Birth Stories: Pierce County African American Women Birth Experiences

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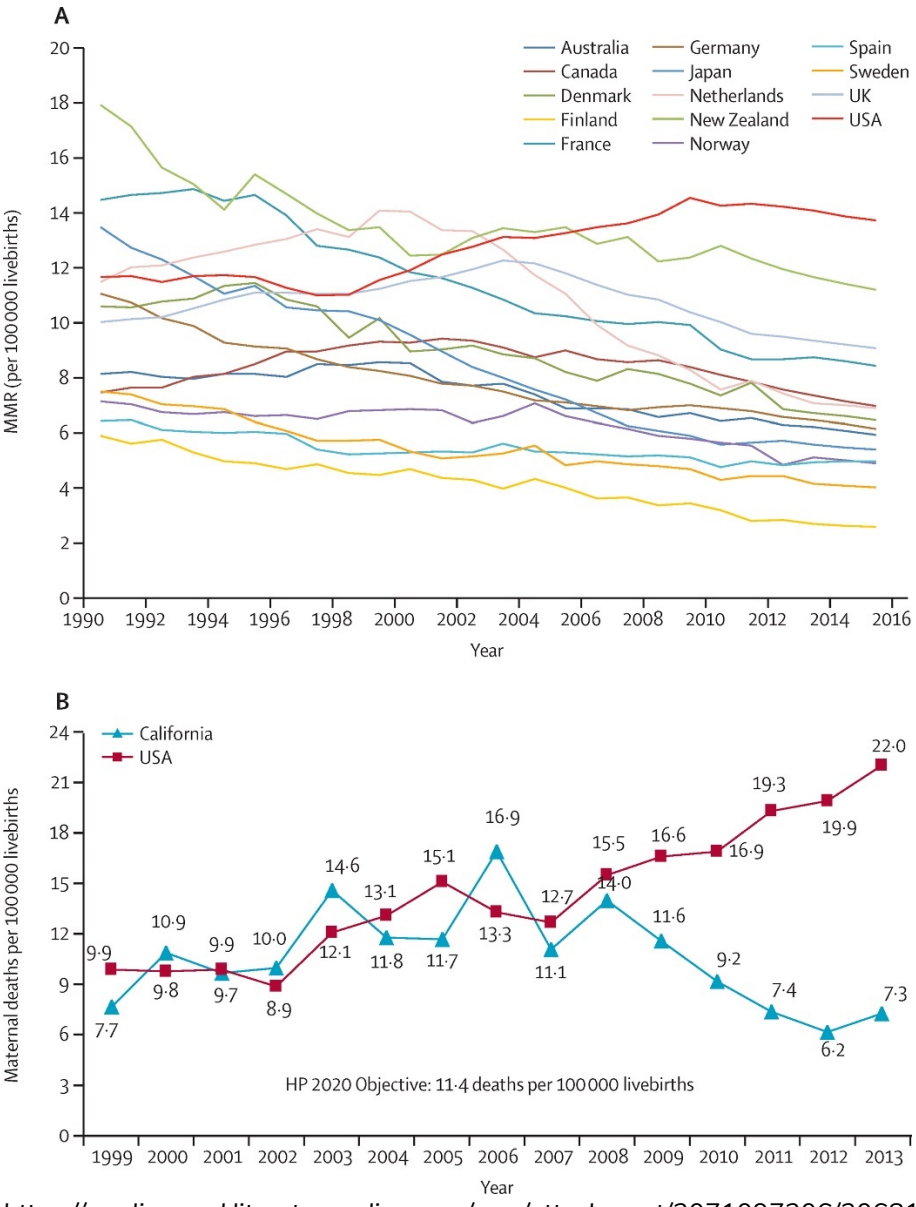
Executive Summary

Maternal mortality is higher in the United States than in any other industrialized, developed, high-income country. [1] This is due primarily to the disproportionately high rates of pregnancy-related deaths in black[1] women, which have for decades been 3-4 times higher than those of white women.[2]

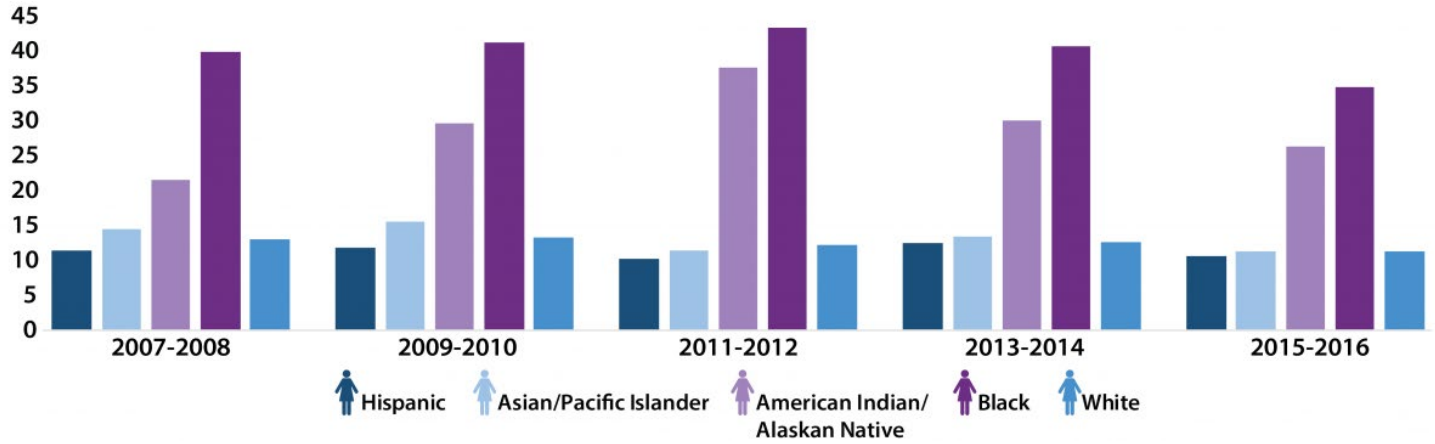
Maternal mortality comparison



https://marlin-prod.literatumonline.com/cms/attachment/2071097206/2068122518/gr1_lrg.jpg

[1] The labels **black** and **African American** can mean different things to different people. In this report, the term African American describes non-Hispanic black people who were born in the United States.

