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African American Women's Lived Experiences with Obstetrics/ Gynecology Services in Atlanta, Georgia

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Walden University

College of Health Sciences and Public Policy

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Audrey Marcinia Blake

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Walden University

2024

Abstract

African American Women's Lived Experiences with Obstetrics/Gynecology

Services in Atlanta, Georgia

by

Audrey Marcinia Blake

MPH, University of South Carolina, 1998

BA, University of South Carolina, 1985

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

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Abstract

African American women in Georgia die during the perinatal period at almost three times the rate of other ethnic groups. Adverse maternal outcomes demonstrate a disparity among African American women. In this phenomenological qualitative study, the lived experiences of African American women receiving obstetrical and gynecological (OB/GYN) care in the Atlanta, Georgia, Metropolitan area were explored. The study included women who identified as African American, ages 18 – 45 years old, receiving OB/GYN care in Georgia. No income limits were applied, allowing women across income levels to be included. Feagin's systemic racism theory, along with Greenwald and Krieger's implicit bias theory, provided a conceptual framework for data collection and analysis. Participants were recruited using social media ads, postings, and meetings with community organizations. Semi-structured interviews using the Zoom audio platform were conducted with 14 participants. Data was analyzed through the interpretative phenomenological analysis approach. Results indicated that while some women felt heard by their doctors, who showed concern and provided them with beneficial resources, others experienced the impact of systemic racism and implicit bias. Their experiences reflected racism, multiple stressors, and perceptions of implicit bias from providers. This included financial challenges, not being heard by the provider, and the need for self-advocacy. Study findings may promote social change by informing providers about prenatal and postpartum care service delivery in Georgia and may impact providers throughout the United States, resulting in maternal quality improvement and positive maternal health outcomes.

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Dedication

I dedicate this dissertation to my mother, Phyllis, now deceased, an educator who taught me the value of education, and my birth mother, Doris, also an educator, who made a huge sacrifice to give me the life I have. This is also dedicated to my paternal aunt Gladys, another educator and retired college professor who inspires me. Finally, I dedicate this dissertation to my family, my sons, Maurice Jr. and William, their mates, and my grandchildren, to inspire them to seek the highest level that they are born to attain and serve the world while leaving a legacy.

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Chapter 1: Introduction to the Study

Maternal death or the maternal mortality rate (MMR) is a measure that indicates the health status of the nation and women (Shahin et al.,2020). MMR refers to the rates of death that occur in women related to pregnancy complications, childbirth, pregnancy termination, or 42 days after delivery (Liens, 2019). The national rate of maternal deaths in the United States increased from 18.8% to 23.8% between 2000 and 2014 (Shahin et al.,2020). In 2019, the MMR decreased to 20.1%; however, the rate increased to 23.8% in 2020 during the COVID-19 pandemic (Stephenson, 2022). In comparison, the rate of maternal deaths among African American women remained high, increasing from 44% in 2019 to 55.3% in 2020 (Hoyert, 2022).

States have established maternal mortality review boards that employ a multidisciplinary, holistic approach to trace the causes of death for women who have died because of pregnancy (Kramer et al., 2019). Maternal mortality reviews have determined that African American women have 233% higher risks of pregnancy-related deaths. There are significant racial disparities in maternal deaths among African American women in the United States, with increasing gaps when compared to other races (Kramer et al., 2019). In Chapter 1, I address the background, problem statement, and purpose of the research study. The research questions and conceptual framework, along with definitions and assumptions, are also presented. I end the chapter with the scope and delimitations, significance, and a summary of the information detailed throughout the chapter.

Background

African American women are at an increased risk for adverse maternal outcomes (Chambers et al., 2020). In the United States, the MMR among non-Hispanic Black or African American women is 55.3%. This is 2.9 times higher than the rate for non-Hispanic White women (Hoyert, 2022). State-level data also reflects disparities and adverse outcomes in maternal health for African American women (March of Dimes, 2021). African American women in Georgia are almost three times more likely to die from complications of pregnancy than other races, with maternal mortality rates of 2.7% (March of Dimes, 2021). Georgia is among the states with the 10 highest maternal mortality rates in the United States, ranked 49th (World Population Review, 2022).

There is a gap in the research on African American women's experiences with obstetrics and gynecologic (OB/GYN) services in Atlanta, Georgia, during the preconception, perinatal, and postpartum periods. Standardized obstetric and gynecologic (OB/GYN) practices often marginalize African American women (Adebayo et al., 2021). Physicians take a biomedical approach to obstetric care, viewing women's bodies as machines equipped to function in specific ways. This can result in a homogenous view of poor health among African American women. A participant in a Milwaukee, Wisconsin study shared that her obstetrician insisted on her taking aspirin as a preventative measure for pre-eclampsia (Adebayo et al., 2021). When she refused because she had not been diagnosed with pre-eclampsia, she was seen as noncompliant (Adebayo et al., 2021). There is a need to explore further the lived experiences of African American women receiving OB/ GYN care.

Care during the preconception period is critical to improving health and reducing the long-term risks of adverse birth outcomes (Walter et al., 2020). Studies have focused on preconception interventions but have not focused on the lived experiences of African American women during the preconception period. Additional focus on the postpartum period and gynecologic services to African American women within the healthcare system in Atlanta, Georgia, was needed (Morgos et al., 2020). The higher rate of maternal deaths among African American women after giving birth (Crandall, 2021) is a social problem that may be impacted by this study. In this study, I explored the lived experiences of African American women receiving OB/ GYN services in Atlanta, Georgia, to gain insight that may contribute to the prevention of adverse maternal outcomes. The social change that may be implemented as a result of this study is the routine application of respectful maternal care (American College of Obstetricians and Gynecology, 2023) among obstetricians, gynecologists, and medical staff providing health services to African American women. This may result in broader social change by decreasing the rates of adverse maternal outcomes among African American women throughout the United States.

Problem Statement

African American women receiving OB/GYN services in Atlanta, Georgia, regularly experience adverse outcomes such as complications during the preconception period, perinatal period, and the postpartum period (Morgos et al., 2020; Shahin et al., 2020). Postpartum death occurs among African American women at almost three times the rate of women in other racial groups (Crandall, 2021). The research problem was that

there is a proven disparity in OB/GYN outcomes among African American women receiving OB/GYN services (see Crandall, 2021); however, all of the reasons for the disparity have not been explored in Atlanta, Georgia. Georgia's State House of Representatives recognized this problem in 2019 by allocating additional funding to maternal health programs, yet gaps continue to exist in exploring reasons for the disparity and understanding women's experiences with OB/GYN services (Hernandez et al., 2023). This study was needed to obtain input from African American women in Georgia and gain a better understanding of the factors that may be contributing to the disparity in maternal health outcomes after receiving OB/GYN health services. This may enable OB/GYN providers to discover ways to deliver effective health services and result in social change for African American women giving birth to have positive maternal health outcomes.

Purpose of the Study

The purpose of this qualitative study was to explore the lived experiences of African American women in Atlanta, Georgia, as they presented for OB /GYN services. These services included care provided during the perinatal period and the postpartum period. Perinatal quality improvement collaboratives have been established in Georgia to explore ways to improve health services for women receiving perinatal and postpartum care (Georgia Department of Public Health, 2022). This effort aligns with the president of the United States' mission to improve health services to women during pregnancy and decrease the rates of maternal mortality in the United States, including Georgia (The White House, 2022). Goal 2 of the White House Blueprint for Addressing the Maternal

Health Crisis is to ensure that all women giving birth are heard, respected, and provided information by the provider (The White House, 2022). This includes African American women presenting for services.

The study provides insight into the lived experiences of African American women across the socioeconomic strata. This approach differs from other studies that conducted research on Medicaid recipients (see Dude et al., 2022) and African Americans with low income (see Peahl et al., 2022). The results of this study provided data that may help advance best practices in the delivery of OB/GYN services to African American patients.

Research Questions

RQ1: What are the lived experiences of African American women in Atlanta, Georgia, receiving obstetric and gynecologic services during the perinatal period and postpartum period?

RQ2: What are African American women's lived experiences of obstetricians' and gynecologists' responses to their presenting concerns during OB/GYN visits in Atlanta, Georgia?

Conceptual Framework

The theories that grounded this study include systemic racism and implicit bias theories. Systemic racism theory was formulated by Feagin (2006). Feagin presented systemic racism as a theory of oppression where policies and institutions keep subordinates in a lower position. My research study was conducted within the conceptual framework of systemic racism theory and its impact on healthcare services. Volpe et al. (2021) found an association between racism and the quality of healthcare received by

African American women. African Americans had an 8% chance of access to care. Volpe et al. found that systemic racism positioned White patients at an advantage to access quality healthcare.

In addition, elevated levels of stress among African American women can result in adverse pregnancy outcomes (Chambers et al., 2020). The adverse outcomes and complications during the perinatal period and postpartum period among African American women in Atlanta, Georgia, were explored within the context of systemic racism theory (see Glover, 2021). Systemic racism theory provided me the context to explore the lived experiences of African American women living in Atlanta, Georgia, including OB/GYN visits and services. Systemic racism theory impacts healthcare services (Adebayo et al., 2021). Villarosa (2022) explained her findings that an African American woman with an advanced degree in the United States is more likely to die from childbirth than a White woman with an eighth-grade education. She pointed out that discrimination against African American women and bias in the healthcare system contribute to poor maternal health outcomes. This has been substantiated by reports of racial bias and the mistreatment of African American patients through the provision of marginalized care in the healthcare system (see Adebayo et al., 2021; James et al., 2023; Mahomes, 2020). There are standard medical practices that marginalize minority groups, such as African American women. Practices include viewing African American women with stereotypical risk factors when taking a biomedical approach and not supporting women who opt to have home births (Adebayo et al., 2021).

The implicit bias theory (IBT) was used in conjunction with the systemic racism theory as the conceptual framework for this study. Greenwald and associates defined IBT as unconscious attitudes and beliefs about individuals based on race (Greenwald & Krieger, 2006). Implicit biases can be revealed in provider communication patterns with patients, and communication is an essential component of providing healthcare (Hagiwara et al., 2019). IBT provided the context to the study in understanding study participants' experiences with OB and GYN providers. Studies have shown that healthcare providers have implicit biases that they may be unaware of, and their decisions on patient care are unconsciously affected. Implicit bias impacts the patient-provider relationship (Feagin & Bennefield, 2014). IBT theory also intersects with systemic racism theory to provide additional context to the problem of African American women experiencing adverse health outcomes and the exploration of the lived experiences of African American women in Atlanta, Georgia, receiving OB/GYN services. Further explanation of these phenomena is explained in Chapter 2.

Nature of the Study

I used an interpretative phenomenological analysis approach (IPA) in my qualitative study. This approach allows participants to express themselves and share their lived experiences while enabling the researcher to conduct in-depth data collection (Smith, 2022). The advantage of using IPA was the bonding that I formed with study participants and increased understanding of the participants' lived experiences. Using IPA in a phenomenological study design allows the researcher to better explore and interpret the experiences through the lens of the participant (Smith, 2022). This view has

strong philosophical roots in psychology, as pointed out by van Manen (2014). Van Manen explains that a phenomenologist must love the thinking of phenomenological minds to inquire about lived experiences. The IPA approach was woven into the research design. Phenomenology can be applied to healthcare and used to understand the patient's practical lived experiences (van Manen, 2014). The lived experiences of African American women with OB/GYN services in Atlanta, GA, were explored within the context of the intersection of systemic racism theory and implicit bias theory. African American women, ages 18 – 45 years old, who were currently pregnant or had delivered a live birth in the past 12 months, received care in Georgia, and currently live in the Atlanta, Georgia Metropolitan area were interviewed to learn about their experiences receiving OB/GYN services. This included women from all income levels living in Fulton, Cobb, Clayton, Dekalb, and Gwinnett counties. All educational levels were included. In-depth Interviews were conducted via Zoom with each participant. Transcriptions were created, followed by thematic qualitative data analysis using the IPA approach with the assistance of MAXQDA, a data analysis software.

Definitions

Implicit Bias Theory: Unconscious attitudes and beliefs about individuals based on race (Greenwald & Krieger, 2006).

Interpretative Phenomenological Approach (IPA): A methodological approach that allows participants to express themselves and their shared lived experiences and allows the researcher to conduct a more in-depth data collection by looking beyond themes to uncover the meaning within the experience (Smith, 2022).

Maternal Mortality: Female deaths related to complications in pregnancy, childbirth, or pregnancy terminations (Leins, 2019).

Maternal Mortality Rate: Rates of death that occur in women related to pregnancy complications, childbirth, pregnancy termination, or 42 days after delivery (Leins, 2019).

Obstetrics and Gynecology Services: Women's health services provided by trained doctors specializing in female reproductive health, pregnancy, and childbirth/delivery (Medical News Today, 2022).

Perinatal Period: The period from the time of conception to 12 months after giving birth (ACOG, 2022).

Phenomenology: A qualitative inquiry framework that inquiries about the lived experiences of research participants (van Manen, 2014)

Photovoice: A visual qualitative research method where participants capture their lived experiences through photographs (Mysyuk, 2020).

Post-Partum Period: The period immediately after birth through 12 weeks after childbirth/delivery (American College of Gynecology and Obstetricians, 2018).

