to understand the meanings and the nature thereof (Finlay, 2009). According to Van Manen (2016), phenomenology is the best research approach to a phenomenon as a lived experience while simultaneously questioning how a person experiences the world. I chose the phenomenological design to give voice to African American women's prenatal care experiences in Southern New York.

The hermeneutic phenomenological design affords researchers access to contextual data and meanings that surface from participants' lived-in and lived-through healthcare experiences (Crowther et al., 2016; Paley, 2016). This approach was not born from one author but is a research paradigm with four key ingredients. The first is metaphysics, and when considering the approach of their study, a researcher is influenced by their ontological and epistemological foundations and then their values (Greenbank, 2003). Ontology is concerned with the reality that, from this perspective, an individual is an individual according to the situation and is multiple, not a single reality (Kafle, 2011). Epistemology means knowledge that will contribute to knowledge itself, and it is subjective.

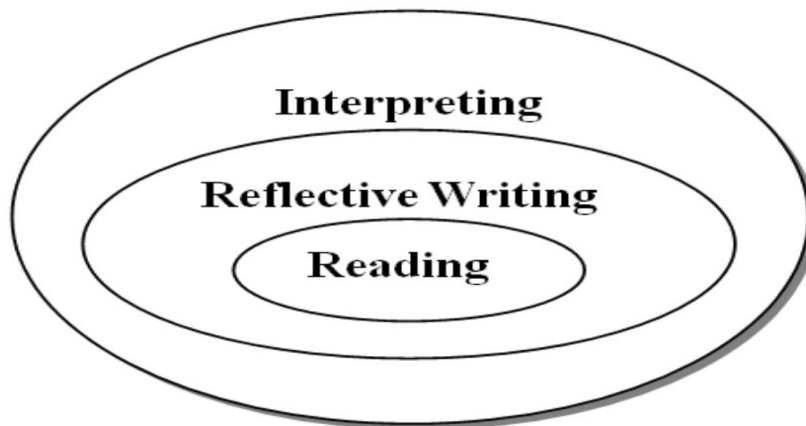
The hermeneutic phenomenology approach was chosen because I was interested in the perceptions of African American women regarding their prenatal care experience in Southern New York. The participants' experiences were the main object of the

research, and this approach considers not only the individual's personal, unique experience but also the context in which that experience takes place. An interaction occurs within the context that has an impact on the experience. The findings depict the commonalities of the phenomenon among the participants (van Manen, 2016). The researcher does more than describe the phenomenon; they also use their judgment to interpret it (Moustakas, 1994).

Figure 2 depicts the hermeneutic circle of analysis comprising reading, reflective writing, and interpretation.

Figure 2

Hermeneutic Circle



Note. From "Hermeneutic Phenomenological Research Method Simplified," by N. P.

Kafle, 2011, *Bodhi: An International Journal*, 5(1), p. 195

(<https://doi.org/10.3126/bodhi.v5i1.8053>). Copyright 2011 by *Bodhi: An International*

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Role of Researcher

My role as the researcher in this qualitative hermeneutic phenomenology study was multiple. I not only developed the interview questions based on prior literature but also conducted the interviews and interpreted them. In qualitative research, the researcher is considered an instrument (Creswell & Poth, 2018). Many new researchers assume they have no biases even though they use their lens to collect and analyze data (Fusch & Ness, 2015). However, all social research contains both the researchers' and the participants' biases or worldviews, whether intentional or not. The better a researcher can recognize their own biases and worldviews, the better they will be able to hear and interpret the behavior of others along with their reflections (Fusch & Ness, 2015). The researcher's experiential and cultural background contains values, ideologies, preconceived ideas, and biases that can have an impact when data is saturated. Therefore, I kept a journal throughout the research process, noting biases and my worldview when they surfaced in my consciousness to mitigate them, for as stated by Fusch and Ness (2015), this "is a crucial component for the study (p. 1411). This allowed me to listen carefully to what the participants were saying to comprehend their perspective of their experiences instead of my own.

Methodology

Participants

The population of a study is the number of people that live in a specific country. In the study that took place in the United States, the target population consists of African American women who have received their prenatal care in Southern New York. A sample

was drawn from the target population using the technique known as purposeful sampling. In purposeful sampling, participants are judged by the researcher to have experienced the phenomenon to provide information that cannot be attained from other sources (Maxwell, 2012). The participants warrant inclusion. The strength of purposeful sampling is that it is low cost, is not time-consuming, is convenient, and is an excellent choice for exploratory research (Taherdosst, 2016). However, the weakness is the inability to generalize to other settings (Taherdosst, 2016).

A sample of participants was chosen based on these criteria. Participants had to self-identify as African American women who received prenatal care in Southern New York City. All participants were over the age of 18 and were able to articulate their experiences as well as be willing to share them. Any education level included, whether single or married, does not exclude them either. What excluded them from participating in the study was obtaining their healthcare from Southern New York over 5 years ago. They must also speak English, as the interviews were conducted in English. Moustakas (1994) emphasized that choosing participants based on the set criteria is essential, and the requirements should always be followed.

Phenomenological research only needs a small number of participants, as Creswell and Poth (2018) suggested a minimum of three and up to 15 participants. I recruited at least 10 participants to ensure the saturation of codes from the data. Two participants underwent interviews to establish that the interview questions would solicit the data required to answer the research question and that the questions were clearly

understood. Potential issues with comprehension were discussed with the dissertation committee, and interview questions were revised as necessary.

Instruments

For my planned research design, I needed to conduct individual in-depth telephone interviews with African American women regarding their perspective on their prenatal care experiences within hospitals in the obstetrics-gynecology labor and delivery department in Southern New York. Primary data were necessary to explore the perceptions of the experiences of African American mothers. The World Health Organization's Research Group on the Care of Women in Childbirth reviewed the research on RMC in-depth in 2015. Quantitative and qualitative data from 65 studies on the abuse of women in childbirth in healthcare settings in 34 countries with varying socioeconomic profiles were analyzed by Bohren and colleagues (Bohren et al., 2015). From verbal and physical assault to a lack of supportive care to neglect, prejudice, and denial of autonomy, the investigators found several instances of disrespect and human rights breaches encountered by women during childbirth. Bohren et al. (2015) identified "mistreatment" as a phenomenon with a wide range of manifestations and defined it along seven dimensions, including but not limited to the following: failure to meet professional requirements of care; failure to establish rapport among women and providers; poor conditions and constraints presented by the health systems; physical abuse; sexual assault; verbal harassment; and prejudice. They suggested that future researchers use this typology to evaluate the efficacy of interventions and better understand the incidence and impact of abuse across jurisdictions or groups. There has

been a flood of responses to the Bohren et al. (2015) typology since 2015, with several authors pointing out the absence of worldwide evidence. Though some researchers have adapted the typology for use in quantitative studies of the incidence and profile of mistreatment in low-resource countries, no one has yet used it to evaluate the quality of care provided in high-resource settings, nor have they conducted a qualitative analysis of the seven domains comprising the typology.

Interestingly, while the descriptive data that supported the Bohren typology came from participants' actual lives, not a single study in this systematic review relied on a patient-led approach to item construction. Based on what we know about what works best in patient-oriented outcome research, those who have experienced the "mistreatment" in question may best define and explain it. Patient-designed measures that may assess the influence of the experience of maternity care are still limited, even though indicators of quality and safety based on patients' experiences are now routinely gathered at institutions in other fields of medicine. As noted in Chapter 1, there are different studies involving a multi-stakeholder team to explore the diverse experiences of women, especially in maternity care. For instance, Vedam et al. (2019) explored how pregnant women and mothers experience inequities and mistreatment during pregnancy and delivery. Their findings show that most women, but particularly those with low socioeconomic status, experience significant cases of abuse. These findings resonate with Taylor's (2020) study, which explored how structural racism affected maternal health among African American women. In another study, Zhang et al. (2021) investigated the

correlation between intimate partner violence, prenatal anxiety, and drug use among Black pregnant women.

On this note, in my study, participants were asked these questions to delve deeper to further explain or expound on those prior findings.

Interview Questions

1. Would you explain to me your experience during prenatal care? Anything you want to share is ok.
2. Do you think you received the best care possible during your prenatal appointments? Can you give me an example?
3. Did you experience discrimination from your providers that you are willing to share? Can you give me an example?
4. Did you experience discrimination from other healthcare staff during your prenatal appointments? Can you give me an example?
5. What would it look like if you could have your ideal birth experience?
6. Did you ever feel fear in any situation related to healthcare and your pregnancy? Please explain with examples to help me better understand.
7. How would you explain the stress you experienced during your pregnancy?
8. Do you believe discrimination and prejudice continue to be a barrier to the healthcare of Black women? If so, please explain why you believe this to be so.
9. Have you experienced any verbal or physical abuse from your healthcare providers?

10. During your prenatal care, were treatments forced upon you or withheld by your healthcare providers? Can you give me an example?

11. Is there anything else you would like to share with me about your prenatal care before we quit the interview?

After the Walden University Institutional Review Board (IRB) approved the study (IRB Approval No. X), I requested to post flyers at clinics in Southern New York and on social media. I used snowball sampling, as women who expressed interest in participating may know other women who fit the criteria for participation. The flyers and social media posts had my contact information (both email and phone).

After volunteers contacted me, I returned their inquiries in the same manner. For example, if they called me on the phone, I would return the call, and if they emailed me, I would email them. I thanked them for volunteering, told them about the study, and asked about audio recording the interview. I then asked if they had any questions for me. If they were still interested in participating, I asked for their mailing address so that I could send them a copy of the consent form to sign and a few demographic questions to ensure they met the criteria for participating. These questions asked about each inclusion criterion. When I received the consent back, I reviewed the demographic information, and if they fit the requirements, I contacted them to set up a time to conduct the interview. I used my cell phone on speaker to audio record the interviews, which were expected to last between 45 and 60 minutes. I used a tape recorder to back up the recording if the cell phone did not record the interview.

After each interview, I transcribed the interview using the NVivo app for iPhone. The same procedure as outlined was used for each interview. Interviews continued until saturation was reached. According to Fusch and Ness (2015), saturation is reached when no new data is forthcoming. When saturation reached, I contacted everyone on the list and thanked them for volunteering. Interview data were transcribed and provided to the participants to confirm transcript accuracy. When all interviews were transcribed, and members checked, I moved forward with the data analysis.