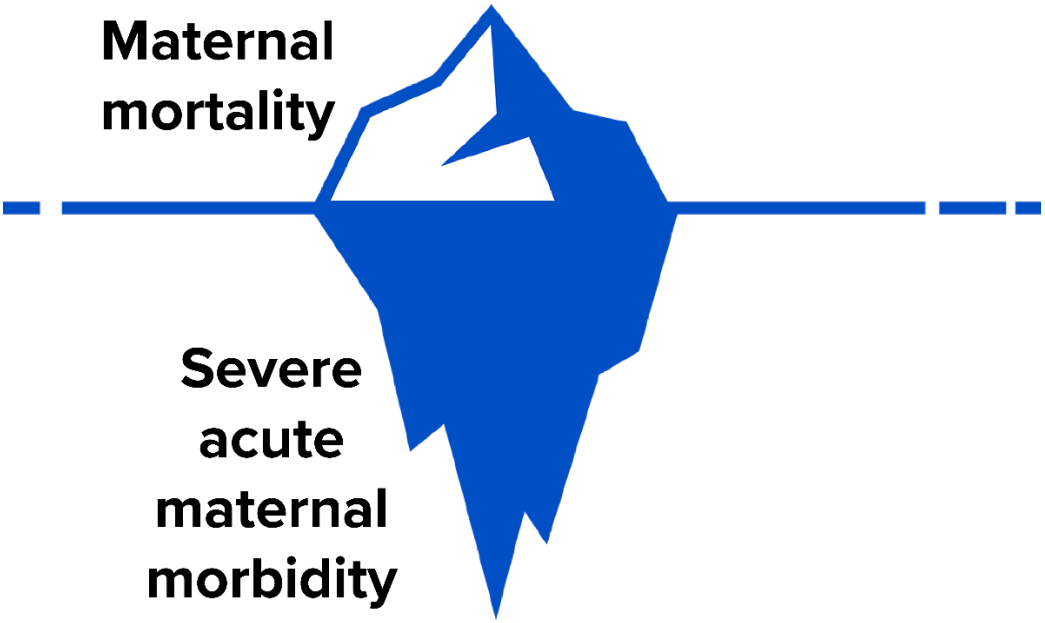
Maternal mortality disparity in the United States



https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html

The Centers for Disease Control and Prevention (CDC) reports that across the US from 2011 to 2015, there were 42.8 deaths per 100,000 live births for black non-Hispanic women compared to 13.0 deaths per 100,000 live births for white non-Hispanic women. Of these, it's estimated that 3 out of 5 – or 60% -- could have been prevented. Deaths are just the tip of the iceberg; severe maternal morbidity (SMM), or "near-miss", is also increasing in the US.[3]

Maternal mortality/Severe maternal morbidity



A portion of pregnancy-related mortality may be attributed to conditions that predated pregnancy, some of which – like asthma and hypertension – are increasing fastest in African American women.[3] However, evidence suggests African American women experience common potentially life-threatening complications of pregnancy at about the same rate as white women, but are more likely to die from those complications.[4]

What leads to such poor outcomes for African American women in the US?

Dr. Emily Petersen, an OB/GYN in the Division of Reproductive Health at the CDC, points to emerging evidence from "a growing body of research on the role of structural racism and implicit bias in health care and its impact on patient care and outcomes."[5]

The US has a long and complicated past when it comes to racism and its specific effects on African American women's sexual and reproductive health.[6] Over hundreds of years, abuse and mistreatment of African American women by medical practitioners have left a legacy of mistrust that can make establishing a close patient-provider relationship difficult.[7]

Good communication between a woman and her health care providers is a prerequisite to shared decision-making and for the woman to have a sense that she is being listened to, respected, and is actively participating in her healthcare.[8] However, there is strong evidence that patients of color experience less-effective interactions with providers and less-patient-centered care than white patients.[9] Even providers who consciously aim to provide equitable care to everyone are subject to unconscious biases and may be less effective in their encounters with patients of color, especially when providers are busy, distracted, tired, or under pressure.[10] This poorer care has direct impacts on the health and wellbeing of African American people.[11]

Although maternal mortality rates in the US are too high, instances of maternal death are still relatively rare. Pregnancy-related mortality ratios are not available by county in Washington, but data on infant deaths show that infants born to non-Hispanic black/African American women in Washington State are more than twice as likely to die as infants born to white women. Pierce County, home to the city of Tacoma, has one of the three highest infant mortality rates in the state,[12] which may suggest there are also racial disparities in maternal mortality and severe maternal morbidity here.

This study provides a glimpse into the pregnancy, birth, and postpartum experiences of non-Hispanic black/African American women in Pierce County in 2017-18. What's going well, and where are the opportunities for improvement?

Methods

Selection criteria

We recruited women living in Pierce County who identified as black and had a baby under the age of 12 months through networking, posting flyers in the community, and distributing flyers through the Black Infant Health Program's[2] Health Ministers.

[2] The Tacoma-Pierce County Health Department's Black Infant Health Program is a partnership of churches, pastors, Health Ministers, community groups, and public health nurses working together to help improve the health of black moms and babies. For more information, see https://www.tpchd.org/healthy-people/family-health/black-infant-health-health-ministers

Most respondents were non-Hispanic black women born in the United States, or African Americans. One respondent was a foreign-born black woman. But because we did not make birth in the US a requirement to participate in the study, we use the more inclusive term “black” to describe the women in this sample. Nevertheless, we recognize that most of the respondents are African American. The lived experience of US-born and foreign-born black women is different, and the intergenerational history of racial inequities affects African Americans differently than it does women who are foreign-born.