Preconception Period: The reproductive years in which a man or woman can conceive a child (Centers for Disease Control and Prevention [CDC], 2020).

Systemic Racism Theory: A theory of oppression and racial discrimination where policies and institutions keep subordinates in a lower position (Feagin, 2006).

Assumptions

I made five assumptions about this qualitative research study. My first assumption was that conversations with the women receiving services needed to occur to better

understand the effectiveness of OB/GYN service delivery to African American women in Georgia. The second assumption was that African American women in Atlanta, GA, would be willing to participate in interviews. I also assumed that they would openly share their stories and lived experiences about OB/GYN services. I also assumed that a subset of participants would be willing to share more in-depth experiences through Photovoice. The final assumption was that community organizations serving African American women in Atlanta, GA, would be willing to assist with recruitment by sharing information about the study with potential participants. These assumptions were necessary elements of the research study.

To gain a better understanding of the effectiveness of OB/GYN service delivery to African American women, I developed key interview questions to encourage participants' sharing of perinatal and postpartum care experiences. These experiences are essential in the context of health services and maternal health. The CDC's "Hear Her" campaign highlighted the need to incorporate the voice of the patient in prenatal care research studies (Peahl et al., 2022; CDC, 2022). This approach has been used by researchers conducting studies with pregnant women in other states. Researchers in Wisconsin interviewed 31 African American women who shared their experiences on the disparity in prenatal services and maternal outcomes (Adebayo et al., 2021). In Mississippi, Tangbe et al. (2023) interviewed women to understand their prenatal care, delivery, and postpartum experiences.

Scope and Delimitations

Inclusion Criteria

Data was collected from African American women ages 18- 45 years old living in Atlanta, GA, who received OB/GYN services in the Atlanta, Georgia, metropolitan area. This included African American women who were currently pregnant or had delivered a live birth in the past 12 months. Income inclusion criteria consisted of all income levels. Education criteria included all levels of education.

Exclusion Criteria

There were a few exclusion criteria in this study. Women who did not self-identify as African American or Black were excluded from the study. As stated above, African American women in Georgia are disproportionately impacted by adverse maternal health outcomes (Gingrey, 2020). Females under the age of 18 or over the age of 45 were excluded. According to the March of Dimes PeriStats (2022), the childbearing age for women in the United States is 15 – 44. I excluded women under 18 due to additional legal implications and permissions. I also included women aged 45 to ensure that I captured data on those who received perinatal or postpartum care during age 44. Women who received OB/ GYN services outside of Georgia were also excluded from the study.

Limitations

One limitation of the study was that interviews were conducted via Zoom phone calls. The disadvantage was that I had less feedback via body language. Another challenge was participant recruitment. Participants may have been reluctant to share their

experiences in a study. Initially, it was challenging to recruit patients who represented various zip codes within Atlanta, Georgia. Recruiting participants across income strata was also a challenge, particularly regarding patients from the middle class. This was exacerbated by the number of universities in Atlanta conducting various studies with a similar population that were able to offer large incentives with grant funding. These challenges were addressed through collaboration with healthcare systems, community-based organizations in the Atlanta, Georgia, metropolitan areas serving African American women, and social media (i.e., Linked-In, Instagram, and Facebook). Also, I submitted an additional request to the Walden University Institutional Review Board (IRB) to offer gift cards for participation.

Another barrier was getting participants to trust the research process, considering the historical mistreatment that has occurred in experimenting on African American women without permission (see Stevenson,2024). This barrier was addressed by sharing the true purpose of the study, the advantages, and the potential to impact social change, and assuring the participants that every effort would be made to protect their information, respect their experiences, and maintain a comfortable and voluntary interview process.

Significance

This study was significant in that the data and findings have the potential to contribute to positive social change. Data collected from this study can inform OB/GYN practices and may result in additional or updated guidance. The rationale for using updated guidance in the delivery of OB/GYN services to African American women lies in the potential to impact maternal death rates in the population and decrease the adverse

outcomes and maternal deaths throughout the United States. Currently, Georgia ranks 49th in maternal deaths among African Americans (World Population Review, 2022). Study findings may also impact physician training in medical schools. All of this may reflect positive social change and may result in better health outcomes for African American women. There is a subset of children growing up without their mothers because of maternal deaths (Eiselt & Lee, 2022). Subsequently, this could result in a strain on the family and society, specifically the African American community. There is also an economic impact that results from the loss of a family member.

Another significance of this study was that the research findings may reinforce the practice of respectful maternity care. According to the CDC (2023)), one in five women in the United States reported that they were mistreated while receiving health services for maternity care. African American women (30%) reported the highest rate of mistreatment. Respectful maternity care involves improving communication by providers listening to and addressing the patient's concerns (CDC, 2023). By exploring best practices in the delivery of OB/GYN services and improving outcomes for African American women, future generations may be positively impacted based on the presence of a mother as opposed to the death of a mother.

Summary

Maternal mortality among African American women is significantly higher than other races and ethnic groups in America (Hoyert, 2022). The social problem addressed by the study is that African American women in Georgia are almost three times more likely to die from complications of pregnancy than other races (March of Dimes, 2021).

The adverse outcomes are evidence that this is a growing issue for African American women. This is both a state and a national problem. Georgia is among the top ten states with the worst maternal mortality rates in the United States (World Population Review, 2022). The House of Representatives in the Georgia state legislature recognized the severity of this problem in 2019 and increased funding to maternal-serving programs. Yet gaps in exploring reasons for the disparity and understanding women's experiences with OB/GYN services continue to exist (Hernandez et al., 2023). The White House (2022) has outlined a blueprint to address maternal health.

The purpose of the research study was to explore African American women's lived experiences receiving OB/GYN services in the Atlanta, Georgia metropolitan area. The study may result in an increased understanding of the need for respectful maternal care. This study has the potential to provide research data that will help obstetricians and gynecologists, along with other health services personnel serving African American women, explore ways to improve maternal health services for the population. The social change that the study may impact is a decrease in adverse maternal health outcomes among African American women throughout the United States. The research has significance, and data findings have the potential to contribute to positive social change, resulting in respectful maternal care and positive maternal health outcomes. Chapter 2 provides a literature review of what has been learned through previous research in the area. The chapter discusses the conceptual framework of the study.

Chapter 2: Literature Review

Health disparities exist for African American women receiving OB/GYN services for perinatal and postpartum care in Georgia. This results in adverse maternal outcomes (Crandall, 2021). The problem I addressed in this study was that adverse maternal outcomes disproportionately impact African American women (see Crandall, 2021). This is evident as the maternal mortality rate among African American women in Georgia is 2.7%, making them almost three times more likely to die from complications of pregnancy than other races (March of Dimes, 2021). The purpose of this study was to explore the lived experiences of African American women in Atlanta, GA, as they presented for OB/GYN services during the perinatal and postpartum periods. OB/GYN health services were explored from the perspective of African American women, ages 18-45, living in the Atlanta, GA, metropolitan area. Exploring these lived experiences with African American women provided insight into maternal outcome health disparities and revealed ways that OB/GYN services may contribute to improved outcomes. An overview of the literature search strategy and a literature review in the areas of maternal health and maternal mortality, including preconception care services, prenatal care services, and postpartum care services, is discussed in this chapter. Systemic racism theory (Feagin, 2006) and implicit bias theory (Greenwald & Krieger, 2006) are discussed as the study's conceptual framework. I close the chapter with a summary of the literature review.

Literature Search Strategy

An online literature search strategy was used to research four topics included in the literature search: *Preconception care services, prenatal care services, postpartum care services, and maternal health outcomes in the United States*. The literature search strategy included Medline, CINAHL Plus, and Pub Med databases from Walden University's online library, Georgia State University's online library, and the University of Georgia's online library. I searched the Thoreau database at Walden University along with Google Scholar. EBSCO at the University of Georgia and Science Direct at Walden University were also assessed. Google Scholar was also used to research scholarly articles related to preconception care, prenatal care, and postpartum care services.

The following search terms were used: *Maternal Mortality with African American women in GA, Maternal Mortality and African Americans, Obstetricians, and Black women or African American women, African American women and Maternal Mortality, Black women, Georgia Maternal Mortality Black women, Black women adverse outcome and US, Preconception care and Black women, Childbirth and the experience of Blacks, Prenatal care and African American women, Obstetricians, perinatal and Black women, Postpartum care and African American women, Postpartum care Obstetrics and Gynecology African American women, African American women and the pandemic, and Black women and fertility*.

Some search terms did not yield results. The search on *OB-GYN Services African American women in the US* yielded zero results. The search term *Maternal Mortality with African American women in GA* also failed to yield results. Likewise, the search on

Childbirth experience Black women health services and Black or African American women and healthcare obstetrical services yielded no results. When searches yielded no results on the Walden University library, additional searches were conducted within the Georgia State University and the University of Georgia electronic libraries. When articles within the last 5 years could not be located, I shifted my search strategy to websites. In these instances, I searched for data and information from the CDC, the National Institutes of Health (NIH), ACOG, The US Department of Health and Human Services (HHS), and The Georgia Department of Public Health (GADPH) websites.

Conceptual Framework

Systemic Racism Theory

The conceptual framework I used as the foundation for this study included systemic racism and implicit bias theories. Feagin (2006) coined systemic racism theory. Systemic racism theory indicates that there is an intentional establishment of policies and institutions designed to keep African Americans and other people of color in a disadvantaged position. Feagin introduced the structural racism theory of oppression and outlined its multidimensional influence in the United States. Dimensions of systemic racism include economics, education, judicial, and healthcare. The impact of generational institutionalized sustainment of wealth by a system of racism that places White people at an economic advantage over African Americans and people of color (Feagin, 2006) can be seen in studies that examined access and the quality of healthcare for marginalized populations (Gillespie & Weeks, 2021). Feagin elaborated on African Americans' awareness of differential treatment by White people based on a historical culture of

racism and oppression. This differential treatment is exercised by major societal institutions, including healthcare, educational, and financial institutions (Feagin, 2006).

I selected systemic racism theory as the conceptual framework for this study because evidence has shown that it is one of the root causes of discrimination in healthcare services (see James et al., 2023). This theory has been applied in research studies surrounding maternal and child healthcare and African Americans. Janevic et al. (2020) examined racial discrimination experiences by African American and Latino women receiving prenatal care. Participants were interviewed regarding their postpartum care experiences. The researchers examined racial discrimination in the context of postpartum care services and hospitalizations. The majority of the study participants reported experiences that were identified as discrimination. Women reported perceptions of discriminatory treatment by providers based on the patient's race (Janevic et al., 2020). Institutional racism and structural racism are terms used interchangeably. Gillespie and Weeks (2021) reviewed data from the 2016-2018 Wisconsin Pregnancy Risk Monitoring Assessment System (PRAMS). Findings revealed that identifying as Black or Non-Hispanic was significantly associated with receiving inadequate prenatal care. Also, the odds of not receiving a postpartum visit were highly correlated with discrimination during prenatal visits. As noted by Janevic et al. and James et al. (2023), the effects of systemic racism have continued to be problematic.

The findings by James et al. (2023) were consistent with Janevic et al.'s (2020) findings about postpartum African American and Latino women. Focus groups were used to collect data on participants' lived experiences with postpartum care services Janevic et

al. (2020). Study findings revealed themes of discrimination in the provision of prenatal care services based on the type of insurance and race. Participants reported receiving differential treatment based on race and implicit bias by providers making assumptions about the type of insurance based on race. The experiences of discrimination and racism impacted patients' use of prenatal care services and ultimately affected birth outcomes (Janevic et al., 2020). Gillespie and Weeks' (2021) review of PRAMS data concluded that structural racism negatively affected maternal health outcomes.

Additional qualitative research studies have been conducted with African American and Afro-Latino women regarding their pregnancy and birthing experiences in the context of structural racism in Florida (Thomas, 2022). Thomas (2022) examined the prenatal and birthing experiences of 25 women who were perceived as Black or African American regardless of their self-identification as Latino or other races. Results revealed that African American and Afro-Latina women experienced similar biased treatment from providers even when they self-identified as Latino (Thomas, 2022). This treatment differed from patients who were not perceived as Latina and non-African American. Researchers applied the framework of phenomenology and the narrative medicine approach to capture women's experiences with prenatal care services and childbirth (Thomas, 2022). The strength of this approach allowed the researchers to glean stories from the women and did not impose on the participants to suggest how they should feel about their discriminatory treatment. An additional strength of the study was the qualitative data analysis approach. The data was interpreted not only by looking for themes and common words, but careful attention was given to voice inflections and

expressions to capture the texture of the lived experiences. Thomas' recommendation was that additional qualitative studies using narrative medicine, and phenomenology are needed to better understand adverse maternal outcomes and reproductive health in historically marginalized populations. In my study, I further examined this phenomenon, focusing on Atlanta, GA. African American women were interviewed using the interpretative phenomenological analysis approach that allows the researcher to fully understand the lived experiences of the participants, and the data collected was analyzed based on in-depth descriptions of the participants' experiences.