Data Analysis Plan

The data generated by the interviews is expected to answer the research question as the interview questions were developed while considering the research question, the methodology, the setting where the study takes place, the characteristics of the participants, and prior literature. The ontology of the researcher was also considered when forming the interview questions, as the researcher has some impact on the data even though the goal is minimization. As there is only one research question, the focus is maintained and emphasized in the endeavor.

Data analysis took the form presented by van Manen (2016) while maintaining a reflective stance throughout the process. In the journal, I kept an ongoing record of reflections while going back and forth between the data and the reflections, crosschecking, comparing, and contrasting findings in the research text. This aids in maintaining faithfulness to the constructs developed by the participants, thus grounding interpretations in the data and authenticity.

Six steps for analysis were developed from hermeneutic and phenomenological principles (van Manen, 2016). Each was identified and explained for understanding and clarity of the method. Implementing the steps one at a time was interspersed with journal recordings, as Lincoln and Guba suggested (2000).

The first step is immersion, in which the researcher organizes the dataset into texts (van Manen, 2016). The iterative reading of the texts accomplishes this, while preliminarily, interpretations are made to facilitate coding. Authenticity must be maintained, so interpretation does not mean making assumptions about the meaning of the text.

The second step is understanding, which means identifying the participants' constructs while maintaining faithfulness to the original text (van Manen, 2016). This step was accomplished using NVivo software for accuracy and speed. No further tasks are required.

The third step is an abstraction that consists of identifying the constructs made by the researcher. The constructs are then organized into subthemes (van Manen, 2016). This is accomplished by recording the text in the journal and paying attention to it. Interpretation is not necessary as these were the researcher's constructs.

The fourth step is synthesizing and developing the themes (van Manen, 2016). The subthemes are grouped into themes. Further elaboration on the themes can now occur while maintaining authenticity by reflecting in the journal. The themes are then compared across sub-discipline groups.

The fifth step is illuminating and illustrating the phenomena (van Manen, 2016). This is where the themes identified in step four are linked with passages from prior literature for support, understanding, and clarification purposes. The aim is to reconstruct the interpretations into story narratives. The stories must be clear and understandable, while prior literature illustrates, endorses, and advocates for the original text. This forms the reports of the findings discussed in Chapter 4.

The objective of phenomenological data analysis is to “transform lived experience into a textual expression of its essence – in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful” (van Manen, 2017, p. 36). The key is the essence, which means there is a combined core meaning of what the participants explained and shared. There is not one essence but multiple essences, and combining the participant’s core essences enhances them due to the diversity of the perspectives of reality. These essences can be considered core meanings of the interview answers (Benner, 1985; van Manen, 2016). It is a process of reducing the manifold interpretations into a single understanding representing the entire theme (Young, 2006). When only one code not encompassed into a theme is not an essence and will be deleted for the singularity, it does not contain commonalities shared by the participants.

Issues of Trustworthiness

According to Lincoln and Guba (1985), the trustworthiness of a study involves actions the researcher needs to implement. Trustworthiness comprises credibility, dependability, confirmability, and transferability in qualitative studies. Credibility means

that the findings and interpretations are reasonable according to the participants (Lincoln & Guba, 1985). Do the results accurately reflect the reality as seen by the participants? Transferability refers to the applicability of results due to the comparability of contexts. Are the conditions similar enough to make insights applicable? Reliability relates to accounting for factors of instability and change within the natural context in which the study occurs (Lincoln & Guba, 1985). Confirmability is the ability to authenticate the internal coherence of data, findings, interpretations, and recommendations. Document the researcher as an instrument and potential sources of bias.

To establish trustworthiness, the researcher must take specifications (Lincoln & Guba, 1985). The first is prolonged engagement, which means researchers must invest adequate time to learn about the culture, build trust with stakeholders, understand the scope and target phenomena being studied, and test for misinformation or misinterpretations due to researcher or informant bias. This ensures credibility and internal validity (Lincoln & Guba, 1985). The second is constant observation, which means that the data collection process continues to allow for the identification and evaluation of salient factors and investigation in sufficient detail to separate relevant (typical) from irrelevant (atypical). This also ensures credibility and internal validity.

Peer debriefing refers to the researcher engaging in analytical discussions with neutral colleagues, such as colleagues who have not been involved in the study during the research process, to ensure credibility and internal validity (Lincoln & Guba, 1985). Members verify the accuracy of data to ensure an accurate representation of the participants' perspectives. This also provides credibility and internal validity. Thick,

detailed descriptions sufficiently portray the methods, context, and participants so that others who might want to replicate the study at a different site can reconstruct the results (Lincoln & Guba, 1985). This ensures transferability or external validity. Keeping an audit trail means that the researcher documents the processes and products of data reduction, analysis, synthesis, methodological process notes, reflective notes, and instrument development. This ensures reliability, corroboration, reliability, and objectivity. Keeping a reflective journal means the researcher's notes and documentation of the researcher's thinking throughout the research process. This assures credibility, transferability, reliability, confirmability, or dependability (Lincoln & Guba, 1985).

Ethical Procedures

The researcher adhered to all ethical standards, beginning with obtaining approval from Walden University IRB. Participants received an informed consent form before the interviews, clearly explaining the study and their rights, including their right to withdraw from the study at any time without incurring any consequences. Participants could ask questions about the research and receive answers from the researcher before participating.

All collected data were labeled with a number instead of the name of the participant to protect confidentiality. Any possible identifying information was also deleted from the transcripts. Privacy was ensured by the researcher conducting the interviews in private. Both recorded interviews and hard copies of transcripts will be kept in a locked cabinet to which only the researcher has the key. All information concerning this study on the computer will be password protected, as will any copies kept on a thumb drive, which will also be kept in the locked cabinet.

Minimal risk for the participants is expected, mainly limited to feeling psychologically uncomfortable about answering questions regarding their prenatal care experiences at the New York Hospital Center, most likely involving medical discrimination and racism.

Summary

This study used the hermeneutic phenomenological method research design based on individual reality and the interconnectedness of social and cultural dimensions (Benner, 1985; Paley, 2016; van Manen, 2016; Young, 2006). Hermeneutics is an interpretation method that deals with problems when addressing meaningful human actions or products, especially texts (Benner, 1985; Paley, 2016; van Manen, 2016; Young, 2006). Hermeneutics has a long tradition because its issues have been dominant in human life and have continuously and consistently called for reflection (Paley, 2016). Interpretation is a pervasive activity that unfolds whenever people strive to capture the interpretations that they consider significant. Hermeneutics can provide a guide to solving interpretation problems by offering a toolbox based on solid empirical evidence. In its historical development, hermeneutics has addressed specific interpretation issues in disciplines such as theology, jurisprudence, and literature (Clay, 2022; Ely & Driscoll, 2020; Paley, 2016).

Chapter 4: Results

Introduction

The purpose of this qualitative hermeneutic phenomenological design study was to understand the personal viewpoint and perspective of the lived experiences of African American women regarding their prenatal care experiences. The emphasis of this research was to provide context for the interpretation of the research findings concerning racial and cultural differences in pregnancy in Chapter 5. The research question used to guide this study was: What are the perceptions of African American women regarding their prenatal care experience in Southern New York City?

This chapter includes a presentation of the results that emerged from conducting the data collection and data analysis procedures described in Chapter 3. The following sections are included in this chapter: (a) setting, (b) participants, (c) data collection, (d) data analysis process, and (e) findings.

Setting

The interviews were conducted by telephone. I used a cell phone with the audio on speaker, which was recorded by a handheld digital audio recorder. No personal or organizational conditions at the time of the study would have affected the participants or should affect the interpretation of the results.

Participants

The participants were 10 women who self-identified as African American and who received prenatal care in Southern New York City within the last 5 years. All participants were over the age of 18. Any education level or marital status was included.

Data Collection

A one-on-one interview was conducted with each of the 10 participants. The data collection setting was the telephone. The interviews were audio-recorded using a handheld digital audio recorder. The average duration of the interviews was approximately 45 minutes. There were no deviations from the data collection procedures described in Chapter 3, and no unexpected circumstances were encountered during data collection.

Data Analysis Process

I chose van Manen's (2016) approach as the preferred approach to analyzing the qualitative data collected in this study on the lived experiences of African American women regarding their prenatal care experience. I preferred to use van Manen's approach to analyze the collected data from the interviewees, which included 10 African American women, ages 18–50, who have undergone at least one pregnancy, regarding their prenatal care experiences in Southern New York. Six steps for analysis were developed from hermeneutic and phenomenological principles (van Manen, 2016).

The first step was immersion, in which the researcher organized the dataset into texts (van Manen, 2016). The iterative reading of the texts accomplishes this, while preliminarily, interpretations were made to facilitate coding. According to van Manen (2016), authenticity must be maintained, so interpretation does not mean making assumptions about the meaning of the text.

The second step was understanding, meaning identifying the participants' constructs while maintaining faithfulness to the original text (van Manen, 2016). This step was done using NVivo software for accuracy and speed.

The third step is an abstraction, which consists of identifying the constructs made by the researcher. The constructs are then organized into subthemes (van Manen, 2016). I used each question topic in this study as a subtheme, as shown in Table 1.

Table 1

Subthemes and Their Prevalence After Analysis

Subthemes	No of participants	Coding references
1. Experiences during prenatal care	10	23
2. Care received during your prenatal appointments	10	20
3. Discrimination from prenatal healthcare providers	10	11
4. Discrimination from other healthcare staff during prenatal appointments	10	11
5. Ideal birth experience	10	15
6. Fear in any situation related to healthcare and pregnancy	9	10
7. Stress experienced during pregnancy	10	12
8. Discrimination and prejudice continue to be a barrier to the healthcare of Black women	8	8
9. Experience of verbal or physical abuse from healthcare providers	10	12
10. Forced or withheld treatments by healthcare providers	9	12
11. Further information about prenatal care	1	1

The fourth step is synthesizing and developing the themes (van Manen, 2016).

The subthemes are grouped into themes (see Table 2).