Data collection and analysis

Interviews took place from March to June of 2018, lasted from 15 minutes to more than an hour, and were carried out at a location that the woman chose – for example, at her home or in a coffee shop. We told women how the information would be used, that we would not release their names, that the interview would be recorded, and that they were free to stop the interview or stop the recording at any time. Women who participated received a $100 gift card in acknowledgement of their time and transportation costs. The interviewer was a woman who identified as white and was studying for a master’s in communication at the University of Washington.

Limitations

Women were self-selected and may not be representative of all black women who gave birth in Pierce County in the year prior to the study. Women who learned about the study and chose to participate may have been relatively healthier than others. In the most extreme scenario, we wouldn’t have captured information from a woman who died from pregnancy-related or -associated causes.

An important limitation is that participants may not have felt they could share fully about their experiences, especially with respect to how race might have played a role in their treatment, because the interviewer was white. The interviewer was trained in qualitative research methods but did not, herself, have direct experience of childbirth or depth of knowledge in the field, and consequently may not have probed adequately or asked follow-up questions that would have clarified certain responses.

Other people—in particular, partners or husbands—were present during some interviews and participants may have felt constrained in their responses because of this (although in some cases the partners actively participated and added information).

Participant Profile

The seventeen black women in this sample came from many walks of life. Two were military spouses; one had immigrated to the US from Africa three years before her youngest child’s birth; two had advanced academic degrees. One shared that her partner had been incarcerated during her pregnancy, and another that she was in recovery from substance abuse. Their ages ranged from 18 to 38, and they had between 1 and 6 living children. Most were insured at least partly through government programs (Apple Health, Tricare), while some had exclusively private insurance coverage and others had a combination of public and private coverage.
A twin born prematurely to one of the women in this sample died on the second day of life. The other twin survived but spent a month in the neonatal intensive care unit (NICU). Three other infants born to women in this sample spent time in the NICU, ranging from a few hours to two weeks.

Birth Stories of Black Women in Pierce County Respondents, 2018 (n = 17)

Age at most recent birth	number
18-19 years	1
20-24 years	3
25-29 years	8
30-34 years	3
35-39 years	2
Number of living children	**number**
One	5
Two	4
Three	3
Four	4
Six	1

Eleven women were cared for by an obstetrician/gynecologist, and 6 by a midwife. None reported using the services of a doula. All but one woman was accompanied by their partner and/or their mother and/or other family or friends during their birth.

Results

Impacts of Racism

Women in this sample did not identify racism as a factor in their treatment. When asked, "Did you ever feel that your care was inferior because of your race?", participants said they did not. However, one woman gave a telling response to this question—she said, "*To be honest with you, I had a black nurse, so I kind of felt regular.*"[3]

Respondents tended to downplay racism as a possible explanation and to instead attribute incidents to "bad service":

> *I was just thinking certain things were bad service … I've encountered so much racism growing up in this area, and it's almost like, "Oh, this person is giving me bad service" … I'm expecting good service. I don't care what I look like.*

Some were labeled uncooperative, threatening, or aggressive by health care providers and staff and made to take additional steps to demonstrate they were not a threat:

> *There was an issue when I was in the hospital having [the baby] with my boyfriend at the time. It was a big issue. He ended up getting kicked out of the hospital and told not to come back for a year. It was*

[3] Text in *italics* is directly quoted.

> *bad because he had a lot of concerns and they were ignoring him and not answering him [...] they felt threatened, I guess, and kicked him out [...] The receptionist totally overreacted. It just made us feel like we were criminals.*
>
> *[If my mom tried to advocate for me] they took it as a sign of aggression almost. Like they were all ... "She can ring the buzzer and just let us know if she needs something." But when I would, sometimes it would take them a while to come ... It was more of an attitude. It wasn't really "Oh, I forgot it, I apologize" it was like "Ugh, let me just go get this for her."*
>
> *Then when I got up there, they gave my husband a hard time because he didn't have an ID.*

Some attributed possible bias to their being overweight, looking young, or having a history of drug use. Women also defended themselves against stereotypes such as unmarried, ignorant, lazy, or had multiple children:

> *Wear your ring; make sure you say that you're my husband.*
> [Interviewer] Do you ever feel like your care, like the way you were treated, especially with your OB/GYN was different because of your race?
> [Woman] *Possibly, and because, I feel like, also, my race, possibly, but I feel like ... they're not used to working with women that are slightly overweight then also you could be treated a little biased as well.*

Why did women downplay race as a factor in their suboptimal care? One possible explanation is that participants may have been reluctant in the context of the interview and in conversation with a white interviewer to assert that a particular incident was related to race. Another is that women have no way of comparing their care or treatment to that received by women of other races and cannot determine on their own if they are treated differently or suboptimal.

We did not compare the stories of black women to those of women of other races. Nonetheless, their stories alone indicate that there is an imperative to improve care for this population.

Provider-Patient Communication

One of the farthest-reaching themes that emerged from these interviews was provider-patient communication. There were instances of empowered communication that was effective and left patients feeling good about their care and building trust in their provider. Unfortunately, most stories the women told were about dysfunctional interactions between provider and patient that left them with gaps in understanding and receiving suboptimal care. In many instances, provider-patient communication was lacking, incomplete, or dismissive.