Implicit Bias Theory (IBT)

The additional conceptual framework grounding this study was IBT. Greenwald and associates developed the Implicit Bias Association test and defined IBT as unconscious attitudes and beliefs about individuals based on race (Greenwald & Krieger, 2006). Studies have shown that implicit biases influence provider-patient communication patterns. Communication patterns with patients are an essential component of providing healthcare (Hagiwara et al., 2019). IBT was used to provide context to my study and understand study participants' experiences as they communicated with OB/GYN providers. Studies have shown that healthcare providers have implicit biases that they may be unaware of, and their decisions on patient care are unconsciously affected. Implicit bias impacts the patient-provider relationship (Feagin & Bennefield, 2014). Studies have also shown that nurses with implicit biases providing perinatal care to African Americans demonstrated verbal dominance when communicating with their patients (Ratten & Bartlett, 2023). African American patients rated the provider poorly in

the areas of positive effect, trust, and confidence. Implicit biases may lead an individual to stereotype and make unintentional judgments about others (Mahomes, 2020). IBT theory intersects with systemic racism theory to provide additional context to the problem I explored of African American women experiencing adverse health outcomes and the exploration of the lived experiences of African American women in Atlanta, Georgia, receiving OB/GYN services. This was my rationale for choosing IBT as the additional component of the conceptual framework for this study.

Literature Review Related to Key Variables and/or Concepts

Preconception Care Services

It is estimated that 52,000 women in the United States experience health complications that contribute to maternal harm or death (Dude et al., 2022). Minority women are disproportionately affected (Dude et al., 2022). Providing care before pregnancy occurs, preconception care is a proven strategy with the goal of risk assessment and intervention before pregnancy to reduce poor maternal health outcomes (Fowler et al., 2021). The CDC (2020) has identified 10 specific areas that pose risks for negative maternal outcomes, and guidelines focus on screening for these risks during GYN visits. Screening includes assessment of tobacco, alcohol, and drug use along with environmental or teratogenic risk factors. GYN guidelines also include an assessment of healthy weight maintenance and levels of physical activity (ACOG, 2020). Preconception care provides services and information to women and men prior to conceiving and addresses health risks, such as pre-existing physical conditions, which could negatively impact pregnancy and birth outcomes (Jack et al., 2020). Interviews with GYNs, family

practice providers, and nurse practitioners revealed that providers recognize the value of preconception counseling services for patients; however, problematic assumptions on the part of the provider pose a barrier to screening patients. Providers may assume that they know their patients and do not need to conduct preconception screening services and counseling (Nacev et al., 2022). Because African American women have higher risks of poor maternal health outcomes, specifically in the state of Georgia, at almost three times higher maternal mortality (Hernandez et al., 2023; Shahin et al., 2020), preconception care services are critical to increasing the chances of positive maternal health outcomes.

Dude et al. (2022) conducted a secondary data analysis of Medicaid claims between 2010 – 2012, where the primary outcome, according to ICD-9 diagnosis codes, was maternal death for women between the ages of 15- 45. They examined the association between preconception care and severe maternal mortality by reviewing the outcomes in the context of seven domains of preconception care. The domains included contraceptive services, pregnancy testing and counseling, achieving pregnancy, basic infertility services, preconception health services, sexually transmitted infection services, and related preventative health services, commonly referred to as routine gynecological exams (CDC, 2009). Dude et al. found that while African American women had a greater likelihood of severe maternal outcomes, results showed that women who received preconception care were at decreased risk for severe maternal mortality (Dude et al., 2022).

Prenatal Care Services

While preconception care, contraceptive services, routine exams, and counseling services are recognized strategies to prepare women and men for a healthy conception (Dude et al., 2022), OB/GYNs agree that the goal of prenatal care services is to optimize the pregnant patient's health and the delivery of a healthy infant (Peahl et al., 2022). ACOG, along with the Health Resources and Services Administration of the HHS, supports initiatives that standardize prenatal care (Marill, 2022). Although prenatal care is important in reducing maternal morbidity and mortality, patients in a Michigan study reported barriers to high-quality prenatal care that included transportation issues, financial challenges, systemic racism, and discrimination (Friedman et al., 2022). Nineteen African American women with low incomes were interviewed concerning their experiences with healthcare services and providers during pregnancy and postpartum, 1 year after childbirth. Participants were questioned about medical services, anticipatory guidance, and medical support. They reported not feeling supported or encouraged to ask questions, in addition to experiencing systemic barriers. These barriers, coupled with a lack of support from the medical practitioner, resulted in a failure to meet the needs of African American patients (Friedman et al., 2022).

In contrast, Badakhsh et al. (2020) conducted a qualitative phenomenological study in Iran exploring the lived experiences of women with high-risk pregnancies. This hermeneutic phenomenological study was conducted in Southwest Iran with 20 women, and the researchers interviewed the women about their experiences with a high-risk pregnancy. The women reported experiences that centered around four challenges: (a)

family challenges that included the burden that may be placed on the family, (b) anticipation of the new baby and both good and bad feelings about the changes of an expanding family, (c) challenges for future pregnancies and worries regarding having a child with a disability, and (d) adaptation - believing that their situation would improve. Healthcare providers played a key role in helping the women by providing emotional support and helping the women adapt to the challenges of pregnancy (Badakhsh et al., 2020).

Postpartum Care Services

Health professionals play an important role in preventing maternal mortality (CDC, 2022). The Georgia Maternal Mortality Review Committee found that 85 % of maternal deaths were preventable (GADPH, 2022). Postpartum care can be seen as the fourth trimester of pregnancy (Glassgow et al., 2023). The weeks following the birth of the baby are critical for the mother and impact her health and well-being. Between 2019 and 2021, the highest number of pregnancy-related deaths in Georgia occurred within 8 to 60 days after delivery (GADPH, 2022). ACOG recommends that women are seen at least 3 weeks after giving birth (ACOG, 2021). Postpartum care is an ongoing process and should not be a single medical visit. Medical visits should be comprehensive and individualized to the mother's health, mental health needs, and presenting concerns (ACOG, 2021). African American women are more likely to die from pregnancy-related complications. Therefore, it is critical to identify risks and address complications during postpartum visits (James et al., 2023). A California study investigated the influence of discrimination experienced by African American women and the number of postpartum

visits. Study results revealed that women who experienced discrimination during childbirth had lower utilization of postpartum visits (James et al., 2023). This study explored African American women's experiences while receiving postpartum care services.

Summary

Major themes in the literature include the disparity in the maternal health outcomes for African American women when comparing their outcomes to other races and ethnic groups regardless of education, access, and income (Shahin et al., 2020). Themes can also be seen around the importance of pre-pregnancy counseling and preconception care (ACOG, 2019) and prenatal and postpartum care (ACOG, 2021). This includes discussing good nutritional habits, healthcare, and stress management. Physicians need to discuss pregnancy plans with patients, and special attention should be given to patients with chronic health conditions such as diabetes, hypertension, and cardiovascular issues (ACOG, 2019). Prenatal care services are instrumental in reducing adverse maternal outcomes (Pehl, 2022). Postpartum care services are essential and should include an assessment of the patient's physical, social, and psychological well-being (ACOG, 2021). These visits present the opportunity for physicians to hear and address women's concerns (ACOG, 2021). The CDC's Hear Her Campaign emphasizes the importance of women being able to express themselves to physicians during pregnancy and feel heard (CDC, 2022). Research studies with African American women and people of color (James et al., 2023; see also Friedman et al., 2022; Thomas, 2022) have revealed that women did not feel heard or supported and experienced

discrimination. In addition, stress experienced from systemic racism in the United States contributed to a higher allostatic load in African American women (Villarosa, 2022).

As maternal deaths after childbirth continue to increase, resulting in higher rates among African Americans (CDC, 2020), it is imperative that researchers fully understand the variables that contribute to the disparity. While studies have been conducted with African American women in other parts of the United States within the context of the Medicaid population, there was a gap in studying African American women across the socioeconomic strata, specifically in southern states. This research study aimed to address this gap by including African American women in the Atlanta, Georgia, metropolitan area, ages 18-45, from all income levels. Unlike studies that have been limited to women receiving Medicaid (Dude et al., 2022; Peahl et al., 2022), this study examined the lived experiences of African American women from multiple income levels. This study collected data that provided valuable insight into the lived experiences of African American women seeking perinatal and postpartum care in the metropolitan area of Atlanta, Georgia. Chapter 3 provides an in-depth discussion of the research methods.

Chapter 3: Research Methods

In this qualitative research study, I explored African American women's lived experiences with OB/GYN services in Atlanta, Georgia. There was a research gap regarding the lived experiences with OB/GYN services among African American women living in Georgia. This study differed from research in other states, as women from multiple income levels were included. Other studies have excluded women who were not receiving Medicaid (e.g., Dude et al., 2022) or did not have low incomes (e.g., Peahl et al., 2022). Using an interpretative phenomenological approach and viewing through the lens of systemic racism theory and IBT, I explored the experiences of the women as they presented for OB/GYN services in the metropolitan area of Atlanta, Georgia. This research may inform the delivery of OB/GYN healthcare services of ways to deliver care to African American women and underserved populations and effectively decrease adverse maternal health outcomes. The results of this study have the potential to ignite social changes throughout the United States. OB/GYNs and other medical personnel may increase the application of respectful maternal care with African American women. Findings from this study may also contribute to a decrease in adverse maternal outcomes and a decrease in the rates of African American women dying after giving birth.

In this chapter, I provide an overview of the research methods, and the rationale used in the exploration of the lived experiences of African American women with OB/GYN healthcare services. The research questions are explained in detail, followed by an expansion on the concepts of systemic racism and IBT that I used to contextualize the study findings. I also discuss the background and role of the researcher and my

relationship with the study population. Subsequently, a detailed description of the methodological process is explained.

Research Design and Rationale

A qualitative research design was chosen to implement this study. The nature of the study influenced my choice of this research design. The phenomenological research tradition allows the establishment of a framework to understand and interpret the lived experiences of study participants (van Manen, 2014). In this section, I discuss the research questions being addressed in the study. The use of the IPA approach and the rationale are explained along with the role of the researcher.

Research Questions

The purpose of this study is to explore African American women's lived experiences while receiving OB/GYN health services. The following research questions were addressed:

RQ1: What are the lived experiences of African American women in Atlanta, Georgia, receiving obstetric and gynecologic services during the perinatal period and postpartum period?

RQ2: What are African American women's lived experiences of obstetricians' and gynecologists' responses to their presenting concerns during OB/GYN visits in Atlanta, Georgia?

The study questions and interview guide were designed to engage participants in a dialogue to provide insight into the lived experiences of African American OB/GYN patients seeking and receiving healthcare services. The first research question (RQ1)

allowed me to collect data on African American women's experiences seeking OB/GYN services, appointment setting, healthcare facility visits, and check-in experiences. The second research question (RQ2) focused on the African American women's interactions with the staff providing health services. This included but was not limited to nurses, medical assistants, laboratory personnel, and physicians. Questions presented to participants helped me gain an understanding of the presenting problems by African American women and their perception of medical personnel's responses and resources provided to their problems. Questions also covered how or if patients presented their health and mental health concerns during medical visits.

A qualitative phenomenological research approach was used in the design of this study. Husserl (2002), the developer of phenomenology, believed that phenomenology provides a way to understand the meaning of the participant's experience (Alase, 2017). This view has strong philosophical roots in psychology, as pointed out by van Manen (2014). Van Manen explained that a phenomenologist must love the thinking of phenomenological minds to inquire about lived experiences. Phenomenology can be applied to healthcare and used to understand the practical lived experiences in healthcare (van Manen, 2014). I used phenomenology, a qualitative inquiry framework and research tradition (van Manen, 2014), to examine the lived experiences of African American women receiving OB/GYN services for perinatal and postpartum care in Atlanta, Georgia. Phenomenologists believe that knowledge is found in what people experience in their everyday world and life experiences. This was the rationale for using this tradition and approach.

I applied an IPA approach to my study during the data analysis process. This approach allowed me to conduct in-depth data collection through interviews. Participants expressed themselves and shared their lived experiences. I viewed the experience through the lens of the participant (see Smith, 2022). It is important that researchers understand that they are entering into the participant's world and genuinely listen to their lived experiences (Alase, 2017). The lived experiences of African American women with OB/GYN services in Atlanta, GA, were explored within the context of the intersection of systemic racism theory and IBT

Role of the Researcher

The role of the researcher defines both the instrument that was used, and the approach implemented in this qualitative research study. Functioning as an interviewer, I applied the IPA approach allowing African American women to express themselves and share their lived experiences while bonding with me to conduct more in-depth data collection and analysis (see Smith, 2022). My rationale for the use of IPA in this qualitative study was the advantage of close engagement with participants to genuinely understand their lived experiences (see Smith, 2022). I drew from my previous work experiences as a research associate and maternal and child health consultant, using my interviewing skills to facilitate individual confidential discussions with African American women regarding their experiences with OB/GYN services. My positionality included the role of a recruiter, research interviewer, data collector, and data analyst along with interpreter of the data. I developed data collection tools, including the preliminary survey,

interview questions, and the interview guide, to ensure dependability in the data collection procedures.

As a qualitative researcher, I remained cognizant of the potential uneasiness that some questions may cause as participants recalled their lived experiences. I exhibited compassion during the interviews and ensured that participants fully understood that participation was voluntary. My previous skillset as a licensed social worker was employed as I listened and observed the participants' level of comfort in discussing the questions. I also included a resource, the state mental health hotline, which was provided in the consent form in case participants needed a referral. There was no potential for power relationships or conflicts of interest in the work environment as I was not working with the maternal and child health population at the time.