Table 2*Main Development Themes and Subthemes Under Them*

Theme / Subthemes	No. of participants	Coding references
Theme 1: Prenatal experience, assessment of whether best care was received, and ideal birth experience	10	57
1.1 Prenatal experience	10	29
1.2 Prenatal best care experience	9	12
1.3 Ideal birth experience	10	15
1.4 Suggested strategies to improve the prenatal experience	1	1
Theme 2: Discrimination and Prejudice experiences and barriers to healthcare	10	29
2.1 Provider discrimination experience	10	11
2.2 Other healthcare staff discrimination experience	10	10
2.3 Discrimination and prejudice experienced as barriers to healthcare	8	8
Theme 3: Negative emotions during pregnancy	10	36
3.1 Fear Experienced During Pregnancy	9	12
3.2 Stress Experienced During Pregnancy	10	24
Theme 4: Abuse experiences during prenatal care	10	21
4.1 Verbal or physical abuse from provider experience	10	10
4.2 Forced or withheld treatment experience	9	11

Following the fourth step of van Manen's (2016) data analysis approach, further elaboration on the themes can occur while maintaining authenticity by reflecting in the journal. The fifth step is illuminating and illustrating the phenomena (van Manen, 2016). This is where the themes identified in step four are linked with passages from prior literature for support, understanding, and clarification purposes. The aim is to reconstruct the interpretations into story narratives. The stories must be clear and understandable,

while prior literature illustrates, endorses, and advocates for the original text. This forms the reports of the findings discussed in the following sections.

Findings

The main themes that emerged from the analysis included the following:

1. Prenatal experience, assessment of whether the best care was received, and ideal birth experience
2. Discrimination and prejudice experiences and barriers to healthcare
3. Negative emotions during pregnancy
4. Abuse experiences during prenatal care

Table 3 shows the description of each of the four main themes.

Table 3

Themes and Descriptions

Theme	Description
Theme 1: Prenatal experience, assessment of whether best care was received, and ideal birth experience	This theme represents the prenatal experiences shared by the interviewees and the views of the interviewees on whether they received the best care possible during their prenatal appointments.
Theme 2: Discrimination and Prejudice experiences and barriers to healthcare	This theme represents interviewees' experiences with discrimination and prejudice from providers and other healthcare staff and the barriers associated with such discrimination in healthcare.
Theme 3: Negative emotions during pregnancy	This theme represents negative emotions such as fear and stress experienced by the interviewees during pregnancy and the causes of such emotions.
Theme 4: Abuse experiences during prenatal care	This theme represents different forms of abuse experienced by the interviewees during prenatal care, including verbal or physical abuse and forced or withheld treatment.

Theme 1: Prenatal Experience, Assessment of Whether Best Care Was Received, and Ideal Birth Experience

The first theme represented the different experiences, assessments of whether the best care was received, and the ideal birth experience by the interviewed respondents.

The other subthemes that contributed to the development of this theme are shown in Table 4.

Table 4

First Theme and Subthemes Contributing to its Emergence

Theme / Subtheme	No. of participants	Coding references
Theme 1 Prenatal experience, assessment of whether best care was received and ideal birth experience	10	57
1.1 Prenatal experience	10	29
1.2 Prenatal best care experience	9	12
1.3 Ideal birth experience	10	15
1.4 Suggested strategies to improve the prenatal experience	1	1

1.1 Prenatal Experience

I asked the interviewees to describe the prenatal experiences that contributed to developing the subtheme prenatal experience. This subtheme represented the different experiences of African American women during prenatal care. This subtheme had three more subcategories that aided in explaining the different prenatal care experiences of the interviewees, as shown in Table 5.

Table 5*Prenatal Experience Subtheme – Categories and Codes*

Subcategories and codes for Prenatal Experience Subtheme	No. of participants	Coding references
1.1 Prenatal Experience (Subtheme)	10	29
1.1.1 Childbirth Experience (subcategory)	5	9
Challenging childbirth experience (codes)	1	1
The feeling of being compelled to adhere to specific standards during childbirth	1	1
Mixed experiences during childbirth	1	1
Satisfaction with childbirth experience	4	4
Unproblematic childbirth experience	2	2
1.1.2 Experience with hospital visits (Subcategory)	5	14
Cancellation of appointments due to doctor's unavailability (Codes)	1	1
The feeling of being burdened by multiple hospital visits toward the end of pregnancy	1	1
Long waiting appointment times	4	7
Overcrowded hospital environment	2	2
Rushed interactions with healthcare professionals	3	3
1.1.3 Communication issues and lack of concern from healthcare staff (subcategory)	3	5
Dissatisfied with communication from healthcare staff (codes)	2	2
Unconcerned healthcare providers	3	3
Experienced healthcare issues during pregnancy	1	1

1.1.1 Childbirth Experience. This subcategory represented the experiences of the interviewees when giving birth. The interviewees shared diverse experiences when giving birth. From the analysis, it was evident that the majority of the interviewed African American Women were satisfied with their childbirth experience, as four of the interviewed women stated the following:

- “Giving birth to my baby went smoothly, and I had no complaints about my pregnancy or delivery” (P3).
- “I received excellent care during and after giving birth at the hospital” (P4).
- “Given the limited resources available to the doctor and nurses, my prenatal care went well” (P8).
- “My experience of giving birth to my child was okay, and there were no problems” (P9).

From the qualitative thematic analysis, it was evident that two of the women from the interview had unproblematic childbirth experiences (see also Byrne, 2022). P9 stated, “I had an okay experience giving birth to my child. There were no problems.”

Only one respondent was unsure about her childbirth experience, hence the mixed reactions, as she stated, “The pregnancy went well, but giving birth was challenging. Fortunately, the healthcare providers were beneficial” (P4).

From the analysis, it was evident from P4 that she was made to adhere to specific hospital-given standards through her statement: “However, sometimes, I feel like I was pressured to conform to specific standards when giving birth.”

1.1.2 Experience with Hospital Visits. This subcategory represented the experiences of the interviewees during their hospital visits for prenatal care. This was the most prominent subcategory under the prenatal experience subtheme, with 14 coding references from five interviewees.

One of the main experiences highlighted by the interviews related to hospital visits during appointments was long wait times, with four respondents stating the following:

- “The wait to see the doctor was exceedingly long” (P1).
- “The doctors were permanently occupied, which resulted in long waiting times and created stress for the patients” (P2).
- “I was frustrated by the long wait time at the doctor’s office, which was made even more uncomfortable by my pregnancy” (P6).
- “The appointment was lengthy, and the waiting area was quite noisy” (P7).

Another prominent experience with hospital visits highlighted by three of the interviewees was rushed interactions with healthcare professionals.

- “The interaction with the healthcare professional always feels rushed” (P1).
- “The staff was always rushing me from one room to another” (P2).
- “I always felt rushed because the clinic was constantly crowded with pregnant patients” (P4).

Two interviewees also identified the overcrowded hospital environment as a significant experience during hospital visits.

- The hospital was frequently overcrowded, leaving some patients nowhere to sit and causing discomfort (P1).
- The hospital always has a high volume of patients, resulting in a crowded waiting area (P2).

Other experiences with hospital visits identified by the interviewees included cancellation of appointments due to doctor’s unavailability and the feeling of being burdened by multiple hospital visits toward the end of pregnancy:

- “My appointments were frequently canceled because the doctor was unavailable. Sometimes, the nurses had to cancel my appointment” (P6).
- “During my pregnancy, I was constantly at the hospital for appointments such as lab tests, sonograms, nutritional classes, and specialist visits, which was overwhelming” (P7).

1.1.3 Communication Issues and Lack of Concern From Healthcare Staff.

This subcategory represented interviewees’ experiences with communication issues and lack of concern from the healthcare staff during their prenatal care. After going through the qualitative analysis process, a pattern of shared meaning emerged from the codes that contributed to the development of the communication issues and lack of concern from the healthcare staff subcategory.

Three of the interviewees indicated that they experienced unconcerned healthcare providers, stating,

- “My experience giving birth in southern Queens was not ideal. I believe the staff could have been more helpful in guiding me through my prenatal care, appointments, and my doctor’s availability” (P1).
- “I believe that the hospital could be improved, particularly in terms of cleanliness. During my previous stay, the staff were on strike, or there was another issue at the hospital. As a result, everyone seemed preoccupied and somewhat distracted” (P5).
- “I had a bad experience with the healthcare provider during my pregnancy. I felt my complaints were not being taken seriously, and they were not listening

to me. This complicated my delivery and prolonged labor and delivery hours” (P6).

From the analysis, it was evident that two of the interviewees were dissatisfied with communication from the healthcare staff. For example, P1 stated, “My experience giving birth in Southern Queens was not great. I believe the staff could have been more helpful in explaining my prenatal care, scheduling, and doctor’s availability.” P6 shared,

My experience of giving birth was not the best. I feel that my healthcare provider was not concerned about my complaints during my pregnancy. I did not feel heard as a pregnant patient. As a result, my delivery was complicated, and I spent several hours in labor and delivery.

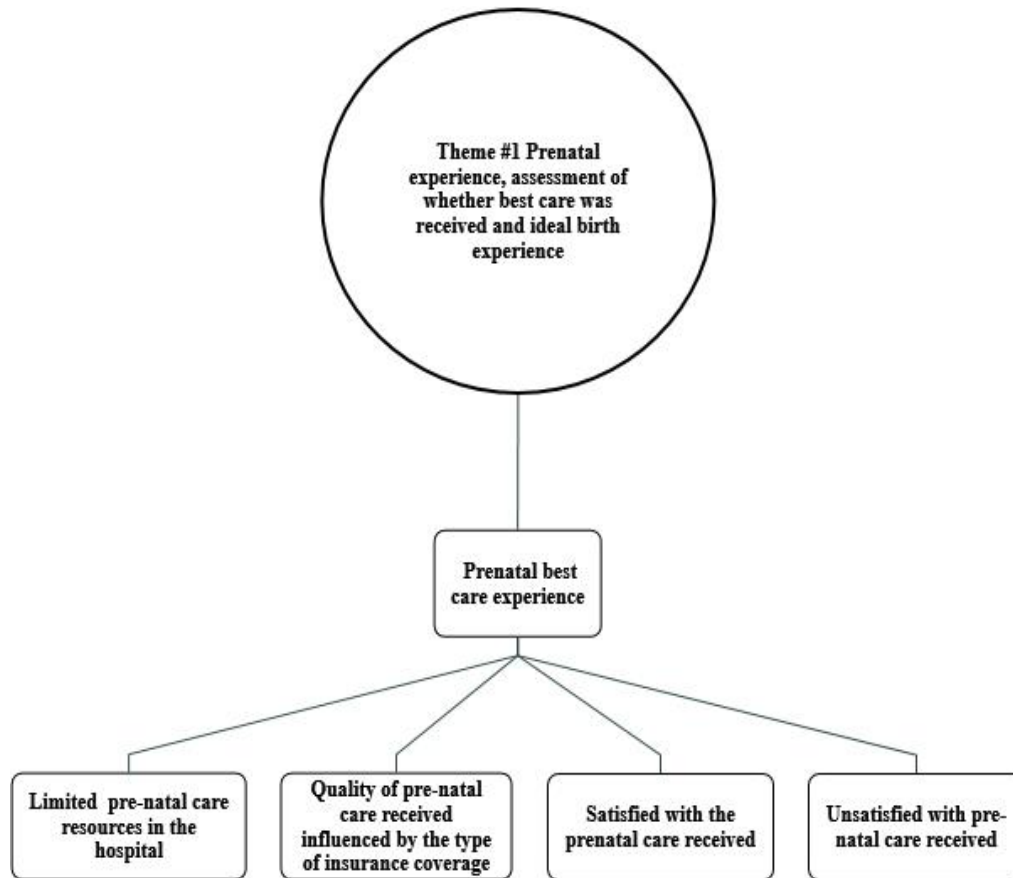
1.1.4 Experienced Healthcare Issues During Pregnancy. Another prenatal experience by the interviewees was healthcare issues during pregnancy, as stated by P7: “It was a difficult pregnancy due to gestational diabetes and swelling in my leg during the summer.”