When communication was clear and the women felt involved in their care, many gave their care teams great reviews and felt they could be trusted:

> *I had a lot of ultrasounds ... I got to get a lot of one-on-one time with my sonographer [...] so, me and her really bonded.*

> *Really good. They were really informative on things that needed to happen and what was going to happen and just always kept me updated. [...] Yeah, [I felt I was part of the decision-making process].*
>
> *It was really good up until the point I figured out she wasn't going to be at the labor. It was really good, she was really like, there, she was supportive. [...] She was giving me all this information, like, if I ever needed help or anything like that. So, she was pretty good.*
>
> *Yeah. Really, really [liked my doctor], because she was helpful. I have a lot of complications [...] I had high blood pressure, really, really, high blood pressure and ... she really took time to explain [to] me what's going on with me.*

Having trust and positive satisfaction with one's provider can improve the relationship and the outcomes in the labor room. People who are trusting of their providers are more likely to take their recommendations and follow a providers' plan of action. A focus on effective trans-racial communication can help build trust between patient and provider that affects the health outcomes of people of color.[13]

Misunderstandings resulted in women receiving suboptimal care when their subjective statements about their experience were not objectively or medically verified in a way that could lead to the best course of action:

> *I was, like, still in pain and they were like, "Oh, the pain is from the C-section and you had a lot of scar tissue." But come to find out, it wasn't just because of that. I ended up having an infection in my incision [...] I told them that something wasn't right, and they weren't really listening to me, so that kind of made me mad.*
>
> [Partner] She told the night nurse that her water broke, but I don't know if the night nurse didn't believe her, but the night nurse was basically saying her water didn't break. [Woman] *But it did break, but they kept saying, "no it didn't, no it didn't," but I felt the pop and water going everywhere in the bed.* [Partner] *Yeah, and then the one nurse came in and said that her water broke, and we got to start pushing right now.* [Woman] *Fifteen hours later.*

Women's care was compromised when providers gave them incomplete information:

> *They tried to give me Cytotec; it's this pill that dissolves into your cheek and helps your contractions start. They didn't explain to me very well how to use it, so when it would dissolve I would just kind of swallow it, rather than it going into my blood.*
>
> [Regarding decelerations of the fetal heartrate] *It was very stressful to me. I was going through contractions the whole time they would randomly come in and say those different things to me. Like, "Basically, we're going to give you a C-section whether you like it or not. You're going to get a C-section whether you like it or not." They just kept coming in and just leading me down that path. It was really bothering me that whole time.*

Women were frustrated when they felt their concerns were brushed aside:

> *Sometimes I would feel like the health care provider was kind of like, "Well, I know better than you do" type of thing, and not necessarily listening.*

> *My mother had toxemia and another aunt of mine had toxemia and one of them passed away during childbirth. But they brushed it off, "Every person is different. You never know." Okay [...] They said that everything seemed healthy. They ran all the tests that, I guess, are required for them to run [...] So, it was "fine." So, I stopped asking questions.*

> *I was like, all the way up to a four, and they were still like, "Come back when you're in more pain." So, at that point, I was pissed off, honestly, and I was like, "I'm just going to have him at home, you guys don't want to do anything for me."*

Providers talked about the women in some instances as if they were not in the room:

> *I heard them whispering about it at first. I can tell that they didn't know how to approach me at first; they were trying to rule that option out until it had to be said. But when I first heard them whispering about it, I had already started talking to her dad. Like, "I heard that this is what they are saying..." so we were preparing for it. [...] "We needed to go ahead and just do a C-section". I was like, you know, "Let's just go ahead and do it."*

Women had unanswered questions regarding their treatment:

> *They were testing for STDs, just all kinds of different stuff like that and making sure I don't have any sicknesses. And confirming that the pregnancy is there for real and I'm wondering if they took a urine sample too? I think they even took a urine sample. [...] I don't know if they checked me for drugs or whatever, but it just seemed like a lot of stuff they tested me for.*

These instances of not being heard led some of the women to withdraw from active advocacy for themselves:

> *If you don't do something right for me the first couple times, I kind of just be like, whatever. And then I don't care.*

> *There were times where I felt like, no, I was not being heard. [...] I felt like that control was taken from me, and that's exactly how I felt ... and I shut down at the hospital. I did, I basically I told them, "Whatever you're going do, do it, just leave me alone."*

A breakdown in communication in which information was not shared contributed to women's overall feelings about the birth. When women and their support team did not understand why something was being offered or done, they disengaged from self-advocacy. Providing information and taking time to answer questions can go a long way toward including women in their own care. Starting to notice the differences in how patient and provider share information can help lead to better care through more patient-centered information-sharing.

Education and Information

Women found the resources they needed in a variety of locations, both in person and virtually. A common theme among the women's narratives was their resourcefulness in finding information related to childbirth and seeking out the support they needed:

> *Ovia? It's the app for women and it follows you throughout your entire pregnancy. It gives you little articles about every stage of your baby's development, what type of doctor appointments are going to be coming up, the things that they're going to be looking for, the types of tests you should be having, all of that. Very detailed.*

> *There was a young lady who used to come see me that works for [a home-visiting program] and so she used to check in with me wherever, she would come to my home, we would meet at a cafe, something like that, and she would just talk with me. And she was a social worker… And she used to talk to me about different stuff … Just about life.*

> *I'm very thankful for this program, for Black Infant Health that I'm in, because they come and weigh the baby, they measure the baby—otherwise I wouldn't know how much she weighs from the time of her last appointment all the way to her two-month appointment […] Of course you don't want to have to go to the doctor's office all the time, but I wish that […] there was a way that I could keep her, that on track.*

> [CenteringPregnancy[4] is a] *healthy way to go about the, I would say, the moral-emotional side of pregnancy.*

Finding information is an important part of women's taking charge of their care and being able to advocate for their wishes. In a few instances, misinformation shared on online platforms added stress and confusion, but overall, the information these women found was helpful. Unfortunately, patient knowledge did not always translate into provider action. In fact, it could lead to an increased disconnect with the provider when a woman felt her provider was not listening to her.