I was aware of potential biases when conducting the study based on my own experiences as an African American woman with OB/GYN services. I designed the participant screening survey (See Appendix A) and the interviewer guide, including the interview questions and instructions (See Appendix B). The interviews were conducted via Zoom phone sessions and recorded on Zoom. The transcription feature of Zoom was used. Thematic data analysis of interview transcripts was performed. As I collected data through interview responses, I reviewed the data within the context expressed by the participants. I implemented the use of the MAXQDA software to review the qualitative data in addition to removing potential interpretive biases. In summary, my role as a researcher involved recruiting participants, collecting valid data, and analyzing and interpreting the data while executing the study in a manner that allowed immersion into

the experience thus gaining an in-depth understanding of the participants' lived experiences. The advantage of close engagement with participants in an effort to genuinely understand their lived experiences drives my rationale for the use of IPA (see Smith, 2022).

Methodology

Population

The city limits of Atlanta, Georgia, have a population of 499,127, with African Americans comprising 48% of the population (U.S. Census, 2022). In this qualitative study, I used in-depth, semi-structured interviews with African American women, ages 18 - 45, who received OB and/or GYN services in the Atlanta, Georgia, metropolitan area. The population was studied to understand the lived experiences of women seeking and receiving OB/GYN prenatal care and postpartum care services in the context of systemic racism and implicit bias theories.

Selection Criteria

African American women, ages 18 – 45 years old, who were pregnant or delivered a live birth in the past 12 months, received care in Georgia, and live in the Atlanta, Georgia, metropolitan area were interviewed to learn about their experiences receiving OB/GYN services. No income criteria was applied, resulting in the recruitment of participants across income levels.

Potential participants were screened via survey to ensure that they met the following criteria: (a) identify as African American, (b) live in the Atlanta, GA metropolitan area, (c) receiving or have received OB/GYN services in Georgia, and (d)

delivered a live birth in the past 12 months, or were currently pregnant. A screening survey was administered to potential participants electronically. Fourteen African American women were recruited to participate in this research study. Participants lived in the Atlanta, Georgia, metropolitan area. This included African American women living in Fulton, Cobb, Clayton, DeKalb, and Gwinnett counties.

Sample Size

The Atlanta, Georgia, metropolitan area has a population of 6.9 million, with 4.8% giving birth in 2019 (US Census, 2020). The Atlanta metropolitan area is comprised of 29 counties (“Atlanta Metropolitan”, 2023). Recruitment focused on participants from the original counties of Fulton, DeKalb, Cobb, Gwinnett, and Clayton. Purposive sampling strategies were used to recruit 14 participants. Purposive sampling allows a researcher to use the approach of recruiting participants who are included in the category being researched and generate new knowledge and comparisons (Denieffe, 2020). The purposive sampling method of snowballing was also employed, where recruited participants were asked to refer additional participants until the desired number was achieved. The use of the quota sampling method allowed me to gather a realistic number of participants.

Quota sampling is a qualitative sampling approach that uses a predetermined number of cases to represent a larger population (Futri et al., 2022). Quota sampling was used to obtain a minimum of 14 participants, with a distribution goal of 50% of the women receiving prenatal care services and 50% of the women receiving postpartum care

services. This was used as a representative sample of the population of African American women in Atlanta, Georgia.

Recruitment and Selection

Recruiting participants can be a challenging part of a study (van Gelder et al., 2019) and may contribute to delays in the commencement of the research. A multiplicity of methods were used to recruit 14 participants for the study. I contacted existing programs and projects that served or interacted with the population. This included collaboration with the Georgia Department of Public Health's maternal and child health division and local health departments, The Healthy Start Initiatives in Atlanta, including the Center for Women's Wellness and Clayton County Healthy Start, along with Black Mama's Matter and Healthy Moms Healthy Babies Coalition. Sorority organizations (i.e., Alpha Kappa Alpha, Delta Sigma Theta, and Zeta Phi Beta) were contacted to share flyers and information with members. Collaborations with the Morehouse School of Medicine's Center for Maternal Health Equity occurred to inform the communities in Atlanta about the research project. This was done through meetings and presentations with outreach staff.

Multivariant methodologies were employed to recruit study participants. Flyers were designed that included information on the study and participation requirements. Electronic versions of the flyer included a link connecting potential participants to the online screening survey. I held meetings with providers and maternal and child health serving agencies regarding either posting the flyers or sharing the flyers with patients and clients via email. Facebook and Instagram ads were purchased to recruit participants.

Videos were produced for Instagram, Facebook, and Linked-In sharing information about the study along with the electronic version of the recruitment flyer (See Appendix C). A private Facebook group was created. Regular notices and flyers were posted to the group to inform members about the study and give potential participants the opportunity to be screened via survey.

A community-friendly name was assigned to the study. This study was known as “Expressions.” The details and purpose of the study were held to the integrity and standards of Walden University’s IRB research expectations. The name “Expressions” was a user-friendly term that I, an African American female, believed would be more openly received and understood by the population being studied. Flyers and recruitment materials included the name “Expressions”

Selection Process

After indicating an interest in the research participation, potential study participants were selected via a survey screening. The prescreening survey (Appendix A) was administered to interested participants. It was used to collect data from potential study participants. I developed this tool, and it was administered via a Survey Monkey link that could be completed online by potential participants. I entered the information from the survey into an Excel spreadsheet and used it to determine if the participant met the study inclusion criteria. Purposive and snowball sampling were used to encourage existing participants to refer additional participants. Those who were selected were notified via text message or email. In addition, a text message notification was sent to the

contact number listed on the survey form, thanking them for their interest. A total of 19 survey participants were deemed eligible to participate in the research interviews.

Instrumentation

Instrument selection is a critical facet of a well-planned research study. Experiences from the COVID-19 pandemic have shown that conducting virtual interviews can be as effective as in-person interviews in many instances (Dubé et al., 2023). I used semi-structured telephone interviews to collect data. Data collection on the participant's lived experiences with OB/GYN services was also obtained using survey questionnaires and interview question guides. Interview question guides I developed (Appendix B) were used to facilitate conversations with individual participants. The interview questions ensured the alignment of data collection within the context of systemic racism and IBT. Open-ended questions were used in most instances to encourage conversation on the experiences of participants with the medical community and the intersection of their daily life experiences. Follow-up probing questions were also used as appropriate to gather detailed data to the extent that participants were comfortable sharing with the researcher.

I reached out to collaborate with projects in Atlanta providing services or researching similar issues with the population. Fulton County Maternal and Child Health, Center for Women's Wellness, Morehouse School of Medicine Center for Maternal Health Equity, and New Georgia Project's Black M.A.M.A.S. Campaign were among the collaborators who referred participants to the study.

Data Collection Instruments

The tools and instruments that I used to collect data during this qualitative research study were carefully selected based on relevancy and design. A Milwaukee, Wisconsin study (Adebayo et al., 2022) that examined African American women's maternal experiences with healthcare used questionnaires to encourage women to share their narratives. As stated earlier, the Interpretative Phenomenological Approach (IPA) and the use of in-depth interview questions guided the discussions. I developed an interview guide with questions designed to promote discussion on participants' experiences accessing and receiving perinatal and postpartum care services.

Questions designed by me facilitated discussions that addressed research questions specific to the participant's lived experiences receiving obstetric and gynecological (OB/GYN) services during the perinatal and postpartum periods and their experiences of OB/GYN's responses to their presenting concerns during visits. The interviewer's guide consisted of questions divided into sections discussing perinatal and postpartum care services. Open-ended questions encouraged discussion on general topics related to participant's healthcare experiences. At the end of the interview, I thanked participants and gave them the option to indicate via email if they would like to be notified about the study findings.

Data Collection Plan

The Survey Monkey online screening survey was assessed by women who indicated an interest in the research study. Contact information was obtained via the survey questions. The "Expressions" participant screening survey (See Appendix A)

results were used to determine potential participants' eligibility for the research study. Each participant was assigned a unique identifier recorded on an Excel spreadsheet maintained by the researcher. Eligible participants were notified of acceptance via welcome email and text message. Participants were contacted via email to schedule an interview, and follow-up occurred with a confirmation email containing the Zoom phone number and meeting link.

Data collection took place within a 6-week time period between June and July 2024. Semi-structured interviews were conducted with African American women participants from various income levels who were between the ages of 18 - 45 years old. I facilitated the interviews. The interviews took place via Zoom phone conferencing. In instances when the participant was unable to access the Zoom call features, participants used Zoom by dialing the phone number provided in the email and text messages. Interview data was recorded via Zoom using the transcription and audio recording features. The photovoice data collection method originally planned was eliminated from the study because I determined that the interviews would provide enough valuable data to analyze and answer the research questions. Upon completion of the data collection process, I sent appreciation for participation emails and gift cards to each eligible participant.

Data Analysis Plan

I employed the interpretive phenomenological approach (IPA) to analyze and examine the lived experiences of the study participants. This approach allowed me to conduct more in-depth data collection and analysis than the general inductive approach

used in qualitative studies. This method looks beyond themes and seeks to uncover the meaning that is within the experience through the lens of the participant (Smith, 2022). Research Question One (RQ1), “ What are the lived experiences of African American women in Atlanta, Georgia, receiving obstetrics and gynecological (OB/GYN) services during the perinatal period, and postpartum period?” This was addressed through interview questions during individual semi-structured interviews. Interview data was recorded and transcribed. Transcripts were uploaded into the MAXQDA software tool. Qualitative data analysis was conducted using this software. Each transcript was meticulously reviewed to fully comprehend participants’ lived experiences within the context of systemic racism and implicit bias. I created a codebook and explored emerging themes from the data. After reviewing the emerging themes detected by the software tool, I conducted a manual analysis of the transcript to determine if additional codes were needed and if additional sub-codes were appropriate. Major category areas were initially color-coded, as shown in Table 1. Transcript quotes representing the themes were highlighted in the same color.

Table 1*Preliminary Codebook Categories*

Category	Color code
Prenatal care experiences	Pink
Childbirth/delivery experiences	Yellow
Postpartum care experiences	Blue
Racism and everyday stressors	Orange
Willingness to share concerns	Green
Reluctance to share concerns	Gold
Feelings of provider bias	Purple

Note. The table illustrates the color coding used for each of the preliminary qualitative category and coding used during data analysis.

Research Question Two (RQ2), “What are African American women’s perceptions of OB/GYN’s responses to their presenting concerns during visits in Atlanta, Georgia ?” was addressed based on thematic revelations using the same methodology as RQ1. Discrepancies were intensely explored, and further consideration was given to the context of the data to determine data validity.

Issues of Trustworthiness

Trustworthiness and validity are used interchangeably in qualitative research. The validity of the data is essential to increase the probability that lived experiences shared by study participants are captured and interpreted with quality and accuracy (Holter, 2022). My protocol for applying the concept of trustworthiness of the data collected during this study is discussed in the following sections. A discussion of internal validity and external validity follows.

Internal Validity

Internal validity examines the way a study is designed, how the research is conducted, and how data is analyzed (NIH, 2018). This examination contributed to the trustworthiness of the study. Credibility and dependability are key components of evaluating internal validity (Peterson, 2019). Credibility looks at the approach and methodologies used by the researcher. Dependability looks at the instruments used and data analysis to evaluate data validity. The sections that follow detail how credibility and dependability were addressed in this study.

Credibility

This qualitative research study used an interpretative phenomenological analysis approach (IPA) in which I was immersed in the participants' experiences, forming a bond in some cases with the participants. Methodologies were employed to increase the validity of this qualitative study as much as reasonably possible. Peer Review was utilized to examine themes and results. A colleague with subject matter expertise was asked to review data analysis and findings. This was a peer practicing in the field at a top government level in maternal and child health with healthcare and research backgrounds. Using peer review can have mixed results. On one hand, there is the advantage of subject matter experts who can lend valuable input. In contrast, there may be biases based on familiarity with the subject matter and a lack of objectivity (Abadal & Melero, 2022).

Dependability

I used triangulation by looking at data collection from three sources: semi-structured individual interviews, transcript reviews, and narrative summarization. These

methodologies were employed to address dependability. Interviews and transcript narratives were strategically selected for data collection based on similar studies with women and prenatal care (Peahl et al., 2022; Thomas, 2022). I created an Interviewer's Guide with questions designed to facilitate discussion on the participants' lived experiences with OB/GYN services and racism. Probing questions were asked, diving deeper into the responses as appropriate. Another researcher can replicate these questions and should be able to facilitate similar discussions.

External Validity

External validity focuses on the potential for study findings to be generalized to other contexts (Andrade, 2018). Factors that measure external validity include transferability and confirmability. Transferability is used to look at the application of the study in other contexts. Confirmability evaluates the neutrality of the study or the potential for researcher bias (Kynge et al., 2020). The following sections explain how this study addressed transferability and confirmability.

Transferability

I implemented efforts to increase the probability of transferability. The Interviewer's Guide provided detailed steps and protocols for conducting individual interviews. Specific questions were included along with probing questions to be executed in the event that more in-depth discussions needed to evolve. Thick description was employed. Data captured from the interviews were detailed in nature. Peterson (2019) points out that the researcher must provide rich information regarding participants, data collection, and analysis that is replicable and may be transferable to other contexts. The

use of quotations can effectively convey themes (Peterson, 2019). Direct quotations from participants were incorporated into the dissertation narrative as specific data.