1.2 Prenatal Best Care Experience

I asked the interviewees to describe their prenatal best care experience that contributed to developing the subtheme of prenatal care experiences. This subtheme represented the interviewees’ thoughts on whether they received the best prenatal care during appointments (see Figure 3).

Figure 3

Mind Map Showing Coding Structure Contributing to Prenatal Best Care Experience



Four interviewees acknowledged that hospitals needed more resources despite the doctors and nurses trying their best to provide the best prenatal care:

- “Having another doctor to assist with the increase in pregnant patients would have been helpful” (P2).
- “The hospital was busy, and the nurses were overworked but provided good care” (P3).

- “The hospital needed significant improvement but rest assured that you will receive the best care available in your neighborhood” (P5).
- “Although the doctors and nurses did their best, they were limited by the available resources” (P8).

The qualitative thematic analysis showed that the quality of prenatal care the Black women received entirely depended on their insurance coverage, as two interviewees responded (Labra et al., 2020):

- “The care and benefits one receives during and after pregnancy depends on their insurance coverage” (P3).
- “The nurses are overworked due to the hospital’s busy schedule, so patients may not receive the best care possible, and the quality of care may be influenced by their insurance type” (P7).

Two of the respondents said that they were satisfied with the prenatal care, as is evidenced by their statements that they had the best prenatal experience from the below excerpts:

- “The prenatal care I received was satisfactory” (P9).
- “I have no complaints about the prenatal care I received from the hospital” (P10).

Two of the respondents reported their birth experience as being unsatisfactory based on the following statements:

- “The doctor frequently kept the pregnant woman waiting, sometimes due to being late or tending to another delivery” (P2).

- “I had a negative experience with a healthcare professional during my pregnancy. I felt unwell, and the lengthy wait time only increased my annoyance. Although the healthcare professional seemed aware of my discomfort, they did not act professionally, making me uneasy throughout the visit” (P6).

One of the interviewees noted that there is a need for additional medical staff to cover the deficit that is there to better the childbirth experience, as evidenced by the following excerpt:

- “The hospital needed an additional doctor to manage the growing number of pregnant patients” (P2).

From the analysis, it was discovered that one of the respondents said that she experienced suboptimal prenatal care due to busy healthcare staff as she stated:

- “Given the circumstances, the care I received could have been better. However, all the nurses were doing their best to assist everyone” (P4).

1.3 Ideal Birth Experience

I asked the interviewees to describe their ideal birth experience, contributing to developing the subtheme of the perfect birth experience. This subtheme represented interviewees’ responses regarding what their ideal birth experience would be or look like. Table 6 shows the codes contributing to the emergence of this subtheme.

Table 6*Codes Under the Subtheme Ideal Birth Experience*

Subtheme/codes	No. of participants	Coding references
1.3 Ideal birth experience	10	15
Concern about medical staff compensation and workload	1	1
Cost concerns about home birth	1	1
The desire for adequate staffing during the birth	1	1
Desire to be surrounded by understanding, considerate people towards pregnant women	1	1
Desire to give birth in a better hospital with better care	6	6
Low expectations and content with what the hospital has, hence does not fancy an ideal birth	1	1
Preference for home birth with own personal healthcare team	2	2
She prefers to have her birth in a different hospital	2	2

Most of the respondents from the interview six desired to have their ideal birth in a better hospital with better care, as depicted in the following excerpts to support the findings:

- “I have lived in this neighborhood and witnessed what happens at Queens Hospital. If I had the option, I would choose a hospital with better staff to have my baby” (P1).
- “I would probably have had my baby in a better hospital that provides better care” (P10).
- “I wish I could have given birth to my baby in a better location and at a better hospital” (P3).
- “My ideal birth experience would not have required much, just a better hospital” (P4).

- “Having a hospital in a better neighborhood with highly skilled doctors and staff would be beneficial” (P6).
- “I would have preferred to have my baby in a hospital that offered better care” (P9).

From the analysis, it was also discovered that two of the respondents described their ideal childbirth experience as if they had their birth at home with their healthcare team to tend to them. This is evident from the following excerpts from the text data:

- “My preferred childbirth experience would have been a home birth attended by my doctor and a nurse” (P1).
- “Having my baby in a nicer area and hospital would have been better” (P7).

Further from the analysis, it was discovered that two of the respondents described their ideal birth experience as giving birth in a different hospital, as stated by the two respondents in the following excerpts:

- “My ideal birth experience would be to have my baby at a private hospital with many doctors and nurses who are not underpaid and overworked” (P2).
- “My ideal birth experience would have been at a hospital with better facilities, staff, and doctors” (P5).

Other ideal birth experiences shared by the respondents included.

They have low expectations and are contented with what the hospital has; hence, they prefer an ideal birth.

- “I do not expect much from the hospital during my prenatal care; in this life, you get what you get” (P8).

Desire to be surrounded by understanding and considerate people towards pregnant women.

- “My ideal birth experience would not involve waiting for hours to see the doctor” (P6).

The desire for adequate staffing during the birth.

- “My ideal birth experience would be to have my baby at a private hospital with many doctors and nurses who were not underpaid and overworked” (P2).

1.4 Suggested Strategies to Improve the Prenatal Experience

This subtheme was developed from the responses provided by the interviewees on suggestions to improve the prenatal care experience.

From the analysis, only one interviewee suggested a strategy to improve the prenatal care experience, stating that there was a need for more healthcare professionals in hospitals.

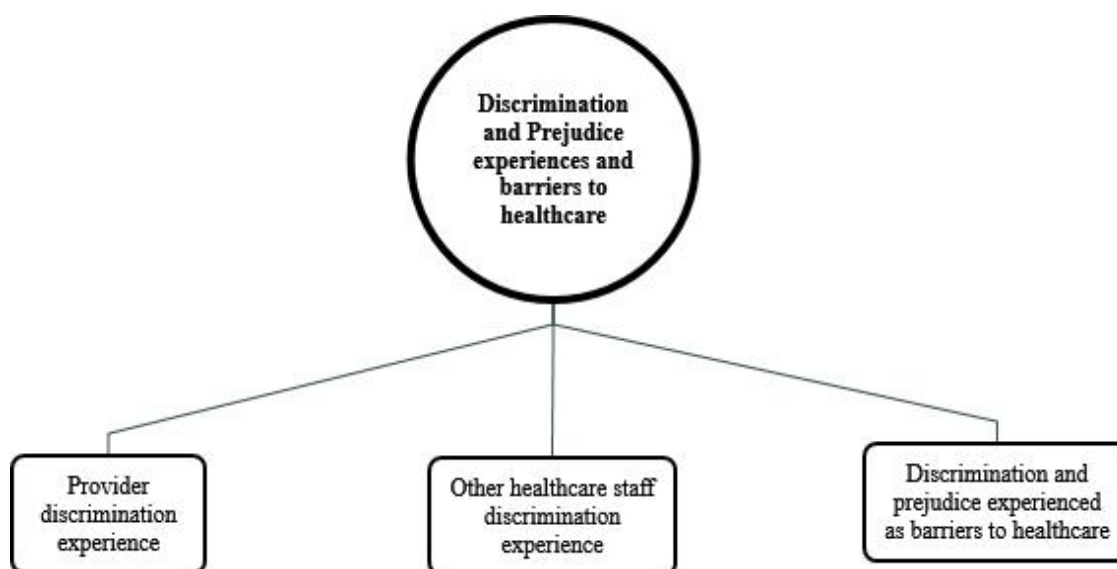
- “The hospital needs more medical staff to cope with the patient influx” (P2).

Theme 2: Discrimination and Prejudice Experiences and Barriers to Healthcare

This theme represented the interviewees’ experiences with discrimination from healthcare providers and other healthcare staff and the barriers associated with such discrimination in the healthcare system. The different subthemes that led to the development of this theme included provider discrimination experience, other healthcare discrimination experience, and discrimination and prejudice as barriers to healthcare, as depicted in the mind map in Figure 4.

Figure 4

Mind Map Showing Subthemes Contributing to Main Themes of Discrimination and Prejudice Experiences and Barriers to Healthcare



2.1 Provider Discrimination Experience

I asked the interviewees to describe the experiences that contributed to developing the subtheme provider discrimination experience. This subtheme represented discrimination experienced by the Black women from the healthcare providers during their hospital visits for prenatal care.

From the analysis, I found out that the majority of the interviewed women (seven) did not experience any discrimination from the healthcare providers, as evidenced in the following excerpts:

- “I did not experience discrimination from the nurses or the doctors” (P1).
- “I did not experience any discrimination from my doctor” (P10).

- “Discrimination did not occur during my prenatal visits with doctors and nurses” (P2).
- “I have not experienced any discrimination from my service providers” (P3).
- “I did not face any discrimination from my service providers” (P7).
- “Discrimination was not present at my doctor’s office or the hospital” (P8).
- “No discrimination from my doctor, no” (P9).

On the other hand, two of the interviewees said that they experienced discrimination from their healthcare provider through uncomfortable comments and remarks, as stated below:

- “Yes, the nurse asked me why I was having this baby and how I was planning to take care of it. Although she was saying it as a joke, her comments made me feel very uncomfortable” (P4).
- “Yes, very settled discrimination comments about not having proper insurance to cover the cost of the care I was receiving” (P5).