Lack of knowledge around the impacts of birth spacing or lack of or unreliable family planning tools led to 1 out of 4 of these women to have unexpected pregnancies:

> *The first one was planned but the second one wasn't planned. The second was conceived when I was breastfeeding my baby for six months.*

> *No, we were on the pill […] He happened anyway.*

[4] "CenteringPregnancy is group prenatal care bringing women due at the same time out of exam rooms and into a comfortable group setting. Centering group prenatal care follows the recommended schedule of 10 prenatal visits, but each visit is 90 minutes to two hours long - giving women 10x more time with their provider. Moms engage in their care by taking their own weight and blood pressure and recording their own health data with private time with their provider for belly check." From https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

> *We were talking about having a baby, but we never went and got the birth control removed […] it just come out by accident.*
>
> *I was pregnant five years back to back to back to back. […] Having sex unprotected, of course you're prepared to have a kid. But I'm thinking, "I just had a kid, I'm good."*

Pain Management

Pain management comprised instances of provider-patient miscommunication, lack of empathy regarding a woman's pain, and assumptions around the patient's choice without adequate consultation.

> *They prepped me to get an epidural; that freaked me out. My biggest fear was epidural, which is why I wanted to do natural. But at this point I was exhausted and so over it, I just didn't care. […] I had a bad reaction to the epidural … apparently, I was super dehydrated, which is because they didn't tell me that I couldn't eat after I got an epidural.* […] *And then baby's blood pressure had dropped also.*
>
> *And then I was like, "No, I need one," because I couldn't deal with this pain. But they were taking too long to give me the epidural, so I ended up having her without it.*
>
> *[The provider was]… insinuate[ing] I was kind of being lazy. […] But when I needed to take time off, she wasn't helping with that as far as communicating that to my job. Like with a note one day, like if I went to a doctor's appointment and I didn't feel well afterwards. She's like, "Oh no, you can go back to work," things like that. […] I had pelvic dysfunction* [symphysis pubic dysfunction] *and I started sensing like a month in, it was just like really intense pain.*
>
> *I did tear and so I needed stitching; that was horrible. […] So they were like, trying to like, squirt lidocaine on me and they gave me something they said that it was supposed to take the edge off. I literally ended up screaming at the top of my lungs as they're stitching me up.*

During the postpartum period, pain was often overlooked or lost in the lack of care for postpartum moms:

> *The prescription they give you is nothing compared to what they give you in that hospital. When you in that hospital you is, heaven. […] When you leave, the pain, oh my, that's like waking from a nightmare. It's all on you like a bad toothache. […] I called them, and I told them, and they upped the dosages on it.*
>
> *They told me take Tylenol. And I'm like, I had a C-section.*
>
> *And I tore a stitch … I told them because they sent me home with a couple Percocets, it was like 2 days' worth of Percocets and maybe like a week's worth of ibuprofen. And I told them […] how my pain was. See, I almost didn't get released because my blood pressure was so high. And my blood pressure was high because of how much pain I was in.*
>
> *"He* (doctor's assistant) *was like, "Oh, she's really, like, in pain" […] But, I knew something was wrong […] And that's why I was like, "No it's something else…" and then come to find out it was definitely something else. […] a staph infection."*

> *My question was, [what to do] if I have any pain, because nobody asked me, you know, sometimes they can just say, "OK, you can come back, we're going to check on you," you know, "and your blood pressure" and something like that. But nothing.*

Some moms noted that they still struggle with traumatic memories from the birth:

> *Oh, I'll never forget it. Some people have a blur later on; yeah, I still have PTSD.*

> *I was really hurt by all of what happened to me there. And when I got home, you know, I was weepy about it … I'm not happy how I was treated. I'm not happy how I was talked to.*

Interestingly, only a few of women's stories included hydrotherapy, a practice known to reduce the discomfort of labor, even though many women mentioned wanting to labor in water:

> *We couldn't … well, the hospital doesn't do water births… […] Yes, that's something that I wanted to do. I was in the bathtub. I was in the bathtub majority of the time because I didn't want to move out the water. I was in pain.*

> *I switched insurance. I figured out that I had a lot more to choose from and that hospital had a midwife center that I was trying to get into so I could give a water birth, but I wasn't able to get into it because I had to be induced.*

> *Actually, I did end up having her in the water. I was just actually sitting in the tub and next thing you know I felt her coming down.*

The group of mothers also included one woman who had her second home birth with the most recent baby. Her labor lasted more than 24 hours, but the interview did not elicit details of pain management.

When considering these women's stories, it is apparent that the reasons why a provider gave, or withheld pain medication were often not clear to them. This gap left women room to question and doubt their providers; in the absence of other evidence, these doubts might align with historic narratives of mistreatment of black women in America.

Poor pain management also undermines women's bodily autonomy and takes control from them, highlighting a dynamic of power disparities between patient and provider. It is also important to be aware of the context in which conversations about pain medication and the African American population are occurring; in one study, "African-Americans often perceived unfair treatment from their clinicians. Many African-Americans felt that clinicians did not provide them with pain medication because clinicians perceived them as drug users."[7]

Understanding this context may help guide providers to know when they might need to share more information about care decisions.

Support

Family and Community Support was mentioned in almost all of the narratives:

> *Like, I have a very, very, very good support system all the way around in my church community and my family, and we have nurses that are in our church community. So, any information I was lacking or didn't get from my midwife or my doctors, I got from those nurses.*

> *I need to express this. Like, I'm not happy how I was treated. I'm not happy how I was talked to, I'm not happy about some of the things [...] I feel that if I didn't have my support system there that maybe things wouldn't have turned out so nice for us.*

> *I remember I had a few breakdowns, even with my enormous family support, I had breakdowns. I can only imagine single moms who go through this.*

Some moms found additional support among classes or programs:

> *Well, with the military we don't have much family around, so it's not like you get to go with your mom ... so* [CenteringPregnancy] *was nice [...] The military provides like a counselor who comes once a week.*

> *Yes, I breastfed all three of them. There was support with this one. I think a nurse just comes around when you just have a baby and shows you, or whatever... but I didn't have anything with the other two. I don't really think I really needed it.*

Support was an area where the women were overwhelmingly positive about their experiences. Whether it was family, partners, mothers, sisters, or cousins, they had people who helped them through the experience. For women who did not have family nearby, most found other social supports in social services or CenteringPregnancy classes. Recognizing this as a strength can inform programs going forward. Incorporating a mom's chosen support person into prenatal education would increase education and information-sharing while using the support people they already trust.