Confirmability

Researcher bias must be carefully evaluated and consistently guarded to contribute to confirmability. Transparency on the connection to the area being studied was pertinent (Peterson et al., 2019). I employed efforts to have a continual awareness of biases as a member of the population being studied. As I immersed myself in the lived experiences of study participants using IPA and applied the contexts of systemic racism (Feagin, 2006) and implicit bias (Greenwald & Krieger, 2006), I was mindful and employed a continued awareness of my own biases. I analyzed the data as objectively as possible for thematic revelations. Data triangulation and reflexivity strategies contributed to confirmability in this study.

Ethical Procedures

In accordance with the requirements of the Belmont Report of 1978 (White, 2022), all risk aversion techniques were employed to ensure that participants were not harmed during the study. Historically, there has been debate about research with pregnant women and the harm versus the benefit (Little & Wickremesinghe, 2017). In this qualitative study, it was recognized that there were no physical risks to the female participants or their unborn child; however, the researcher remained cognizant of the mental and emotional risks that could be associated with women sharing their lived experiences. Jenson et al. (2022) studied pregnant women's lived experiences with obesity and recognized the delicate nature of this topic as women were interviewed.

There were no ethical issues related to recruiting women to study as I was not employed by the agencies and organizations that I approached to post flyers. As a researcher employing the IPA, I exerted efforts to observe and be conscientious about the impact of the discussions on participants' emotional and behavioral health.

Prior to the commencement of the research, I submitted all required forms and attachments to the Walden University Institutional Review Board (IRB) for approval. Walden University's approval number for this study was 05-01-24-0746472. IRB also approved the use of a 25-dollar electronic gift card to share with participants upon completion of the interview as a token of appreciation for their time. This is a standard practice among universities in Atlanta, GA. In addition, I completed the CITI Certification for researchers working with pregnant women and have been certified. Once approved, I followed all research standards and requirements. All participants selected for the study received an informed consent via the online survey and email prior to participation in the study. The informed consent included clear options that participation was voluntary, and women could choose to discontinue participation at any time or opt to refrain from responding to specific questions. I also listened to the feedback and voice intonations during each interview to ensure that participants were comfortable and not experiencing trauma or triggering behavioral health episodes. Participants were reminded that everything shared was confidential and that the conversation was a safe place. At the end of the session, participants were thanked, and resources were available for those who needed to debrief as a result of the conversation. I was connected to a network of behavioral health and medical colleagues who could assist with community resources,

referrals in Georgia, and national resources. Also, the Georgia Mental Health Hotline number was included on the consent form.

Data Confidentiality and Security

In my role as a researcher, I implemented procedures to protect the data collected from participants, including data confidentiality and storage. All data was stored on a terabyte drive securely locked away in a locked file drawer to which only I have access. An Excel spreadsheet was created and used to assign each participant unique identifiers. The identifier, along with the participant's name and cross-reference, was located solely in the Excel spreadsheet saved on the external terabyte drive. The identifier began with the letter "EXPR" and included a number based on the spreadsheet row. Transcriptions were de-identified, and names were replaced using the assigned Excel number during the data analysis process. Quotations used as part of the presentation or findings included the participant number (i.e., Participant 6). This was done to protect the identity of the participants. Study data will be securely stored for a minimum of 3 years from the date of the completion of the study. This is in accordance with the Office of Human Research Protections and the federal registry 45 CFR 46 (US Health and Human Services, 2023).

Summary

The qualitative research study was conducted by gathering data directly from African American women, ages 18 - 45, specific to their phenomenological experiences with OB/GYN healthcare services. "Expressions" was the community-friendly name assigned to the study. Two research questions guided the agenda for the research study

design and methodology. The primary question was, “What are the lived experiences of African American women in Atlanta, Georgia, receiving OB/GYN services in Atlanta, Georgia?” The second question addressed was, “What are African American women’s lived experiences of obstetricians’ and gynecologists’ responses to their presenting concerns during OB/GYN visits in Atlanta, Georgia ?”

The IPA approach was used to conduct semi-structured interviews with 14 African American women living in the Atlanta, Georgia, metropolitan area who were receiving prenatal and postpartum care services. I bonded with the participants and was immersed in the discussion and experiences using IPA while simultaneously maintaining an awareness of any discomfort or trauma triggers caused by the discussion. Participants were informed that they could voluntarily choose to abstain from responding to a question. During the recruitment process, participants were screened via a survey, as mentioned in the selection process section, and only African American women who met the study criteria were enrolled as study participants.

Participants recruited additional participants through snowballing. This allowed several recruits from the same community or cohort to join the study. Community agencies and organizations were used as resources to increase awareness of the study. In addition, social media was employed to post electronic recruitment flyers with links directly to the prescreening survey. Prior to the study, IRB approval was obtained. Informed consent occurred with each participant via the survey.

My roles as a researcher included recruiter, interviewer, data collector, and data analyst. I analyzed the data within the contexts of systemic racism and implicit bias

theories. Thematic codes were used along with MAXQDA software to analyze the data. Data collection through interview questions and transcript reviews, along with three stages of IPA narrative summarization, comprised the triangulation of the data, thus contributing to data trustworthiness and credibility. To ensure ethical considerations, special efforts were made to explain the study to participants and ensure that they were fully aware of the research study's purpose and how the data collected would be used. A protocol was implemented to ensure data security and confidentiality. The data collection and analysis plan were consistently and meticulously implemented to increase the probability of non-biased findings.

Chapter 4 provides an introduction to the study and further details on the research. This includes participant demographics and study settings data. Data collection and data analysis methodologies will be discussed, along with the implications for trustworthiness. Chapter 4 concludes with the study results and a summary of answers addressing the research questions.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore African American women's lived experiences with OB/GYN services in Atlanta, Georgia. Two research questions were posed to examine these experiences. RQ1 was, "What are the lived experiences of African American women in Atlanta, Georgia, receiving obstetric and gynecologic services during the perinatal period and postpartum period?" This question was used to explore actual experiences that the study participants encountered as they presented and received medical care during and after pregnancy. Further exploration of participants' OB/GYN experiences occurred by seeking responses to RQ2. RQ2 was, "What are African American women's lived experiences of obstetricians' and gynecologists' responses to their presenting concerns during OB/GYN visits in Atlanta, Georgia?" A total of 21 interview questions were developed and discussed with 14 participants to collect data that would provide insight into the research questions. Eleven questions were discussed with women who were pregnant, and 10 questions were asked of women who had an infant under the age of one.

In this chapter, I provide details of the research and the study results. These details include information on the study setting, participant demographics, data collection, and the data analysis process. Evidence of the research study's trustworthiness is discussed, including credibility, transferability, dependability, and confirmability. followed by a summary of the chapter.

Setting

Informed consent was obtained from each participant prior to scheduling an interview. This was done using the Survey Monkey tool along with obtaining email and phone contact information. Using an automated self-scheduling process through the Calendly app, participants were sent a link via email and a text message that allowed them to autonomously schedule the interview at a time and date most convenient for their schedule. I sent out reminders via email or text message one day before the interview. Participants that were not on Zoom after 10 minutes of their scheduled time, were called to inquire if they were still available or needed to reschedule. Most participants continued to participate in the interview and had simply forgotten or were running behind schedule prior to my phone call.

Participant semi-structured interviews were conducted virtually using the Zoom platform with audio and nonvideo calls. I was the sole interviewer. Interview questions were asked in accordance with the interviewer's guide approved by Walden University's IRB prior to the commencement of the research (See Appendix B). Participants called via telephone at a time that they previously selected using a link to my calendar. They called from various settings including their homes or outside. Participants were made aware that calls were being recorded for documentation and transcription purposes, and they agreed to be recorded. All participants were African American women or had a partial identity of African American. They had stressors that they were dealing with daily by virtue of being or perceived as Black/African American in America. Research has shown that Black women report higher levels of stress due to racism and discrimination (Chambers et. al.,

2020; James et al., 2023). Interviews started with a brief conversation on where participants received care to enhance the bonding process by making connections with the participants. Participants were reminded that the interview was confidential, and they were free not to answer any questions that made them uncomfortable. Participant interviews were conversational, with the interview questions guiding the discussion.

Demographics

Survey Monkey was used as a screening tool to ensure that participants who met the selection criteria outlined in Chapter 3 were offered the opportunity to be interviewed. Informed consent to participate in the research study was also obtained via Survey Monkey. Participants in my study all lived in the Atlanta, Georgia, metropolitan area and were African American women ages 18-45 who were either pregnant or had delivered a live birth within the past 12 months. Each woman interviewed (93%) reported receiving prenatal care in Georgia. One participant (7%) was currently seeking prenatal care as she had recently found out that she was pregnant. There were no educational or income restrictions in the selection criteria. Women interviewed reported a mix of insurance, secondary insurance, Medicaid, and being uninsured. Some women reported that they were college graduates with professional and graduate degrees. The research study was targeted to women with the following demographical characteristics: women who self-identified all or in part as African American or Black, ages 18 - 45 years old, pregnant, or had a child under the age of one.

Data Collection

Data collection took place within the metropolitan areas of Atlanta, Georgia, and via social media using the Survey Monkey online tool during the months of June and July 2024. This commenced after approval from Walden University's IRB - approval # 05-01-24-0746472. There were 21 women who took the survey, and 19 (90.4%) of the survey participants met the study criteria. Fourteen (74%) of eligible participants agreed to and followed through with the interview. Interviews were conducted via Zoom audio conference calls. These calls were recorded and transcribed using the Zoom transcription services. Participants self-identified as African American, with one participant identifying as both African American and Latino. Of the 14 participants that were interviewed, 64% ($n = 9$), were postpartum with infants under the age of one.

Participation was divided into two stages. Stage 1 involved the administration of screening questions included in a short survey to assess the eligibility of interested participants. I developed the survey questions on Survey Monkey. Both a QR Code and a link were made available via social media platforms, including Instagram, Facebook, Threads, TikTok, and LinkedIn. I also developed printed postcards that IRB approved. Electronic versions of the postcard were displayed on social media platforms and sent to colleagues as an email attachment (See Appendix C).

Question 5 of the survey included the consent form explaining the study procedures and resources. Informed consent was obtained via the survey by indicating yes or no. Once consent was indicated, contact information was also obtained via the survey, and the link to schedule an interview was sent to the participant. Upon selection

of a scheduled time by the participant, an automated Zoom link was sent to the participant's email. Text and email reminders were also sent to participants prior to the scheduled interview time.

Participants called into the Zoom line by phone or logged in via mobile phone using the Zoom login information sent to them after completing the survey and consenting to participate. I reminded participants of the voluntary nature of the study and that they could decline to answer any question that they were uncomfortable discussing. Participants were also notified when the recording started. All participants were given the opportunity to share additional information related to their experiences.

Discrepant Surveys

As data collection was nearing completion, I noticed a large influx of surveys being entered into the Survey Monkey application. I also observed that several of the surveys were completed within minutes apart. The survey number increased from 21 to 167 within a 3-day time period. I carefully reviewed each survey and noticed that there were multiple duplicate IP addresses. Also, several phone numbers entered on the surveys were incomplete. I carefully vetted these suspected fake survey entries to determine their authenticity. Each survey participant who qualified for the study received instructions to click on a link directing them to Calendly and schedule their interview with the researcher. Calendly, an interview appointment scheduling tool captured the IP addresses and the geographic location of the individual selecting the interview. Further investigation revealed that fake surveys were coming from an IP address outside of the United States. The geographic locations for all of the fake surveys, after survey number

21, were from West Africa. Based on this information, surveys numbered 22 and above were eliminated from the study. Due to the reasons outlined above, these were believed to be fake surveys. Upon reviewing one of the 14 interviews, the transcript for participant EXPR0020 was not used as the validity of the interview was in question. It also appeared to be a fake survey that should have been excluded, as the responses were questionable. The participant gave very vague answers and, after the interview, expressed extreme interest in receiving the gift card.

Data Analysis

After using Zoom to convert the audio recording to transcripts, I also used Adobe to convert the PDF documents to Word documents so that that data could be de-identified. This was done using the replace and find functionality of Microsoft Word. Participants' names were replaced with their assigned Expressions Study ID. Expressions Study IDs were assigned to each participant as they were enrolled in the study by entering their first name and the initial of their last name on an Excel spreadsheet next to a prefilled number (e.g., EXPR0022, EXPR0023). The last two digits of the Expressions Study ID replaced a participant's name when statements were quoted (e.g., Participant 22, Participant 23). Transcripts were saved in a specific secure file to be accessed as needed. I reviewed each transcript to get a general idea of common themes. Transcripts were also uploaded to the qualitative software MAXQDA to assist with data analysis. Based on the categories, codes were established and placed in a codebook in MAXQDA.

The IPA approach was implemented to analyze the study data. The first stage included a three-step process used to apply the IPA method. This included the initial

coding process, the summary process, and the extrapolation of the meaning of the data. The IPA method allows the researcher to immerse themselves into the experience of the participants in an effort to fully understand their lived experiences (Smith, 2017). This methodology required the researcher to recall their own experiences and put themselves in the shoes of the participant (Smith, 2017). The following steps were executed in the data analysis of this study.