Other provider discrimination experiences identified by the interviewees included: Perception of mutual hostility and dismissiveness with the healthcare professional

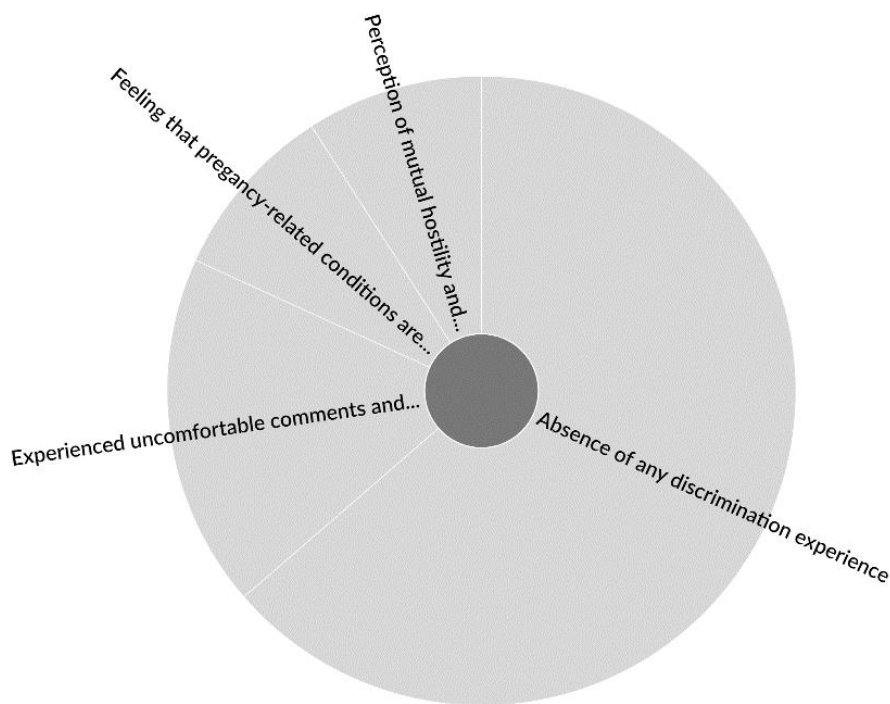
- “I have experienced discrimination by healthcare professionals. There was always a tension between us, as they thought I had an attitude, and I felt the same way about them. This led to a mutual feeling of unhappiness and anger towards each other, with the healthcare professionals appearing settled and dismissive towards me” (P6).

- “I believe the healthcare providers failed to take into consideration must take into consideration the women’s condition of being pregnant, and they are unwell from time to time” (P1).

The above excerpts and codes can be summarized using the hierarchy chart in Figure 5 to show the distribution of the codes under the provider discrimination subtheme.

Figure 5

Hierarchy Chart Showing Interviewees’ Responses to Provider Discrimination Experience



2.2 Other Healthcare Staff Discrimination Experience

This subtheme represented discrimination experienced by the Black women from the healthcare staff during their hospital visits for prenatal care. Table 7 shows the different codes under this subtheme.

Table 7

Participant Responses Contributing to the Subtheme Other Healthcare Staff Discrimination Experience

Subtheme/ codes	No. of participants	Coding references
2.2 Other healthcare staff discrimination experience	10	10
Absence of discrimination from healthcare staff	5	5
Experienced discriminatory comments from the healthcare staff	2	2
Perception of not being listened to due to dissatisfaction	1	1
The presence of discrimination based on the kind of insurance coverage	2	2

This is the most occurring code in this subtheme, as evidenced by the following excerpts from the data, which show that most interviewees did not experience discrimination from other healthcare staff.

- “I did not encounter any form of discrimination from the healthcare staff” (P1).
- “I did not experience any discrimination from healthcare providers during my pregnancy” (P2).
- “I did not experience any discrimination from my service providers during and after my pregnancy” (P3).

- “I did not face any discrimination from my service providers” (P7).
- “I did not experience any discrimination from other healthcare staff” (P8).

Based on data analysis, it was evident that two of the respondents from the interview stated that they experienced discrimination from healthcare staff based on their kind of insurance coverage, as stated below:

- “At times, I felt that the quality of my care depended on my insurance plan’s limitations” (P9).

Two of the interviewees also indicated that they experienced discriminatory comments from the healthcare staff, stating:

- “Discrimination: Yes, she would make comments about my insurance being paid by the state, that they do not pay much to the doctor for the care she is providing, and that she is working too hard to help the Black community” (P4).
- “During my doctor’s visit, the nurses asked personal questions about my baby’s father and my financial situation, which made me feel discriminated against” (P5).

The thematic analysis showed that one respondent experienced discrimination through her not being heard while she was pregnant, as shown in the excerpt below (Braun & Clarke, 2019):

- “No, I do not think I was listening to it because, once again, I was a depressed pregnant woman” (P6).

2.3 Discrimination and Prejudice Are Experienced as Barriers to Healthcare

This subtheme represented interviewees' responses on whether discrimination and prejudice were a barrier to the healthcare of Black women. Table 8 represents their actions that contributed to the development of this subtheme.

Table 8

Various Responses by the Interviewees Contribute to the Subtheme of Discrimination and Prejudice Experienced as Barriers to Healthcare

Subtheme/codes	No. of participants	Coding references
2.3 Discrimination and prejudice experienced as barriers to healthcare	8	8
Lack of knowledge regarding discrimination and prejudice in healthcare for Black women	1	1
Persistent discrimination as a barrier to healthcare for Black women	7	7

Seven of the interviewees perceived persistent discrimination as a barrier to healthcare for Black women. The following excerpts from the data show this:

- “I believe discrimination and prejudice against Black women and Black people in general continue to be significant problems in American society” (P1).
- “Black women face discrimination from other races, which is a persistent issue” (P3).
- “Discrimination and prejudice will always be a problem in America because of the racist individuals we have to interact with every day. Some are very subtle in their behavior, while others are more overt” (P4).

- “Discrimination against African American women will always remain a problem in this country” (P5).
- “Discrimination and prejudice often occur together. However, it is not limited to only Black women” (P6).
- “Black women face discrimination from other races that keeps them down” (P7).
- “Discrimination exists, but unfortunately, life has been and still is structured in a way that allows it to persist” (P8).

From the analysis, it was discovered that one of the respondents lacked knowledge about whether discrimination and prejudice remained a barrier to health care as she stated:

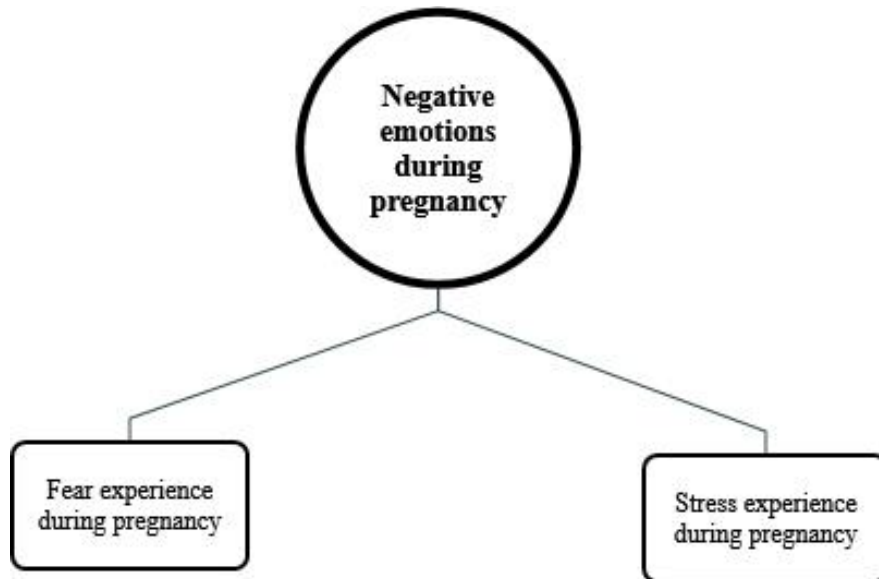
- “I cannot answer the question regarding discrimination and prejudice related to the barrier to health care” (P2).

Theme 3: Negative Emotions During Pregnancy

This theme represented the negative emotions, such as fear and stress, that the interviewees experienced during their pregnancy and the causes of such emotions. The main subthemes contributing to the development of this theme included fear experienced during pregnancy and stress experienced during pregnancy, as shown in the mind map in Figure 6.

Figure 6

Mind Showing the Different Negative Emotions Interviewees Experienced During Pregnancy



3.1 Fear Experienced During Pregnancy

This subtheme represented interviewees' responses to the question of the fears they experienced during pregnancy. Table 9 shows the prominent reactions provided by the interviewees. The codes represent the direct responses of the participants.

Table 9*Interviewees' Responses Related to the Fears They Experienced During Pregnancy*

Subtheme	No. of participants	Coding references
3.1 Fear Experienced During Pregnancy	9	12
Absence of fear or feeling of being unsafe	5	5
Experience of being scolded and having an attitude toward the staff	1	1
Fear of having a baby	2	2
Fear related to safety concerns during hospital visits	1	1
Financial strain	2	2
Unsure if she experienced discrimination	1	1

Most of the interviewed women expressed a lack of fear and never felt unsafe during their pregnancy, as they stated:

- “I have never felt unsafe or afraid regarding my healthcare providers” (P1).
- “I have never felt discriminated against, fearful, or unsafe around my doctor or nurse” (P10).
- “I did not feel any fear during my pregnancy” (P4).
- “I did not experience any fear while receiving healthcare services during my pregnancy” (P5).
- “My healthcare provider always makes me feel safe. I never feel any fear” (P8).

Of the interviewed women, two acknowledged that they were afraid of having a baby, as they stated:

- “Bringing a new life into this world was a fearful experience” (P3).

- “Bringing a new life into this world was terrifying for me, given the financial hardship, housing issues, and lack of family support” (P7).

From the interviews, two of the interviewees indicated that they had a fear resulting from their lack of money as there was an incoming baby.

- “A lack of finances at that time and the need for better housing and family support made me fearful” (P3).
- “Bringing new life into this world of finances, housing, and family support was daunting” (P7).