Navigating the System

Navigating systems of care was challenging for many participants. Beginning with provider choice, many women experienced confusion around different types of providers:

> *I had a doula for my first, but other than that I just have always had an OB/GYN.*

> *To be honest, there wasn't really a difference, like I don't see the difference in my care at all, honestly. [The midwife] did everything a regular doctor would do. She did my ultrasound; she did my exams ... So, honestly, I feel it's just like the label, whereas, just like a PA and a doctor is the same thing.*

> *I was thinking about a midwife, but ... I just keep seeing and hearing kind of mixed things about them ... they were like, "if you get a midwife you can't have that procedure." That's what I was told. And I was*

> *like, I'll just get an OB/GYN. That's why I ended up choosing an OB/GYN, because I was told that I couldn't have an epidural.*

Provider choice, clear understanding of the differences and commonalities, and finding the right type of provider for the birth can affect pregnancy outcomes.[14] In some cases, the women interviewed made choices about providers based on false or misleading information from their networks. While providers might think the differences between provider degrees and approaches are clear, patients experience a lack of clarity; this undermines their ability to make an informed choice.

Complicating provider choice is insurance and the fog that surrounds understanding how to access covered services with insurance. Many women experienced uncertainty regarding what was covered and accessible under their insurance:

> *I was on the phone so much with health care authorities and the different types of coverages and different special programs for when you're pregnant and it was really confusing … it was like walking in the dark. So, it was kind of tough, but I got it all figured out.*

> *So … if we end up starting it in the birth center and then going to the hospital, is it going to charge twice? Things like that. The nurse would be like, you know, "You got to talk that over with your insurance."*

> [Regarding pain management and follow up appointments] *I didn't ask because after one month … I didn't have insurance anymore […] I stayed a long time with no insurance. I think I feel like I still have the [high] blood pressure.*

Knowing how to navigate insurance and get necessary services covered may affect women's care by causing stress during the pregnancy and diminishing their choices.

Infant feeding

Women did not receive the care needed to support their breastfeeding efforts or encountered misinformation in the community or family which interfered with their reaching their breastfeeding goals. Over one third of respondents wanted to breastfeed but didn't get adequate support:

> *I kept asking for a lactation nurse. They kept saying that she was going to come, but she never came to the room, never came to the NICU to show us.*

> *Not happy because I wanted to breastfeed, and I couldn't […] I'm pretty sure [the infection] could have been caught in the hospital. And I could have gotten the right antibiotics in the hospital, the right fluids.*

> *It's kind of breast milk every now and then but mostly formula, just because at first, I wasn't making enough anyway. So, I just decided to keep pumping every now and then to give her some breast milk.*

> *Because he was so prem[ature], he can't [breastfeed].*

Women felt pressure to feed differently than they had chosen to:

> *My mom still says, "When are you going to give him some water?" I'm like, "Mom, I'm breastfeeding."*

> *I feel like if you breastfeed you get more information. […] I was asking them, "do I need to have my sister get some formula? What type of formula is it that I'm supposed to be using? Do I just go ahead use the same one that you have here?" […] because they weren't bringing [formula] like I needed it.*

> *I was frustrated that my doctor's office gave me samples and I found one that I liked and then the WIC[5] office said that they […] need a form from my doctor's office and my doctor's office won't sign the form … if they have gas colic, then that doesn't count for a reason apparently. But I'm like, "You guys are the ones that gave me the samples. Now you're not signing the forms?!"*

In the cases where moms were successful with breastfeeding, they found support from lactation counselors and family or friends. Five of the moms specifically mentioned having lactation support and two of the women breastfed their most recent baby with support after not nursing older children:

> *So, the baby's nurse came in there and basically showed me, she taught me about a nipple shield. And the only thing I would say about nursing or lactation consultants, like I don't mind the information, but sometimes I don't think that they realize how, it's like that hidden line, underline, be they're telling you, "Yeah don't worry, nurse, you nurse how you want to. You nurse how you want to." But like they kind of make you feel like there is a wrong way of nursing.*

> *"If nothing else, [breastfeeding] is free. So, I'm like, yes! Breastfeeding! Formula is expensive. I'm not interested in paying twenty dollars for one can."*

Two of the women discussed nursing older children and nursing through or stopping during subsequent pregnancies. One felt they did not have information on what the safest choice for nursing during pregnancy:

> *I started bleeding because I was nursing the [older] baby […] If I had a way of informing ladies not to breastfeed while pregnant, [I would] … I asked [my providers] every time, "I'm still breastfeeding, it is ok?" And they were like, "Oh yeah, go ahead! Yeah, sure!" […] And there's no studies that confirming, I guess there's not enough people to confirm […] But in general, … one of the things about breastfeeding, it contracts your muscles to build, just to shape your womb and body which could kill anything else left inside … It's a bad thing if there's a baby inside, because then it ejects it out of the body.*

> *I wanted to do it until they were two, but I would always give birth right before they turned two. So, there were so many reasons I stopped. It would be a few months into my pregnancy, and I would wean them all.*

[5] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. From https://www.fns.usda.gov/wic

Breastfeeding was a strong preference among the women interviewed, and their success related directly to the support they received. Making sure all moms have resources, information, and support had material impacts on their ability and preference to breastfeed. In cases where mom did not want to breastfeed or preferred formula feeding, there was a gap in the support they received in accessing formula and information regarding feeding with formula. Finding ways to get support through lactation consultants who are non-judgmental and well educated on both breast- and formula-feeding and have access to low-cost or free formula can lead to less stress on the part of new moms.