Stage 1: Initial Coding and Categorization

Throughout the analysis process, I maintained self-awareness of my experiences with OB/GYN services while ensuring that I viewed the data through the participant's lived experiences. Using the inaugural codebook categories, codes were developed in the software MAXQDA. Each transcription was reviewed, and descriptive codes were assigned to text sections based on the description ($N=13$). One record was not used as I was unsure of the validity of the interview based on the answers. A preliminary codebook was developed based on the interview questions. Specific colors were used to represent coded areas. Codes included the major categories as follows: pregnancy complications, positive pregnancy experiences, positive postpartum care, provider implicit bias, racism, and everyday stressors (See Table 1). After reviewing the transcripts in three cycles, each time gaining clarity on the context of each response, I updated the codebook and assigned the most appropriate code to participant statements via coding nodes in MAXQDA. Subcategories were created and grouped under the major category headings. In instances where none of the codes fit the data, a new code was created and added to the codebook. Descriptions of the new codes were written within MAXQDA to ensure clarity on the

meaning of each code. After completing the initial IPA and coding, I moved to Stage 2 of coding.

Stage 2: Coding Summary Process

Upon completion of coding the transcripts ($N=13$), summaries were created from the coded narratives of participants' lived experiences receiving OB/GYN services. During Stage 2, coded selections were arranged into a grid view using the MAXQDA software. Coded sections were reviewed, and short summaries were written for each coded area. Codes and subcodes included the following: positive pregnancy experiences, with the subcodes of being treated well by the provider, nontraditional birth, being pleased with appointments, positive postpartum care, having support during pregnancy, and adhering to prenatal care. Another major category was provider implicit bias which included subcategories of dismissive responses by the doctor, concerns not being heard by the doctor, provider discomfort, and provider unfamiliar with mental health issues. The category of felt heard by the doctor and staff contained the subcategories of felt heard by another doctor or medical professional, referrals made based on concerns, doctor provided education on conditions, and willingness to share concerns with doctor and staff. The other major categories included racism and everyday stress, uncomfortable sharing concerns, selective about a provider, and concerned about statistics. The final category derived from the interview questions and responses was ways to improve healthcare, which included a subcategory of barriers to care stressors. These categories (codes) were analyzed and summarized initially within the context of implicit bias and

systemic racism, then proceeded by summarizing the remaining codes (i.e., positive pregnancy experiences). See Table 2.

Table 2*Codebook*

Category	Code	Code Color
Positive pregnancy experiences	Treated well by the provider	Purple
	Pleased with appointments	
	Positive past-partum care	
	Had support during pregnancy	
Implicit bias	Dismissive responses by the doctor	Red
	Concerns not being heard	
	Provider unfamiliar with mental health issues	
Felt heard by the doctor and staff	Felt heard by another doctor or medical professional	Green
	Referrals made based on concerns	
	Doctor provided education on conditions	
	Willingness to share concerns with the doctor and staff	
Racism and everyday stressors	Racism and everyday stressors	Orange
Uncomfortable sharing concerns	Uncomfortable sharing concerns	Light orange
Concerned about statistics	Concerned about statistics	Orange
Ways to improve health care	Ways to improve health care	Blue

Note. Final codebook, categories, codes, and code colors used in the IPA data analysis.

Stage 3: Summarization and Themes

The final stage of data coding and analysis involved a careful review of the summaries and extrapolating the main and concise meaning that captured the essence of the statements. Alase (2017) emphasized that this is the most important stage of the IPA coding process. This process allowed me to break statements down to the core meaning of the participant's lived experiences. A compilation of statements from participants reflecting their lived experiences was grouped and placed in a table. Then, categories or coded areas were labeled, and categories or coded areas were grouped into statements. This step allowed me to understand the experience of the participants. Creswell (2012) pointed out that this phase of the IPA presents a textual response of the data. In addition, I used MAXQDA to create a code matrix and a segment matrix. This tool provided a visual picture and quantified patient statements by category. This stage of the IPA data approach allowed me to narrow down prevalent themes reflecting the lived experiences of African American women receiving OB/GYN services in Atlanta, Georgia. This information was used to write what Smith (2017) called the long paragraph or a contextual representation of participants' lived experiences. The summary is discussed in the results section of this chapter. Study results showed that there were variations in how women felt they were treated. While some participants felt heard and treated well by the provider, other participants did not feel heard, felt that their concerns were dismissed by the doctor, and felt that they were not treated with value. More details are discussed in the results section.

Evidence of Trustworthiness

Internal and external validity are significant components of a research study and contribute to and measure the quality of a phenomenological study (Peterson, 2019; Andrade, 2018). The quality of the IPA research is paramount to the validity of the research methods (Alase, 2017). Methodologies were applied to this study to ensure trustworthiness. This included the selection process of participants to ensure that the lived experiences were captured. The researcher connected with individuals such as midwives, patient navigators, and maternal and child health advocates to share information via postcards and flyers to invite women to take the survey who had a high probability of meeting the survey criteria. This contributed to the quality of the study, resulting in a high probability of receiving surveyed participants who met the study criteria. This approach resulted in 90.4% ($n=19$) of those who took the survey ($N=21$) meeting the inclusion criteria.

Credibility

The interpretative phenomenological analysis approach (IPA) was implemented in this research study. Alase (2017) pointed out that ensuring quality using the IPA process begins with the selection of participants. This was done using the Survey Monkey screening tool. The use of the Survey Monkey screening tool helped to ensure that participants met the study criteria. The data summary tables with de-identified data were viewed by a colleague and subject matter expert in the field of maternal and child health for feedback on themes. Also, throughout the data collection and data analysis process, I maintained a constant awareness of potential bias by self-reflection on personal

experiences with OB/GYN services during the pregnancy and postpartum period.

Screening and interviews were the data collection methods used.

Transferability

I developed a detailed step-by-step interview guide with protocols that were used in conducting each interview. The guide included specific questions that were used to execute an in-depth discussion with each participant. Researchers must be thorough in collecting the data during the IPA approach to contribute to the quality and validity of the process (Alase, 2017). Probing questions were used to take discussions to a deeper level while bonding with the participants through their lived experiences. During the interview phase, I occasionally would share a small amount of my experiences when it coincided with what the participant was sharing as her own experience. This enabled a bonding process that was an integral component of the IPA approach. Personal sharing would occur only after the participant shared her experience. In my role as the researcher, I reflected on my own experiences with prenatal and postpartum care services. This self-awareness allowed me to avoid interjecting my own experience when conducting the analysis and focus solely on the women's experiences. Direct quotes from participants were used to determine prevalent themes reflecting participants' lived experiences. Quotations were extracted from transcripts using the MAXQDA software to conduct a detailed analysis of the narratives as I discovered reoccurring themes from their experiences.

Dependability

A shift from the triangulation sources mentioned in the research proposal took place. Photovoice was eliminated as a data collection method. Surveys were used as screening tools. Instead, I employed semi-structured interviews, transcript reviews, and narrative summarization. Data triangulation included reviewing the data in each transcript for key phrases and quotes that reflected lived experiences, using MAXQDA to code each transcript with categories derived from the transcript narrative, and summarizing each coded area and each transcript to capture a concise theme reflected in the participant's experience. The interviewer's guide was followed closely with some variation based on the direction of the discussion. Probing questions were used to gain more details when participants gave concise responses.

Confirmability

Peterson (2019) pointed out that the researcher must consistently evaluate the process to safeguard the interjection of bias. Smith (2022) explained that during the IPA process the researcher must see the phenomenon through the lens of the participant. Each interview was valued as a specific lived experience of the participant. I meticulously engaged with the woman and heard her story. During the data analysis, each transcript was analyzed separately, and quotes that reflected the essence of the lived experiences were extracted and used to form categories and themes.

Results

Interpretative Phenomenological Analysis of the narratives from the interviews revealed several themes reflecting the lived experiences of African American women

receiving OB/GYN services in Atlanta, Georgia. Themes surrounding racism and everyday stress, provider dismissiveness, provider implicit bias, and not feeling heard emerged. Positive pregnancy and postpartum care experiences also emerged. Following is a discussion of these themes and relationships to the research questions with quotes that demonstrate the lived experiences of African American women as they sought and received services. The research study posed two questions at the commencement of exploring the lived experiences of African American women with OB/GYN services in Atlanta, GA. Following is a discussion of emerging themes related to each research question.

Emerging Themes and Research Question One

RQ1: What are the lived experiences of African American women in Atlanta, Georgia, receiving obstetric and gynecologic services during the perinatal period and postpartum period?

There were two emerging themes that addressed the lived experiences of African American women in Atlanta, Georgia, receiving obstetric and gynecologic services during the perinatal and postpartum period. This included positive pregnancy experiences along with racism and everyday stressors. At least one positive pregnancy experience was mentioned by 100% ($N=13$) of the women interviewed. In contrast, racism and everyday stressors were also experienced by 69% ($n=9$) of the women interviewed. Sixty-nine percent of participants reported experiencing a mixture of positive pregnancy experiences along with racism and everyday stressors. These themes are explained below.

Theme 1: Positive Pregnancy Experiences

All participants reported at least one positive prenatal or postpartum experience (See Table 1). Patients who reported positive prenatal and postpartum experiences ($N=13$) were seen by providers from the same ethnic group, African American, or services were provided at facilities associated with a historically Black university, or the participant worked in the healthcare field. Women reported short wait times to see the doctor, being treated kindly in a family-oriented atmosphere, and receiving information and resource referrals (See Table 2). Participant 23 expressed the following sentiments about her doctor and the medical staff.

So, they would definitely make me feel at home. I really do appreciate them. They 're better than my old doctor, I can say, cause to go to [deleted]... With this doctor, I am able to like schedule. I like how it is convenient, like I am able to schedule my ultrasound and my OB appointment in the same place. When I had my son, I was with [deleted]. It was like going to 3 different appointments all over the Atlanta Metro area. Nobody was like on one accord. If that makes sense, like, oh, they know that you send her over there to do x, y, and z. I feel like this doctor's office, it's like they are more together, organized, and everybody knows what's going on with me.

Table 3*Coded Positive Pregnancy Experiences Among African American Women*

Category	Code	<i>n</i> = 9	Participant
Positive pregnancy experience		9	6, 7, 9, 11, 12, 13, 15, 16, 23
	Pleased with appointments	1	16
	Felt supported	1	16
	Felt heard by provider	7	6, 7, 12, 13, 16, 15
	Treated well by the provider	6	6, 7, 12, 13, 15, 16, 23
	Referrals made based on concerns	4	6, 7, 15, 16
	Positive postpartum	4	7, 9, 11, 12

Note. This table shows categories and codes that captured positive pregnancy experiences from participant interviews.

Table 4*Quotes by Participants with Positive Pregnancy Experiences*

Categories	Codes	Quotations	Participants
Positive pregnancy experiences	Pleased with appointments	“They check and make sure that I’m okay, and if I need anything.”	#16
Positive pregnancy experiences	Felt supported	“I had patient navigators, and I had a lot of different things now that I didn’t have at first, and it’s a lot of help.”	#16
Positive pregnancy experiences	Felt heard by the doctor and staff	“I felt that she took them[my concerns] seriously, and then she reassured me about things that I was anxious about.”	#6
Positive pregnancy experiences	Treated well by the provider	“They were great. Overall, they were great. I feel like they gave me a lot of opportunities to have informed consent, and they did help me figure out how to apply for Medicaid so I could get everything covered fully, which was amazing.”	#12
Positive pregnancy experiences	Referrals made based on concerns	“They’ve offered me grief counseling.”	#15
Positive pregnancy experiences	Positive postpartum	“I feel like my experience was pretty good overall. My doctors were pretty much on top of my care.”	#7

Theme 2: Racism and Everyday Stressors

Systemic racism, a term coined by Joe Feagin (2006), includes efforts used by institutions like the healthcare system by those in positions of power to keep a group of individuals in a subordinate position. There were 71 coded references to racism and

everyday stress during the interviews. Racism was the most coded theme from the transcripts (See Figure 4). Women reported high levels of daily stressors and racism that occurred during their prenatal and postpartum care experiences. Women also reported not being treated well by their providers (See Table 3). One expectant mother (Participant 15) shared that her older son had been killed during her pregnancy, and she was dealing with the loss while trying to maintain her health and mental health during this pregnancy.

Participant 17 shared her experience of how provider bias and a lack of training in dealing with mental health issues contributed to the discriminatory treatment of her partner during pregnancy. The provider expressed concerns about the participant delivering at their hospital due to staff fearing her partner, a Black man with mental health challenges. She explained, “The staff told the expectant mother, “We don't know if it would be safe for you to have the baby here. So we would just rather you transfer your care to a hospital.” Women also reported experiences of racism (See Tables 3 and 4). Participant 9 stated, “I think that it kind of boiled down to medical professionals not viewing Black women the same in terms of their pain, tolerance, and levels of what they can tolerate, and how they feel.” African American women ($n=3$) reported that they were not taken seriously regarding their mental health. Participant 9 shared her experience when returning to her postpartum appointment. When conducting the depression screening, the provider did not give her a chance to express her feelings. The provider asked her, “You're not feeling depressed, or anything are you? Like I mean you look great. You look great, sound great. I mean you just look good. So, you are good.” Women expressed that their mental health needs were dismissed. She also asked her doctor to

approve an extended time off for maternity leave. She stated, “He came back around. He was like, oh, well, he says, you know you look fine, so medically, there's no reason for you to still be off.” Participant 6 also felt similar and expressed her feelings of experiencing provider implicit bias, “When I had the urgent care incident, you know where, and I won't say that he was trying to disregard me, but it was just very much like, you didn't even test anything. You didn't ask me any questions, you know, so now was that bias? I don't know. I don't know the man, but I know he irritated me. He heard me, and stressed me out for no reason.”