One of the interviewed women felt fear when she was making her hospital visits, as she stated:

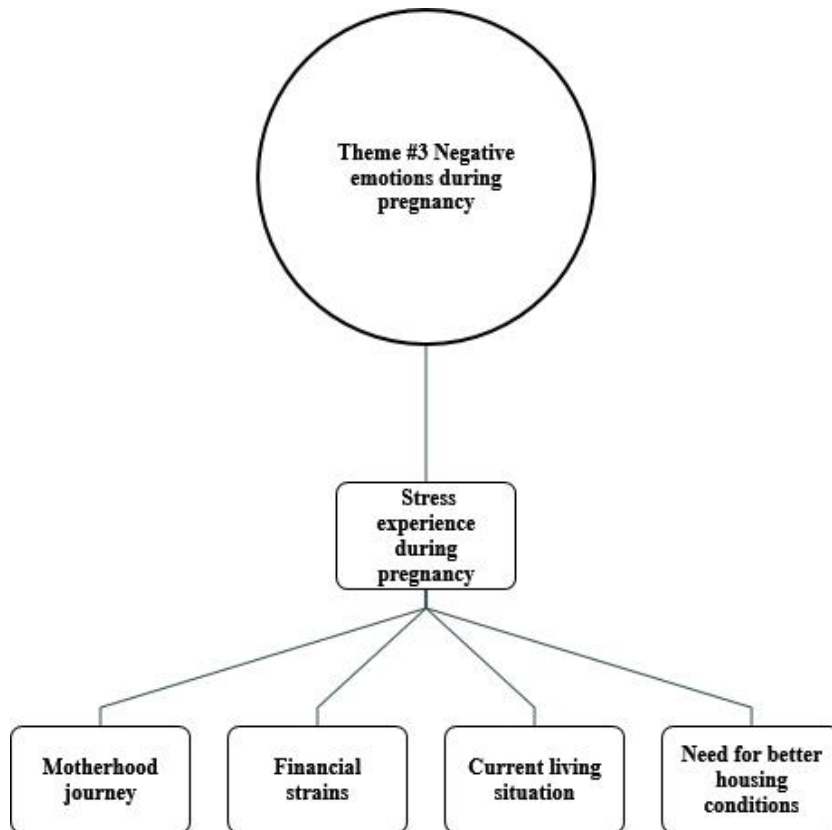
- “I have felt fear at times when going to the hospital for treatment due to the presence of drug addicts. Walking in the snow also added to my fear, as I was afraid of slipping and falling” (P2).

3.2 Stress Experienced During Pregnancy

I asked the interviewees to describe the types of stress experienced during pregnancy, leading to developing the subtheme of stress experienced during pregnancy. This subtheme represented the causes of stress among the interviewees during their pregnancy (see Figure 7).

Figure 7

Mind Map Showing the Connection Between Theme Subtheme and Codes



3.3 Motherhood Journey

The motherhood journey, in general, was highlighted as a source of stress among the interviewees. The interviewees identified different elements of the motherhood journey as a source of stress, including:

3.3.1 The Stress of having a Baby. Most of the women in the interview, at some point when pregnant, faced the stress of having a baby. This is evident through the following excerpts:

- “Being pregnant can be very stressful at times for women” (P1).
- “I did experience much stress due to the unknown and the arrival of a new baby” (P10).
- “Bringing a new life into this unpredictable world was scary and stressful” (P3).
- “The stress of managing work and children while dealing with the unknowns of having a baby can be overwhelming” (P5).
- “Bringing a new life into this unpredictable world was a scary thought” (P7).
- “I feel stressed due to the uncertainty of my living situation and the upcoming arrival of a new baby” (P9).

Handling Multiple Responsibilities During Pregnancy

I also discovered from the analysis that, at some point during pregnancy, two of the interviewed women faced stress arising from having to handle multiple responsibilities in the house during pregnancy. The following excerpts from the data clearly show this:

- “Managing other children, my job, and doctor’s appointments was a natural cause of stress” (P4).
- “The stress of managing work and other children while navigating the uncertainties of having a baby can be overwhelming” (P5).

One of the interviewees said that she was stressed during pregnancy as she was afraid of becoming a mother. She stated:

- “The distress I felt during pregnancy was intense due to the certainty of motherhood, which made it fierce at times” (P1).

Four interviewees viewed their state of finances as a stressing factor when they were pregnant, as they stated:

- “I experienced much stress due to the unknowns, a new baby, my living situation, family dynamics, and my challenging financial situation” (P10).
- “A lack of finances at that time, along with a need for better housing and family support, left me feeling fearful” (P3).
- “A lack of finances at that time and the need for better housing and family support made me fearful” (P7).
- “I experienced much stress due to the uncertainties surrounding the arrival of a new baby, my living situation, my family dynamic, and my financial struggles” (P9).

Two of the interviewees indicated that the need for better housing conditions was a significant cause of stress during their pregnancy.

- “A lack of finances at that time made me fearful, as I needed better housing and family support” (P3).
- “A lack of finances, the need for better housing, and family support made me fearful” (P7).

Again, I discovered from the analysis that two of the interviewed women had stress because they needed to improve or change their current living situation since there was an incoming baby, as they stated:

- “I was experiencing much stress due to the uncertainty of having a new baby and my living situation” (P9).

One of the interviewees indicated that they experienced stress during their pregnancy because of being ignored by healthcare providers.

- “I felt stressed during my prenatal visits because my doctor did not have enough time to listen to my pregnancy-related problems” (P2).

Again, from the analysis, I discovered that one of the interviewed women was stressed during pregnancy due to the way the society treats Black women in any situation, even when they are pregnant, as she stated:

- “Black women often face inadequate treatment during and after pregnancy, which can cause significant stress” (P6).

One of the interviewed African American women stated that during her pregnancy, she did not experience any stress and continued with her normal life as usual as she stated:

- “I did not experience stress. I approached my life one step at a time to make it better” (P8).

Theme 4: Abuse Experiences During Prenatal Care

This theme represented the different forms of abuse experienced by the interviewees during their prenatal care, including verbal or physical abuse and forced or withheld treatment by their healthcare provider or other healthcare staff. The two main subthemes that contributed to the emergence of this theme are shown in Table 10.

Table 10

Difference Subthemes Connected to the Central Theme of Abuse Experiences During Prenatal Care

Theme/ subthemes	No. of participants	Coding references
Abuse experiences during prenatal care	10	21
4.1 Verbal or physical abuse from provider experience	10	10
4.2 Forced or withheld treatment experience	9	11

4.1 Verbal or Physical Abuse from Provider Experience

I asked the interviewees whether they experienced any form of abuse when pregnant during their hospital visits. All the interviewed women did not experience any form of abuse while at the hospital, either from their healthcare provider or other healthcare staff. The following excerpts show what they stated:

- “No instances of verbal or physical abuse occurred during my pregnancy care” (P1).
- “I did not experience any physical or verbal abuse from my doctors and nurses” (P10).
- “I did not experience any physical or verbal abuse from my doctor” (P2).
- “No, I did not experience any form of verbal or physical abuse from my doctor during and after my pregnancy” (P3).
- “I did not experience any form of verbal or physical abuse from my doctor” (P4).

- “No, I did not experience any verbal or physical abuse from my doctor during my pregnancy” (P5).
- “No, I did not receive any physical or verbal abuse from my doctors or nurses. However, I felt as though the provider was always talking to me about my anger, and the staff was not happy with me” (P6).
- “During my pregnancy, I did not experience any physical or verbal abuse from my doctors or nurses” (P7).
- “No, I did not experience any verbal or physical abuse from my healthcare providers during my pregnancy and delivery” (P8).
- “I did not encounter any physical or verbal abuse from the doctor or nurses” (P9).

4.2 Forced or Withheld Treatment Experience

I asked the interviewees for their views on whether any medical treatments were forced or withheld from them by their healthcare providers during prenatal care (see Table 11).

Table 11

Main Response by Interviewees Contributing to the Subtheme Forced or Withheld

Treatment Experience

Subtheme	No. of participants	Coding references
4.2 Forced or withheld treatment experience	9	11
Did not experience forced or withheld treatment from healthcare providers	5	5
Experienced differing medication approaches by the healthcare provider	1	1
Forced medical operation	3	3
Forced treatment through prescriptions by the healthcare provider	2	2

Five interviewees stated they did not experience forced or withheld treatment from healthcare providers.

- “No medical treatment was forced or withheld during my pregnancy. I complied with all my doctor’s orders to ensure my baby’s health” (P1).
- “I do not recall any instance of forced or withheld treatment during my pregnancy or delivery” (P10).
- “I was never made to undergo any treatment against my will, nor was any treatment ever denied to me” (P2).
- “Throughout my pregnancy, I was never pressured into receiving or withholding any treatments” (P5).
- “I received complete prenatal care, and no treatment was ever withheld from me” (P9).

In contrast, three of the interviewed women stated that they had forced medical operations by healthcare providers.

- “My doctor scheduled a c-section for me because she had two other c-sections scheduled for that day, and it would be more convenient for her” (P3).
- “I had a Caesarean section that was forced on me because the doctor stated my baby may come at night when she is not available” (P4).
- “In my opinion. I believe the doctor could have waited longer before deciding to perform a C-section on me” (P7).

Two of the women shared that they were forced to take unnecessary medications that they thought they did not necessarily need, as they stated:

- “I did not need the vitamins and the iron medication the doctor prescribed for me” (P3).
- “I did not need the vitamins the doctor prescribed for me” (P7).

Chapter 5: Discussion, Conclusions, and Recommendations

The qualitative inductive design of the phenomenological study was used to comprehend the perceptions of African American women concerning their care during pregnancy in South New York. Through exploring the real-world experiences of this group, the study aimed at revealing the cultural and racial differences in prenatal care and offering interpretations of research results to healthcare professionals so they could understand the psychological and social factors influencing prenatal care experiences for African American women from Southern New York later. The thematic analysis of the study revealed these barriers, and some measures that can be put in place to relieve these obstacles were suggested.

The study was instrumental in revealing the multiple dimensions of the prenatal care of Black women that was offered in a particular regional setup. The qualitative research, guided by hermeneutic phenomenology, aimed to capture the participants' subjective experiences and perceptions about societal structures and the cultural milieu where the experiences played out. Thematic analysis of the data collected from the interviews of African American women of prenatal care in Southern New York states several major health themes. The themes encompass the nature of treatment from prenatal care staff, perceptions of the quality of prenatal care, and experiences of racism and culturally unaccommodating behavior from the healthcare system. These themes were examined in detail, and their contribution to regional African American women's prenatal care experience was studied. As a result, valuable insights into the factors influencing African American women's experience of prenatal care in the region were provided.