Returning to Work

Nearly half of the women returned to work before they were ready or wanted to due to financial need or lack of accommodation from their employers. In several cases this return to work affected their breastfeeding relationships. Two mothers struggled with infant care while their babies were very young, one whose husband who was overseas and another because Child Protective Services approved only the home of one of her relatives and would not allow her baby to stay home.

Advice for other Moms

During the interviews we asked the women what advice they would give to other expectant moms. The answers had several common themes, with the woman's personal experience often directly relating to the recommendation.

They emphasized the need for flexibility:

> *Plan ahead. Even though I was semi-planned … You never know what could happen, so try to make sure you have a back-up plan for your plan.*

Finding good support was emphasized by a quarter of the mothers:

> *Support, support, support. Like family, community, healthcare.*
>
> *Have a doula along with your doctor … It's like having a sister at some point.*
>
> *Just keep somebody that's always able to be around to talk to, because you know the baby blues hit you now and then.*

Two mothers encouraged moms to not be afraid of pain medications, and one admonished them to avoid a Cesarean section due to the long and painful recovery. Another advocated delaying childbearing:

> *Just wait! Like, if you are young, just wait, OK? You have your whole life to live ahead of you! Just wait.*

Knowledge and confidence in oneself and one's decisions were additional themes. Women mentioned seeking information from online sources, friends, family, mommy groups, and books. Knowledge and information lead to confidence in your decisions, and many of the women advised self-advocacy regarding interactions with their providers.

Don't be afraid to do stuff that's not conventional.

Never feel afraid to ask questions.

Discussion

The voices of black women from Pierce County echo those from across the US, who have spoken about feeling a diminished sense of being seen and respected.[15]

The bottom line is that African American women in Pierce County—like people everywhere—want patient-centered care.[7]

Fundamentally, most of the issues raised by the women interviewed for this report are about quality of care. The stories black women in Pierce County told showed that some of the care they received was disrespectful or of low quality. Individually, the women we interviewed did not perceive this as being tied to their race, nor did they attribute their experience to larger structural racist policies or procedures. However, taken together, and considering data indicating African American women and their babies have higher chances of having problems or even dying during and around the time of childbirth in Pierce County. These stories point to ways in which health care providers and the health care system can improve to ensure all women—black women especially—have the best possible outcomes to their pregnancies.

It is important to point out that with one exception, none of the women mentioned that their providers were people of color. This reflects the current health care workforce, in which black women are often cared for by someone whose racial and/or ethnic identity differs from theirs. According to the American Medical Association, only 9% of medical doctors in US are underrepresented minorities.[cited in 9] Discordant ethnic/racial patient-physician encounters have been associated with higher mistrust and suspicion and may affect black patients' response to the interaction.[9] Increasing the number of African American providers or providers of color has potential to build trust and improve patient relationships even before patients interact with that provider. Providers of color also have shared experiences that help them understand the reality of mothers of color in a different way than their white peers.

However, regardless of racial and ethnic identity, what comes through clearly is that everyone wants patient-centered care.[7,10] They want technically competent providers with people skills who communicate effectively and provide individualized treatment.[16] These characteristics are more important to patients of color than having a provider of the same race.[7]

The Institute of Medicine has defined patient-centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" and equitable care as "care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status." [17]

"[S]ubconscious bias occurs when a patient's membership in a target group automatically activates a cultural stereotype in the [provider]'s memory regardless of the level of prejudice the [provider] has."[18 cited in 19] Most providers aspire to provide high-quality care to all patients, but when they are "busy, distracted, tired, and under pressure,"[10] then "hidden stereotypes or attitudes"[20 cited in 19] are likely to influence their behavior. These "Implicit attitudes affect verbal communication and nonverbal behaviors … even among people with egalitarian explicit attitudes."[21 cited in 19] When implicit bias manifests, providers may be more likely to exhibit "nonverbal behaviors reflecting anxiety (e.g., increased rate of blinking), aversion (e.g., reduced eye contact), or avoidance

(e.g., more closed postures) when interacting with minority rather than white patients."[11 cited in 19] They may use verbal approaches that steer patients toward certain decisions, or give only partial information; such "packaging" reinforces the power differential between patients and providers.[8]

African American patients pick up on these cues.[19] One result is decreased trust on the part of patients and lower frequency of shared decision-making between African American patients and their providers.[8,22] This was manifested by the stories women in our sample told about feeling that their choices were constrained, feeling that they had incomplete information, feeling that they weren't heard and "shutting down" because of that, feeling that their pain was not adequately managed, feeling that their goals to breastfeed their infants were not supported.

Higher scores on the test of implicit bias[23] are associated with less patient-centered care,[9] so it stands to reason that interventions to reduce implicit bias might improve patient-centered care and, by extension, improve patient outcomes. However, the evidence about what works is still limited. In one of the few studies to report on the effect of cultural competence education of providers on health outcomes, black women's perceptions of health care providers were higher in intervention group.[24] More recent initiatives have integrated critical race theory and race-conscious health care delivery to address provider implicit bias.[9] It's also necessary to work at a systemic level, as many women encountered obstacles navigating the health care system.

Recommendations

In his book Health Disparities in the United States: Social Class, Race, Ethnicity, & Health, Donald A. Barr, MD, PhD, proposes five steps to reduce health disparities:

1. Take explicit measures to eliminate unconscious bias and ethnic bias as a cause of health disparities.
2. Monitor patterns of care to identify disparities when they exist.
3. Strengthen the physician-patient relationship, especially when physician and patient are from differing backgrounds.
4. Increase the racial and ethnic diversity of the medical profession and other health professions.
5. Assure access to care through universal health care.[19]

Black Mamas Matter Alliance, a multisectoral black maternal health, rights and justice advocacy group produced a "*Black Paper*".[6] The document summarizes recommendations through the lens of holistic care:

1. Listen to black women.
2. Recognize the historical experiences and expertise of Black women and families.
3. Provide care through a reproductive justice framework.
4. Disentangle care practices from the racist beliefs in modern medicine.
5. Replace white supremacy and patriarchy with a new care model.
6. Empower all patients with health literacy and autonomy.
7. Empower and invest in paraprofessionals.
8. Recognize that access does not equal quality care.