Stressors

These experiences were compounded by every stressors experienced by African American women. One mother was dealing with the loss of her older son while pregnant. Participant 15 shared that she had to continue adhering to prenatal care while dealing with loss. “At the end of the day, I have no choice but to get up and still go to work and maintain my household. So, it's like, how do you really grieve?... There was one conversation that you are never prepared for; it is a possibility you can bury your child. So, that's something you just have to deal with. Like I said, I'm okay, but I have my moments.” Social determinants of health contributed to the stress experienced by the women in this study. Participant 23 described how the doctor gave her resources and assigned a doula for support to help her cope with depression and stress, “ She gave me a Doula, as far as me like, you know, going through depression and stuff like that. But I'm going through a home-like, you know, my house is falling apart, and I'm due any moment, and my kid gotta go back to school. I'm just very stressed.”

These experiences left women feeling frustrated and devalued. Participants reported the need for self-advocacy in an effort to get providers to take them seriously and address their concerns. Participant 17 shared that she felt she had to advocate for herself to receive the services she and her baby needed. She expressed the following. “Don’t be afraid to speak up for yourself, and don’t be scared to go through multiple channels to get what you want, because I guarantee if 5 doctors say yes, there’s gonna be one that gonna I mean if I say no, they gonna be one that gonna look at you and tell you yes.”

Stress caused by perceptions of implicit bias from the provider and systemic racism was experienced by women who reported negative experiences. Two participants mentioned that they experienced anxiety attacks due to provider treatment. Participant 12 shared, “I had a full anxiety attack and had to stay in their office longer.” This occurred after the medical staff told her she should deliver at another hospital due to their concerns about her partner - a Black man. Participant 14 mentioned that the way the medical staff treated her and her concerns over the medical cost resulted in anxiety and elevated blood pressure levels. “...Almost 3 months on blood pressure medication, in the end, my primary doctor, he arrived at the conclusion that I did not have high blood pressure, that it was anxiety.”

Table 5

Coded Racism and Everyday Stressors Experienced by African American Women

Categories/codes	<i>n</i> =8	Participants
Racism and everyday stress	8	6, 9, 12, 15, 17, 18, 22, 23
Not treated well by the provider	7	6, 12, 14, 15, 18, 22, 23
Stressed	6	6, 12, 14, 15, 18, 22

Table 6*Additional Quotes by Participants Experiencing Racism and Everyday Stressors*

Category	Codes	Quotations	Participants
Racism and every day Stressors	Not treated well by the Provider	“ They didn’t have any OBs available when I called [Hospital A], and I was just so irritated by her [nurse] nasty attitude.”	#18
Racism and every day Stressors	Not treated well by the Provider	“...A lady gave me attitude, and it was just like they sent my paperwork over there [doctor’s office] already for me to get my labs. She pretty much forced me to go back to get the same paperwork again.”	#15
Racism and everyday Stressors	Stressed/financial stress	“ I could not afford them [doctor] until I got secondary insurance...It was a huge barrier in my pregnancy “ I had a full anxiety attack and had to stay longer [during the office visit] because I couldn’t breathe.”	#12
Racism and everyday Stressors	Stressed/financial stress	“I felt uncomfortable because each exam that they did they charged me \$2,000.”	#14

Emerging Themes and Research Question Two

RQ2: What are African American women's lived experiences of obstetricians' and gynecologists' responses to their presenting concerns during OB/GYN visits in Atlanta, Georgia? Emerging themes of provider dismissiveness and not feeling heard, along with provider implicit bias, addressed research question two. Women expressed that their concerns were not heard by providers, and they were treated as though their questions were not important or valid. Their experiences reflected instances of concerns not being taken seriously.

Theme 3: Provider Dismissiveness and Implicit Bias

Women shared that they did not feel valued by providers. This appeared evident when providers would call them by the wrong name or did not know their names. Participant 23 stated, "You know what I'm saying like they didn't even know my name. They didn't know, like I have to tell them every time." A few women expressed that they did not feel that the doctor heard their concerns during pregnancy. Participant 17 shared, "I feel like I was just thrown off to the next available person who they had there, and she was so dismissive. She did not care to really listen to my concerns." Providers would not address their concerns or dismissed concerns as experiences that should be expected during pregnancy. Another Participant, 9, expressed her provider's dismissive responses as follows, "Anytime I brought up any concerns, it was always I felt dismissed in terms of oh, that's normal, that's regular. But then I couldn't get an explanation as to why it was normal or like what was causing me [discomfort]." Participant 12 shared, "I felt uncomfortable because of how dismissive she was." Women also reported responses and

reactions from providers that they felt were a revelation of implicit bias from the provider (See Table 6). Women shared that providers were dismissive based on the type of insurance they accepted. Participant 18 shared “I’ve tried to reach out several times to different OBs in different places where I thought I could go, and I haven’t actually been able to get any response. I’ve been denied due to my insurance.” Participant 17 reported that providers were more concerned about the type of insurance coverage than hearing her concerns and providing services. She stated, “So it was [like] she was more so worried about what type of insurance I carried. You’ve got to work on your own, like predispositions about those people, but they’ve got to work on their stereotypes and their prejudice.” Participants were aware that the treatment by their doctors revealed implicit biases toward African American women. Participant 17 pointed this out in the following statement, “When a patient tells you that something’s wrong, they feel like something is wrong. People should believe them.”

Table 7

Coded Provider Dismissiveness and Implicit Bias Responses

Categories/codes	<i>n</i> = 7	Participants
Provider implicit bias	7	6, 9, 12, 17, 18, 22, 23
Concerns not heard by the doctor	4	6, 17, 18, 22, 23
Dismissive responses by the doctor	4	9, 17, 18, 22
Unfamiliar with mental health issues	2	9, 12

Table 8*Quotes by Participants Experiencing Provider Dismissiveness and Implicit Bias*

Categories	Codes	Quotations	Participants
Provider dismissiveness	Concerns not heard by the doctor	“I feel like I was just thrown off to the next available person who they had there, and she was so dismissive.”	#17
Provider dismissiveness	Concerns not heard by the doctor	“...She was older, so she was kind like straight to the point, like no real type of sympathy [empathy].”	#22
Provider dismissiveness	Dismissive responses by the doctor	“I call. I leave voice mails. It doesn't seem like there's any urgency to respond at all.”	#18
Provider dismissiveness Provider implicit bias	Unfamiliar with mental health issues	”You're not feeling depressed, or anything. Are you like. I mean, you look great. You look great, sound great.”	#9
Provider implicit bias	Unfamiliar with mental health issues	“They told me they had safety concerns. We don't know if we would need to call security on him. So we would just rather you transfer your care to a hospital.”	#12

Contextualized Lived Experiences within Racism and Implicit Bias

Experiences shared by participants showed a clear intersection of systemic racism coupled with provider implicit biases. Although many participants reported positive experiences while receiving OB/GYN services, prenatal and postpartum care was coupled with additional experiences of implicit bias on the part of the providers demonstrated by dismissiveness towards women's concerns (See Figure 1). Sixty-nine percent of participants shared that they experienced both feeling heard at times along with dismissed concerns and requests. These experiences motivated women to advocate for themselves in order to receive improved services. As evidenced by their experiences, (See Tables 4 and 6) women experienced both positive and negative treatment during OB/GYN serviced in Atlanta Georgia. Recommendations for improvement were provided by the women in response to their lived experiences when seeking OB/GYN services.

Figure 1*Contextualized African American Women's Lived Experiences*

Note. This figure demonstrates the intersectionality of systemic racism and perceived provider implicit bias in the lived experiences of AA women.

Figure 2

Thematic Word Cloud of African American Women's Lived Experiences



Summary

Fourteen participants were interviewed and shared their lived experiences with OB/GYN services in Atlanta, Georgia. One “participant” was excluded from the data analysis due to a suspected false interview. The name of the provider she mentioned prior to the start of the interview does not exist. Thirteen transcripts were analyzed using the interpretative phenomenological analysis approach (IPA). Multiple stages of the analysis revealed three major themes representing the lived experiences of African American

women in Atlanta as they received OB/GYN services. RQ1, “What are the lived experiences of African American women in Atlanta, Georgia receiving obstetric and gynecologic services during the perinatal period and postpartum period?”, was answered by the description of two major themes. These themes included positive pregnancy experiences, and racism and everyday stressors. They demonstrate a mix of positive and negative experiences among women receiving services. While 13 participants (100%) experienced at least one positive prenatal or postpartum care service, 9 (69 %) also shared experiences of racism and perceived implicit biases from providers and staff. (See Appendix D)

Insight into RQ2, “What are African American women’s lived experiences of obstetricians’ and gynecologists’ responses to their presenting concerns during OB/GYN visits in Atlanta, Georgia, was gained from the third theme of provider dismissiveness and implicit bias. Women shared numerous stories of asking providers questions that were dismissed, including requesting additional leave time from work to spend with their baby and refusing to support additional parental leave time, stating, “You look well” (Participant 12). These experiences exacerbated the women’s stress levels that were previously elevated by their daily lived experiences with systemic racism.

Recommendations were made by the women interviewed on improvements to OB/GYN care in Atlanta, Georgia (See Table 7). This will be discussed further in Chapter 5. Chapter 5 provides further details and interpretations of the findings of this study, limitations, and recommendations for OB/GYN practice, along with the implications for social change. The study conclusion is detailed in the following chapter.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to explore the lived experiences of African American women in Atlanta, Georgia, receiving OB /GYN services and presenting for perinatal and postpartum care. This closely aligned with efforts to improve maternal health services and outcomes in Georgia and the United States. Georgia has Perinatal Quality Improvement Collaboratives reviewing ways to improve health services for women seeking prenatal and postpartum care. The White House (2022) set outcome goals aimed at improving services and outcomes for women during the prenatal and postpartum periods. The implementation of these statewide and national efforts to improve services and reduce maternal mortality construct an ideal environment to explore the experiences of African American women seeking care.

Key Findings

While some women reported being treated well, with concerns being heard by their providers and feeling comfortable discussing concerns, others felt unequal treatment and implicit bias. Women who expressed positive experiences were treated by African American physicians or by physicians working at facilities affiliated with a historically Black college university school of medicine. These women expressed feeling heard by the provider, receiving patient education, resources, support (doulas), and feeling valued. All women interviewed reported at least one positive prenatal or postpartum experience while receiving OB/GYN services; However, 69 % of these women also shared experiences of racism, stress, and perceptions of provider implicit biases coupled with

dismissiveness. Providers were dismissive, unwilling to listen to their concerns, and were more concerned about payment and insurance coverage.

Women offered several recommendations regarding how to improve healthcare services for patients seeking OB/GYN services for prenatal and postpartum care. They stated that physicians should listen to their patients and realize that they know their bodies better than anyone else. Participants shared that physicians and medical staff should provide more resources to help mothers prepare for the birth of their baby (i.e., doula services) and supportive education after the birth of the baby (i.e., breastfeeding). Table 9 outlines recommendations from the women interviewed on how to improve their experiences.

Table 9

Recommendations to Improve OB/GYN Services

Recommendations	Area	Participant
[Women] “Listen to yourself, and trust your instincts [intuition].”	Self-advocacy	#17
[Doctors] “You’ve got to work on your own like predispositions about those people.”	Implicit biases	#12
“Not all women are the same, and everybody cannot tolerate or are not strong enough to endure certain things throughout pregnancy.”	Mental health awareness	#17
“I think they need to educate a little more on certain things. I think there should be [more education] as far as the younger community.	Patient education	#15
“I did do a birthing class through my provider.”	Patient education	#9
“Having a doula is important.”	Resources and support	#9

Interpretation of Findings

These study findings were consistent with previous studies, which included African American and Latino participants. Thomas (2022) examined the treatment of African American or Black women who presented for prenatal care. Study results revealed that African American women and LatinX women whom providers perceived to be African American experienced biased treatment and discrimination. James et al. (2023) conducted a secondary analysis of African American women surveyed in California and found that women also reported not feeling heard and experiencing discrimination from providers. Previous research included participants with low-income coverage (Gillespie & Weeks, 2021; James et al., 2023; Thomas, 2022). The current research study, Expressions, included women covered by Medicaid and women across income and educational levels; however, the impact of racism, stressors, and biases were also experienced. This suggests that the facilitators of systemic racism in healthcare institutions posed by Feagin (2006) continue to permeate healthcare services. Perceptions of provider implicit bias were also consistent with previous studies (see James et al., 2023), with 69% of the women interviewed reporting incidences of not being heard, requests being denied, and provider dismissiveness.