Besides, the research uncovered some social factors related to getting prenatal care, including the scarce interactions and cases of discrimination from healthcare professionals. Also, some possible solutions to eliminate these barriers were contained in the conclusion, including increasing racial diversity among healthcare providers, training healthcare providers, and creating patient-centered approaches. Above all, the study's analyses reveal the intricacy of the issue that African American mothers face concerning maternal care in Southern New York. By tackling the social, ethnic, and systemic elements in charge of this narrative, healthcare providers can strive to enhance the quality and equity of prenatal care programs for this group.

Interpretation of Findings

The study research question shaped the examination process of African American women's perspectives on their prenatal care services, unveiling three significant themes. Prenatal care employees were mostly noted to be less talkative or less time-stretched but not offensive to the patient. Second, women had varied reports of prenatal care quality mode, where some felt rightly contented with the care, and others reported it as poor. Furthermore, during prenatal care, a high level of racism and cultural insensitivity were considered characteristics that African American women experienced as general issues. These themes cumulatively reveal that these complexities and challenges are altogether inseparable from the prenatal care delivery experience of the African American women living in Southern New York. The report delivers an insightful view of the need for the provision of healthcare to address systemic barriers, build on cultural understanding, and

develop appropriate care practices that ensure respect and equity for all women during the prenatal stages.

Theme 1: During Prenatal Care, Interaction with Personnel and Professionals Was Limited or Brief but Hardly Ever Discriminatory

Based on the study's findings (see Chapter 4), which addressed the issue of access to prenatal care for African American women and its social barriers, this theme will explore the interaction of these women with their care providers in even greater detail. The findings from the study emphasized the extent to which there were interactions of an uncomfortable nature, issues regarding patient-caregiver relationships, and the general experience of prenatal care among African American women. One of the most critical aspects shared by women was the shortage of time allocated for substantive conversation with their healthcare providers. This mirrored the predicament faced by women attending clinics with huge patient loads who had little time for meaningful communication with their doctors (McLemore, 2018).

Nonetheless, many who experienced no deliberate discrimination felt excluded or stigmatized within their healthcare interactions. This finding corresponds to previous works identified in the literature regarding how implicit bias can be expressed through assumed behaviors or different treatments (Maskrey, 2019). However, covert discrimination is limited to the perceived racial biases in prenatal care settings that bespeak the ongoing impact of systemic racism in emergency rooms and medical facilities.

The evidence underscores the complexity of individual discrimination perception induced by personal or cultural feelings and views. One must understand and resolve this bias for a fair application of care toward a patient, regardless of race or ethnicity. Cultural competence training and the enhancement of awareness about racial discrimination are the most essential techniques for the reduction, if not the elimination, of all forms of discriminatory treatment in prenatal care settings. Also, cultivating patient-centered care settings by providing adequate time and empathic communication can counterbalance the negative effect of time-limited appointments and tackle the emotional dissatisfaction of being neglected or overlooked by medical personnel.

The research explored the multilayered picture of prenatal care experiences among African American females in Southern New York, with a variety of views about the quality of care provided. Some of the participants told nurses they received good care. They were not displeased with the doctor's recommendations, and other group members complained about the inadequacy of in-utero care they received. Participants have brought attention to the points when they felt they were pushed or missed in the prenatal appointments, suggesting the absence of them being meaningfully involved with the medical staff. These results thus reflect the most significant function of effective patient-provider communication in developing trust and agreement within the doctor-patient partnership.

The study further demonstrated the overlapping implications of race and socioeconomic status on antenatal healthcare. Women who expressed dissatisfaction tended to point at economic rather than racial discrimination, which was an apparent

reason. This implies that the quality of care was dissatisfactory within the system, which, in turn, provides a clue that the care was likely unequal and disproportionately affected the vulnerable groups. Based on the previous studies, the following recommendations were brought up to improve prenatal quality care and remove the disparities. Conducting evidence-based practices, increasing the diversity in the healthcare workforce, and strengthening cultural competency training were three methods that proved to be superior in securing equitable treatment. Healthcare providers may contribute to a more inclusive and culturally sensitive care environment through which diverse requirements of African American women during pregnancy are fully met because each patient is entitled to good prenatal care.

Further, the implications were the value of community-based programs and advocacy activities for the remediation of social health determinants and the call for collective action. The collective action of policymakers, healthcare professionals, community organizations, and grassroots activists cannot be ignored if the goals of improving equity in maternal care are to be met. Lastly, the paper focuses on the gaps in the quality of prenatal care of African American women, which embodies the necessity of encompassing interventions that address systemic issues and the provision of equitable health care delivery. Disparities in health amongst women can be addressed by looking into underlying causes, thereby moving towards a healthcare system where inclusivity is encouraged and all women deserve proper and quality care from pregnancy.

When studying the participants, a wide range of views emerged concerning the quality of prenatal care they received. Some patients reported being pleased with the

service they received, while others complained about not taking the best treatment approach. Such varying perceptions give insight into complex relationships and factors that affect prenatal care quality for African American women of southern New York. One of the factors leading to varied satisfaction outcomes regarding pregnancy care quality is the presence of communication barriers between patients and healthcare professionals. The participants recalled the cases where they felt unattended in their issues and reported incidents where they needed help understanding the medical advice they were given. Such communication problems may become the reasons for reluctance, frustration, and the failure of care in the long run.

Communication barriers can be addressed through patient education opportunities and provider training programs, improving patient-provider interactions and quality of care (Maskrey, 2019). Additionally, racial biases and stereotypes became primary hindrances to equal quality prenatal care. Several participants recounted that they felt discriminated against by healthcare providers or discarded because of their race. However, these instances enhance the idea that a systemic bias within the healthcare setup aids in intensifying disparities in care delivery, decision-making, and health outcomes. To overcome racial biases in prenatal care facilities, training in diversity, awareness of implicit biases, and culturally competent care must be included (Pendergrass, 2020). Thus, these recommendations can be put at the forefront of healthcare systems to make healthcare delivery more inclusive and equitable, whereby all patients' needs can be catered to.

The common theme among African American women's prenatal care experiences in southern New York was the pervasive racism and insensitivity to cultural diversity in most healthcare settings. Women's narratives proved to be informative as they gave clear indications that systemic racism and lack of cultural sensitivity were the significant challenges in accessing prenatal services. Participants narrated incidences where they were overtly ignored and mistreated only because of their race when they visited prenatal centers. Although more open forms of discrimination were less likely to be reported, more insidious acts such as racism and stereotyping were frequently lived. These exchanges resulted in women wasting their time justifying their bodies to a medical professional who did not correctly understand their health issues. Therefore, women felt marginalized and disempowered within the healthcare system.

Besides, the data showed a troublesome habit of cultural insensitivity on the side of prenatal care providers. Women complained that healthcare providers disregarded their cultural backgrounds by not recognizing or acknowledging them. In addition, there were substandard care experiences. Consequently, cultural incompetency reinforced the distressful feelings of isolation and distrust in the minds of Black women who were presented with prenatal care services. Data from Chapter 4 clearly show the urgent need for interventions that are geared towards eradicating racism and promoting cultural sensibility among personnel who offer prenatal care. Strategies including cultural competency training of health providers, diversification of the health care workforce, and community outreach were found to be instrumental tools in the struggle for an environment of health care that is more inclusive and equal.

In addition, the data demonstrated the priority of empowering the stories of African American women to have the capacity to redefine healthcare issues. Elevating the experiences and perspectives of communities that are marginalized would allow the policymakers and leaders of healthcare to understand better and respond to the unique needs and problems the African American women experience during pregnancy. The study's exploration of racism and cultural insensitivity within prenatal care experiences, therefore, delineates the utmost need for significant reform within the healthcare system.

By breaking down the structural barriers and teaching the healthcare providers to have cultural humility, the stakeholders will work alongside each other to ensure that all the women, irrespective of their ethnic background, get worthy, dignified, and culturally responsive care during their prenatal growth stages. Moreover, tackling structural racism within healthcare systems includes incorporating multiple strategies, such as sources of barriers to access, opportunity, or equity. Discriminatory practices, hesitance to embrace differences and social determinants of health are the hurdles that need to be removed to make the system more responsive to the needs of all and ensure just health care (Chambers et al., 2018; Mehra et al., 2017; Ncube et al., 2016). Through the promotion of antiracism and acceptance of African culture within the prenatal care system, healthcare systems can be instrumental in the reduction of racial disparities in care quality and improving the health of African American women and their families.

Limitations of the Study

One of the limitations of this study was that it relied on the perspectives and lived experiences of pregnant and postpartum mothers. While the study's objective was to

capture their subjective understanding of the services offered, emotions rather than the reason might have influenced the reliability of the data. Recruitment of enough respondents was challenging as some mothers were unwilling to participate in the study. Potential participants were assured of confidentiality, and interviews were scheduled based on their availability and convenience to encourage many to participate.

There were also some limitations of this study related to prenatal care of African American women who received healthcare from one hospital in Southern New York. Only one group of women was included: African American women between the ages of 18 and 50. There may be other women, or even other African American women older or younger, or others who received prenatal healthcare at other similar facilities that had not been included; due to this study being a qualitative case study, inferences could not be made, nor could correlations, so there might be alternative explanations that could be valid. Furthermore, case study findings are only suggestive and cannot be generalized elsewhere.

I also limited this study to answering the research questions with two adopted theoretical perspectives: the choice of participants and the theoretical framework. This indicates that the findings would be bound within the constructs of the two theoretical perspectives. Limiting the study to specific theoretical perspectives could limit its application to other theoretical perspectives in the future, as different theoretical perspectives have their assumptions, limitations, and biases. Further, using limited theoretical perspectives constitutes bias and incomplete understanding of the research study's topic or phenomenon.

Recommendations for Future Research

The recommendations for future research were based on the limitations of this study. This study was limited to the perspectives and lived experiences of pregnant and postpartum African American mothers. Failure to include pregnant and postpartum mothers from other races would indicate limited transferability of the research outcomes to other populations as only one group of women was included, that of African American women between the ages of 18 and 50. Based on this limitation, I recommend that future researchers consider including other postpartum mothers in examining their experiences of prenatal care.