Eliminating racism-based disparities in maternal and infant health outcomes will require changes in our current health care delivery system, and availability of culturally safe maternal supports for African American women. Systemic change will have a longer timeline while effective supports such as developing payment structures for doulas and peer breastfeeding counselors could be implemented in the shorter term. Expanding maternal mortality reviews, such as in Washington State, and standardizing data collection will lead to a better understanding of maternal deaths and inform prevention.[7] Key to any policy or program development to address maternal health disparities must include asking, listening, and partnering with African American women, who's lives depend on it.

[6] Black Mamas Matter Alliance is a Black women-led cross-sectoral alliance advocating for policy change, Black led research, holistic care and culture change to address Black maternal health inequity.

[7] Established in 2016 and authorized by RCW 70.54.450, the Department of Health convenes a Maternal Mortality Review Panel to conduct comprehensive and multidisciplinary reviews of all maternal deaths in Washington, identify factors associated with those deaths, and make recommendations for system changes to improve healthcare services for women in the state.

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Resources

Personal Stories

https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html-A story about a mother's tragic birthing experience and the reality of health care for African American women.

https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth Includes story of CDC epidemiologist. Listen to NPR story *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*

https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why Podcast CDC epidemiologist story

https://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html Serena Williams' birth story

The Whys: Background

Dismantling Structural Racism, Supporting Black Lives and Achieving Health Equity: Our Role

Why Racial Gaps in Maternal Mortality Exist -A brief explanation on health disparities and its impact on maternal mortality among black women.

The Impact of Racism on Child and Adolescent Health-An article on the impact of racism among adolescent health outcomes.

https://www.npr.org/sections/health-shots/2019/11/29/760231688/black-mothers-get-less-treatment-for-their-postpartum-depression -A discussion about the reasons why black women are more likely to suffer from post-partum depression.

Statistics

Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017- Maternal mortality statistics.

https://www.medscape.com/viewarticle/896250?src=WNL_infoc_180519_MSCPEDIT_obgy&uac=130197SJ&impID=1635783&faf=1 -Data on the rise of maternal mortality and how California has created a model system that lowers maternal mortality rates.

Commentary provided here by Dr. Joia Crear-Perry, founder and president of the National Birth Equity Collaborative (NBEC): https://rewire.news/article/2018/04/11/maternal-health-replace-race-with-racism/

Resolutions & Raising Awareness

https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/MaternalMortalityReviewPanel -Findings, recommendations and information from Washington states' Maternal Mortality Review panel.

https://lasentinel.net/harris-colleagues-introduce-resolution-designating-april-11-17-2018-as-black-maternal-health-week.html- To raise awareness about the alarming Black maternal health crisis and high maternal mortality rate across the nation, U.S. Senator Kamala D. Harris and her colleagues introduced a resolution to designate April 11-17, 2018 as Black Maternal Health Week.

Organizations/Programs

Black Mamas Matter https://blackmamasmatter.org/ You can follow on Twitter @BlkMamasMatter
An organization based in Atlanta, GA. They work to improve maternal health outcomes for black women.
Their Resources

- Black Mamas Matter Toolkit https://www.reproductiverights.org/document/black-mamas-matter-toolkit-for-advancing-human-right-to-safe-respectful-maternal-health-care
- http://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf
- https://blackmamasmatter.org/resources/literature/

The American College of Obstetricians and Gynecologists https://m.acog.org/About-ACOG/News-Room/ACOG-on-the-Record/Our-Commitment-to-Changing-the-Culture-of-Medicine- ACOG as made a commitment to improving women's health outcomes by eliminating health disparities.

National Institute for Children's Health Equality https://www.nichq.org/sites/default/files/resource-file/Implicit%20Bias%20Resource_Final_0.pdf- Talks about implicit bias, the steps to minimize it, and provides a quiz to assess your own implicit bias.

California Black Infant Health Program https://www.cdph.ca.gov/Programs/CFH/DMCAH/BIH/Pages/default.aspx-A program that provides support services to black women who are 30 weeks pregnant at time of enrollment. The goal is to improve health and social outcomes among black women.

Tacoma Pierce County Black Infant Health Program https://www.tpchd.org/healthy-people/family-health/black-infant-health-health-ministers- A program that connects black women and their children to resources and support in Pierce County.

MaMa Toto Village https://www.mamatotovillage.org/-Based in Washington D.C, it is an organization that provides career pathways, perinatal support, and empowerment to women of color.

Jamaa Birth Village https://www.jamaabirthvillage.org/-A holistic and culturally based midwifery and doula organization in Ferguson Missouri.

Open Arms – Seattle https://www.openarmsps.org/-Provides community-based support during pregnancy, birth, and early parenting.

Videos

Death by Delivery (43 min) -A documentary by Fusion TV, covering the issue of high maternal mortality rates in America among black women.

What is bias? An explanation of implicit and unconscious bias (5min) https://www.youtube.com/watch?v=E_qERP-Y0Jw&list=PLHWxeEqcNV7xH3a9-6J8IP4z9ej0_K-Q1

Unequal Opportunity Race (4 min)- Metaphorical video on race inequality. https://www.youtube.com/watch?v=vX_Vzl-r8NY

Chocolate Milk-A documentary on the lack of breastfeeding amount black mothers.
http://www.chocolatemilkdoc.com/film

Articles/Books

https://www.propublica.org/series/lost-mothers-Includes tool kit for community conversations you can download. The initial project is a fascinating example of using social media and crowd funding sites to tell the story, as maternal mortality data are not consistently collected/reported.