Limitations of the Study

The initial proposal for this research study was submitted during the height of the COVID-19 pandemic in the United States. In-person interviews were prohibited due to the potential exposure and spread of infection. This limitation allowed me to explore the Zoom platform and phone calls to conduct study interviews. Also, the use of the Survey

Monkey tool to screen potentially eligible women presented a limitation. There were no external controls on survey participants who may have entered false information to qualify for the study and receive the participation incentive. This potential threat was negated by researching the IP addresses for duplication. Surveys with duplicate IP addresses were excluded. An additional limitation of this study was that the use of only telephone-based Zoom interviews did not allow me to see participants' body language and facial expressions. Video interviews would have provided further insight into the women's lived experiences. The final limitation was the small sample size ($N=13$). Due to funding limitations and human resource constraints, the sample size was small. This study should be replicated with a larger sample size with grant or sponsored funding to cover research and participation incentive costs.

Recommendations

Previous studies have recommended that women across various income levels be included in exploring lived experiences (Thomas, 2022). My study included a small sample of women with self-reported varying income levels and insurance coverage (i.e. private insurance payors, health maintenance organizations, and Medicaid). It is recommended that a similar study be conducted with a more significant number of participants. It would also be advantageous to survey OB/GYNs to measure the degree of implicit bias that exists toward patients who are people of color. Participants identified several areas of improvement, as listed in Table 9. This included respectful maternal care, listening to patient concerns, providing support resources for mothers postpartum, and patient education. The prevalent recommendation that emerged was the need for doctors

to hear their concerns and take these concerns seriously by acting on them. The women expressed the need to be heard. This included their mental health and emotional support needs along with their physical and new parent concerns. Women felt that they needed to be taught how to advocate for services to ensure that they were heard.

Implications: Positive Social Change

This study has direct implications for positive social change in African American communities. Insights gained from the interviews provide a foundation for creating policies and protocols that could reinforce the need for increased practices of respectful maternal care. There is also the need to address provider implicit bias through training of current medical residents and practicing OB/GYN physicians. The implementation of culturally sensitive changes in practice may increase the likelihood of women's concerns being heard and addressed, enhancing the opportunity to decrease instances of adverse maternal outcomes due to not treating the patient in a timely manner. A reduction in adverse maternal outcomes may result in children with mothers in their lives, helping nurture and care for them. This social change may have a ripple effect, with the replication of best practices throughout the state of Georgia and the United States resulting in positive outcomes and decreased maternal mortality rates.

Conclusion

The problem of adverse maternal outcomes and increasing maternal mortality rates can be addressed through positive changes and consistent practices in OB/GYN services. Studies such as this continue to reveal that additional work must be done in this area to impact change. Obtaining first-hand information regarding healthcare experiences

from patients can be beneficial when planning quality improvement initiatives and developing policies (White House, 2022). Implementing suggestions by patients and creating policies that address areas of need have the potential to change the narrative on maternal health outcomes through the delivery of improved services (White House, 2022). Allowing patients to share their stories and hearing their concerns and suggestions can result in improvements in the quality of healthcare services for women during the prenatal and postpartum periods.

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Appendix A: Participant Screening Survey

***Invitation to Participate in the
“EXPRESSIONS” STUDY******Instructions***

Thank you for your interest in being a part of the “EXPRESSIONS” study. These questions will help determine if you are eligible to participate in this study. The study will explore African American women’s experiences with their doctors and medical staff when receiving healthcare services. Please answer the following questions.

Contact Information:

First Name:

Middle Initial:

Last Name:

Phone Number:

Email Address:

(1) Do you identify as African American, Black, or Afro-American? Yes/ No

(2) Are you between the ages of 18 -45 years old?

(3) Are you currently pregnant or have a baby under age one?

(4) Do you live in the Atlanta, Georgia area?

(5) PLEASE READ THE FOLLOWING CONSENT BEFORE ANSWERING THE

ADDITIONAL 4 QUESTIONS

EXPRESSIONS CONSENT FORM (Inserted)

(6) If you feel you understand the study and wish to volunteer, please indicate your consent by answering yes. After you complete the survey, I will send you an email with a link to my calendar to schedule a confidential interview. Do you consent (agree) to participate in this study? Yes/No

(7) Email Address: (You will be contacted at this email to schedule an interview)

(8) Please enter your first name and the initial of your last name: (Example: Audrey B.)

(9) Phone Number

Thanks for taking the time to complete this survey

Appendix B: “Expressions” Interview Guide

“EXPRESSIONS” INTERVIEW GUIDE

Audience: African American Women receiving health care services (Perinatal, and Postpartum Care)

Purpose:

- To gather feedback from women regarding to their experiences receiving Obstetric and Gynecologic (OB/GYN) services in Atlanta, Georgia.
- To explore the lived experiences of African American women in Atlanta, Georgia as they present for OB/GYN services.

Toolkit: What’s Included

Items	Quantity
Interviewer Script-Facilitator	1
Script-Note taker (If Available)	1
Consent forms	1

Instructions

1. Call the participant at the scheduled time. Be on Time!
2. Introduce yourself and maintain a smile in your voice. If this is a phone call, keep the tone friendly. If this is a video interview, keep a pleasant expression or appropriate expression as information is shared.
3. Review the informed consent document with the participant at the beginning of the session. Remind the participant that the session is voluntary, and they may choose to refrain from answering a question or choose to stop participating at any time during the session.
4. Ask additional probing questions where indicated and as needed for clarification.
5. Use a conversational tone when speaking with participants and asking questions.
6. Do not “overshare” when reinforcing similar experiences.
7. Select the correct set of interview questions based on the participant’s category as follows:
 - **Perinatal/Prenatal** (Participant is currently pregnant)
 - **Postpartum** (Participant has a baby and gave birth within the last 12 months)

Date	
Participant Number (i.e., EXPR001, EXPR002)	
Facilitator's Name	
Note Takers Name(s)	
Introduction of Interviewer and other team members if applicable.	<p>Hello, my name is _____. <i>This is _____.</i> <i>They will be supporting me by taking notes today.</i></p> <p>Thank you for agreeing to participate in the “EXPRESSIONS” study and giving me/us this opportunity to discuss your healthcare experiences. Today I want to talk about your experience seeking and receiving healthcare services from your obstetrician and/or gynecologists. The questions are all being asked within the context of systemic racism and implicit bias.</p> <p>Systemic Racism is a theory or thought that there are policies and institutions that keep subordinates or people not in positions of power, in a lower position.</p> <p>Implicit Biases are unconscious attitudes and beliefs about individuals based on their race.</p> <p>My role is to learn as much as I can from you about your experiences.</p> <p>I really appreciate your time and willingness to share your insights.</p>
Intro to interview	<p>This should take about 30 minutes or less than hour.</p> <p>I will ask several questions that were prepared in advance to guide our conversation, but feel free to bring up anything you think would be useful. You're the expert. I am here to learn from you. The interview will be recorded to help us remember what is said, and to capture the information. No identifiable information will be shared unless you give me permission.</p>
REVIEW THE INFORMED CONSENT DOCUMENT	<p>Let's take a minute to discuss informed consent and confidentiality. You have received and signed the informed consent statement. I would like to emphasize a few key points:</p> <ol style="list-style-type: none"> 1. This interview is completely voluntary. 2. While I would like to get responses to all questions, you have the right to decline to answer any question. 3. Everything discussed here is confidential.

	<p>4. This is a safe space to share your feelings and experiences</p> <p>Read the entire consent form as participants follow along.</p> <p>ASK If you Do Not have the consent form already: Did you have a chance to complete the electronic consent form?</p>
Questions	<p>Before I continue, do you have any questions?</p> <p>Are you ready to begin? <i>If no, answer any remaining questions or concerns.</i></p> <p>The virtual meeting will begin now.</p>

START SESSION RECORDING NOW

<p>INTERVIEW QUESTIONS</p> <p><i>Notes (do not read italicized notes aloud)</i></p>
<p>Perinatal/Prenatal (Participant is currently pregnant)</p>
<p><u>Introduction:</u> These questions will discuss your experience so far during</p> <ol style="list-style-type: none"> 1. Who are you receiving prenatal care services from? (Obstetrician, Family Doctor, Nurse Practitioner, Other: Please Specify) 2. Tell me about your experience making an appointment to see a doctor? PROBE: How were treated during the phone call to make the appointment? PROBE: How long did you have to wait for an appointment? 3. Tell me about your office visit experience. PROBE: Were you treated kindly? PROBE: Did you notice any difference in the way you were treated versus other patients of other races in the office? Please explain. 4. When you arrived at your appointment, please share what took place from the moment you entered the office until you were called to be seen. PROBE: How long did you wait to be seen/called to go to the exam room?

INTERVIEW QUESTIONS

Notes (do not read italicized notes aloud)

5. Did you feel comfortable or free to express any concerns about your health or mental health to the doctor?
PROBE: If yes, please explain.
PROBE: If no, please elaborate.
6. Tell me about your experience when you presented your concerns to the doctor or medical staff?
PROBE: Did you feel that your concerns were taken seriously? Please explain.
PROBE: How did the medical personnel make you feel when they responded to your question(s)?
PROBE: What are your perceptions of the doctor's attitude toward your concerns?
7. Tell me about your experience receiving referrals or resources to address your concerns from the doctor or medical staff.
PROBE: Did the doctor or medical staff clearly explain your options?
9. Did the doctor have any concerns about your health or mental health during the visit?
PROBE: Please elaborate
10. Overall, during your office visits, what are your perceptions of the way you are/were treated by the doctor and other office staff?
11. Is there anything else you would like to share regarding your experience with OB/GYN services?

Postpartum Care Services

(Participant has a baby and gave birth within the last 12 months)

INTERVIEW QUESTIONS

Notes (do not read italicized notes aloud)

Introduction: This set of questions will discuss your experiences within the last year. If at any time, you feel uncomfortable discussing anything, please feel free to say so. The information you share is safe and is very important to the research. Please feel free to be open about your answers and feelings.

1. Did you experience any complications during childbirth?
PROBE: If you feel comfortable, please explain. You do not have to share if you do not feel comfortable.
2. How long was it after your baby was born before you had a follow-up appointment with your doctor? (How many weeks)
3. Tell me about your experience during your first appointment after having your baby.
4. Did you feel comfortable or free to express any concerns about your health or mental health to the doctor or medical staff?
PROBE: If yes, please explain.
PROBE: If no, please elaborate.
5. Tell me about your experience when you presented your concerns to the doctor or medical staff?
PROBE: Did you feel that your concerns were taken seriously? Please explain.
PROBE: How did the medical personnel make you feel when they responded to your question(s)?
PROBE: Did you feel heard? Please explain.
PROBE: What are your perceptions of the doctor's attitude toward your concerns?
6. Did the doctor have any concerns about your health or mental health during the visit?
PROBE: Please elaborate
7. Tell me about your experience receiving referrals or resources to address your concerns from the doctor or medical staff.
PROBE: Did the doctor or medical staff clearly explain your options?

INTERVIEW QUESTIONS

Notes (do not read italicized notes aloud)

8. Overall, during your office visits, what are your perceptions of the way you are/were treated by the doctor and other office staff?
9. How are things going in your life in general since giving birth?

ADDITIONAL INFORMATION

10. Is there anything else you would like to share regarding your experience with OB/GYN services?

RECAP & CLOSE

Notes (do not read italicized notes aloud)

Thank you	Thank you for participating in the interview. Your answers will be used to provide insight into your experiences receiving OB/GYN care and will be helpful in understanding the maternal health crisis in our state. We have learned a great deal from you.
Re-explain confidentiality	As stated previously, everything we discussed today will be confidential.
Offer contact information	If you have any questions or concerns, please feel free to contact Audrey Blake via email at _____. If you are interested in knowing the results of the study, please email Audrey Blake @ _____.
Thank you	Once again, Thank you for your time and expertise,

STOP THE RECORDING

Appendix C: Recruitment Flyer

**“EXPRESSIONS”
Research
Study**

Exploring African American Women’s
Experiences with OB/GYN Doctors in
Atlanta, Georgia



Participants Needed

- Women ages 18–45
- Identify as African American
- Living in Atlanta ,GA Area
- Pregnant or,
- Has a baby under age 1


You will receive a **\$25 E-Gift Card** by email after the
interview.

**Please scan the QR Code with
your phone or copy the link
below & paste to search bar,
if you are interested in
participating.**




<https://www.surveymonkey.com/r/F67NPQ3>

Appendix D: Infographic—Lived Experiences Themes and Quotes



African American Women's Lived Experiences with OB/GYN Services in Atlanta, GA

Lived Experiences Themes and Quotes

Positive Pregnancy Experiences

"All of my [doctors] even my nurse is African, American. My previous like interactions with doctors. I was very shocked and pleased at the same time, because I'm like, Oh, wow! They really do care." (Participant #23)



Racism and Everyday Stress

(Referring to the death of her older son) "There is one conversation that you are never prepared for is the possibility that you can bury your child. That's just something I have to deal with." (Participant #15)



Feeling Dismissed by Providers

"..He Say , Oh well, You look fine, so medically there's no need for you to still be off." (Participant #9)



Provider Implicit Bias

" I just think it boiled down to medical professionals not viewing women the same in terms of pain tolerance and levels of what they can tolerate and how they feel." (Participant #9)