This study was also limited by a qualitative hermeneutic phenomenological design. Due to this study being a qualitative hermeneutic phenomenological study, inferences could not be made, nor could correlations and small sample size be used, so there might be alternative explanations that could be valid. Furthermore, case study findings are only suggestive and cannot be generalized elsewhere. In this regard, future research should be conducted using a quantitative research design to permit inferences and correlations of variables using a larger sample size and enhance the generalizability of the research findings to a broader population of postpartum mothers in New York, the United States.

The study was limited to two theoretical perspectives and one setting. Limiting the survey to specific theoretical perspectives and one set could limit its application to other theoretical perspectives and populations in other locations in the future, as different theoretical perspectives have their assumptions, limitations, and biases, with different

locations having diverse conditions. Thus, there is a need for further research to investigate the experiences of prenatal mothers using various theoretical perspectives and diverse settings in New York to enhance the generalizability of findings to different locations and theoretical perspectives.

Implications

Implications for Positive Social Change

The study had various implications for social change. This research's findings would help create knowledge that informs appropriate interventions to improve utilization and pregnancy results among African American women in New York. The healthcare experiences faced by African American women during pregnancy are an essential topic. The findings indicated discrimination and stereotyping from prenatal care staff against African American women. Sharp racial discrimination and disparities in treatment, even in the health sector, is an issue African American women frequently deal with. This service crisis further enlarges the interdisciplinary approach that the importance of healthcare for all is a genuine issue. Thus, healthcare organizations would use the study findings to address discrimination cases among prenatal care staff by promoting diversity through diversity training programs. The findings indicated that lack of cultural sensitivity was perceived as a general problem encountered by African American Women in Prenatal Care.

This study would have particular significance for African American women who are pregnant and seeking prenatal healthcare. Healthcare professionals could use the information from the findings to provide better healthcare for African American women

so outcomes can improve. African American women believe that their health and the health of their babies are affected by the disrespect and discrimination they experience in interactions with healthcare professionals (McLemore, 2018). The information shared or withheld by healthcare professionals influences issues such as the power dynamic between the professional and patient (Altman et al., 2019). In addition, contextual factors such as judgment toward the patient and bias can also impact the interactions between healthcare professionals and patients (Altman et al., 2019). As a result, healthcare professionals would enhance their interaction with postpartum mothers to improve service delivery.

Theoretical Implications

CRT was used to guide this study. The CRT targets oppressive laws by highlighting various instances of racial inequalities within policies in the United States (Bell et al., 1995). CRT provided a foundation and theoretical lens to examine the prenatal care experiences of African American women in Southern New York. In the study, CRT is especially applicable through the five constructs, mainly that racism is a normal and regular social phenomenon, race is a social construct, and stories and storytelling are used to challenge Eurocentric philosophies.

The CRT construct of racism and regular phenomenon in society can be used to explore the intersectionality of gender and race in prenatal care experiences among African American women. CRT can also be used to establish race as a social construct and the need for cultural sensitivity to mitigate structural problems within the healthcare sector. The aspect of some participants receiving the best care while others not receiving

better prenatal care can reflect convergent interests among care staff and patients, thus increasing racial disparities in the provision of healthcare services. The CRT construct of storytelling has been addressed by the findings, including participants' narratives regarding their experiences of prenatal care. Research findings concerning limited cultural sensitivity among prenatal care providers offer some great insights into the perspective of African American women regarding prenatal care experiences.

Recommendations for Practice

The findings revealed that racism and lack of cultural competence are the issues facing African American women in prenatal care. Based on this finding, training and development programs on cultural diversity should be adopted by healthcare organizations to address the various challenges faced by African American women with postpartum status. Yoder and Welch (2018) highlighted the need for training and development on different cultures to help care providers offer equal services regardless of patient's racial and cultural backgrounds.

Diversity should be promoted in the healthcare system by implementing various policies, including mandatory inclusion of African American women in healthcare staff recruitment. This could help healthcare organizations mitigate racism against African American women in prenatal care. Employing prenatal care of color would provide enhanced cultural diversity in the provision of prenatal care among healthcare professionals, thus leading to increased and improved care quality. Wren and Donnelly (2016) recommended adopting diversity training programs to promote a future where the needs of African American women in prenatal care would be sufficiently resolved. The

current research findings have contributed to the previous literature by establishing various challenges facing African American women in accessing prenatal care.

Conclusion

The purpose of this study was to understand the personal viewpoint and perspective of the lived experiences of African American women regarding their prenatal care experiences. African American women feel unsafe when receiving prenatal care. Although the research provides significant insight regarding prenatal care services received by African American women, there were mixed findings as reported by participants. While some participants denied receiving the best prenatal care, others acknowledged receiving the best possible care in a better hospital with better service. Racism and lack of cultural sensitivity were perceived as challenges facing African American women in prenatal care as prenatal care providers lacked cultural sensitivity concerning African American patients. Research findings provide essential information regarding the experiences of African American women in prenatal care, indicating the need for enhanced diversity in the healthcare system to mitigate racism and discrimination against minority women such as African American women. The study outcome can help healthcare stakeholders develop essential policies and programs to enhance equity in healthcare systems.

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Appendix: Code Book

Name	Description
Theme #1 Prenatal experience, assessment of whether best care was received and ideal birth experience	This theme represents the prenatal experiences shared by the interviewees and the views of the interviewees on whether they received the best care possible during their prenatal appointments.
1.1 Prenatal experience	Experiences of the interviewees during their prenatal care
1.1 Childbirth experience	Experiences of the interviewees when giving birth
Challenging childbirth experience	
The feeling of being compelled to adhere to certain standards during childbirth	
Mixed experiences during childbirth	
Satisfaction with childbirth experience	
Unproblematic childbirth experience	
1.2 Experience with hospital visits	Experiences faced by the interviewees during their hospital visits for prenatal care

Name	Description
Cancellation of appointments due to doctor's unavailability	
The feeling of being burdened by multiple hospital visits toward the end of pregnancy	Feeling burdened by the multitude of hospital visits, ranging from labs, ultrasounds, and nutritional classes, towards the end of pregnancy
Long waiting appointment times	
Overcrowded hospital environment	
Rushed interactions with healthcare professionals	
1.3 Communication issues and lack of concern from healthcare staff	Communication and concerns between the interviewees and the healthcare staff during their prenatal care
Dissatisfied with communication from healthcare staff	
Unconcerned healthcare providers	
Experienced healthcare issues during pregnancy	

Name	Description
1.2 Prenatal best care experience	Thoughts of the interviewees on whether they received the best prenatal care appointments
Limited prenatal care resources in the hospital	Acknowledges a limitation in resources despite the doctors and nurses trying their best to provide the best prenatal care
Need for additional medical staff to accommodate all the patients	
The quality of prenatal care received is influenced by the type of insurance coverage.	
Satisfied with the prenatal care received	
Suboptimal prenatal care due to busy healthcare staff	
Unsatisfied with prenatal care received	
1.3 Ideal birth experience	Interviewees responses regarding what their ideal birth experience would be or look like
Concern about medical staff compensation and workload	

Name	Description
Cost concerns about home birth	
The desire for adequate staffing during birth	
Desire to be surrounded by understanding, considerate people towards pregnant women	
Desire to give birth in a better hospital with better care	
Low expectations and content with what the hospital has, hence, does not fancy an ideal birth.	
Preference for home birth with own personal healthcare team	
She prefers to have her birth in a different hospital.	

Name	Description
1.4 Suggested strategies to improve the prenatal experience	Suggestions by the interviewees to improve the prenatal care experience
Need for more healthcare professionals in hospitals.	
Theme #2 Discrimination and Prejudice experiences and barriers to healthcare	This theme represents interviewees' experiences with discrimination and prejudice from providers and other healthcare staff and the barriers associated with such discrimination in healthcare.
2.1 Provider discrimination experience	Discrimination experienced by Black women from the healthcare providers during their hospital visits for prenatal care.
Absence of any discrimination experience	
Experienced uncomfortable comments and remarks from the healthcare provider	
Feeling that pregnancy-related conditions are not put into consideration	

Name	Description
Perception of mutual hostility and dismissiveness with the healthcare professional	
2.2 Other healthcare staff discrimination experience	Discrimination experienced by Black women from the healthcare staff during their hospital visits for prenatal care.
Absence of discrimination from healthcare staff	
Experienced discriminatory comments from the healthcare staff	
Perception of not being listened to due to dissatisfaction	
The presence of discrimination based on the kind of insurance coverage	
2.3 Discrimination and prejudice experienced as barriers to healthcare	Interviewees believe that discrimination and prejudice are barriers to healthcare for Black women.
Lack of knowledge regarding discrimination	

Name	Description
and prejudice in healthcare for Black women	
Persistent discrimination as a barrier to healthcare for Black women	
Theme #3 Negative emotions during pregnancy	This theme represents negative emotions such as fear and stress experienced by the interviewees during pregnancy and the causes of such emotions.
3.1 Fear Experienced During Pregnancy	Interviewees' fears related to healthcare and their pregnancy.
Absence of fear or feeling of being unsafe	
Experience of being scolded and having an attitude toward the staff	
Fear of having a baby	
Fear related to safety concerns during hospital visits	
Financial strain	
Unsure if she experienced discrimination	

Name	Description
3.2 Stress Experienced During Pregnancy	What was the cause of stress experienced by interviewees during their pregnancy?
Absence of feeling any stress during pregnancy	
Better housing conditions	
Current living situation	
The feeling of being unheard during appointments	
Financial strains	
Motherhood journey	Stress from the interviewees resulting from the responsibilities of motherhood
Becoming a mother	
Handling multiple responsibilities during pregnancy	
The stress of having a baby	
Societal treatment of Black women, even when pregnant	
Support from family	

Name	Description
Theme #4 Abuse experiences during prenatal care	This theme represents different forms of abuse experienced by the interviewees during prenatal care, including verbal or physical abuse and forced or withheld treatment.
4.1 Verbal or physical abuse from provider experience	Interviewees' perception of whether they have experienced any verbal or physical abuse from their healthcare providers.
Did not experience physical or verbal abuse	
4.2 Forced or withheld treatment experience	Interviewees' beliefs and perceptions of whether any medical treatments were forced or withheld from them by their healthcare providers.
Did not experience forced or withheld treatment from healthcare providers	
Experienced differing medication approaches by the healthcare provider	
Forced medical operation	
Forced treatment through prescriptions by the healthcare provider	