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Black Women's Perspectives of Respectful Maternal Healthcare in Georgia: A Qualitative Exploration of Facilitators and Barriers

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Black Women's Perspectives of Respectful Maternal Healthcare in Georgia: A Qualitative Exploration of Facilitators and Barriers

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Abstract

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Background: In the United States, rates of maternal mortality and morbidity have been steadily increasing. Georgia is one of the states with the highest rates of adverse maternal health outcomes in the U.S., which disproportionately affects racial and ethnic minority women.

Objective: The goal of this study is to understand the barriers and facilitators to maternal healthcare seeking among Black women in Atlanta, Georgia. This paper also aims to provide Black women-led recommendations for improving respectful care in healthcare settings, which could be used to inform future interventions addressing racial disparities in maternal health.

Methods: This exploratory qualitative study used a community-based participatory research approach to collaboratively develop the study design and collect data with the Center for Black Women's Wellness (CBWW). The research team conducted four focus group discussions over Zoom among Black women who were enrolled in the Atlanta ECHO cohort study and delivered their child at either Emory Midtown Hospital or Grady Memorial Hospital. A member of the research team conducted a thematic analysis of the focus group data using MAXQDA data analysis software.

Results: Participants identified numerous barriers and facilitators to maternal healthcare seeking that fell into three categories: quality of interpersonal relationship and communication, adequacy of service, and sociocultural factors. Participants also offered recommendations that were grouped into three categories: quality of interpersonal relationship and communication, quality of service, and a culture of respect.

Discussion: Most of the barriers, facilitators, and recommendations provided by Black women in our study were related to provider and health system level factors while others were linked to more social and cultural influences. This study recommends more training on implicit bias, communication, and interpersonal skills among providers to improve Black women's perinatal health experiences and quality of care. Additionally, respectful maternity care should be promoted on the provider and health system level to help address maternal health inequities.

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Chapter 1: Literature Review

A growing body of research suggests that maternal health disparities are a complex, multi-layered issue. This chapter will provide background information about maternal mortality and morbidity in the United States. It will also explore potential drivers of disparities in maternal mortality and morbidity as well as present information about the importance of respectful maternal healthcare.

This literature review was conducted from January to March 2022. A literature search of the following databases was conducted: PubMed, JStor, and Google Scholar. In addition, the following websites were visited: World Health Organization, United Nations Children's Fund, and Center for Disease Control and Prevention. The following keywords were used for the search: "maternal mortality", "racial maternal mortality disparity", "maternal morbidity", "severe maternal morbidity", "respectful maternity care", and "respectful maternal care". For this paper, I will refer to "Non-Hispanic Black women" as Black women and "non-Hispanic White women" as White women.

Definition and Measures of Maternal Mortality

Maternal mortality can be categorized and measured in multiple different ways. The World Health Organization (WHO) defines maternal death as, "the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes (Review to Action, n.d.). The Center for Disease Control and Prevention (CDC) defines pregnancy-related death as, "a death during or within one year of

pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy" (Review to Action, n.d.). Pregnancy-associated death is defined as, "a death during or within one year of pregnancy, regardless of the cause" (Review to Action, n.d.).

The causes of maternal mortality are classified into two categories: direct and indirect (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019) (Patel, Burnett, & Curtis, 2003). Direct deaths are those "resulting from obstetric complications of the pregnant state (pregnancy, labor, and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from [a combination of these factors]" (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). Direct causes include obstetric hemorrhage, hypertensive disorders in pregnancy, and obstructed labor are classified as direct maternal deaths (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). In contrast, indirect deaths are those "resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes but were aggravated by the physiologic effects of pregnancy" (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). Indirect causes include pre-existing illnesses such as heart disease, hypertension, diabetes, and renal disease that may be aggravated by pregnancy (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019) (Patel, Burnett, & Curtis, 2003).

Indicators commonly used to measure maternal mortality are the maternal mortality ratio, maternal mortality rate, lifetime risk of maternal death, and proportionate mortality ratio (U.S. Census Bureau, 2015) (Ronsmans & Graham, 2006). The maternal mortality ratio (MMR) is the

“number of maternal deaths during given time period per 100,000 live births during the same time period” (Ronsmans & Graham, 2006) (United Nations Children's Fund (UNICEF), 2022). This measure represents the probability of dying once a woman is pregnant and is also often referred to as the obstetric risk (Ronsmans & Graham, 2006). The maternal mortality ratio is also the most commonly used indicator for maternal mortality (Patel, Burnett, & Curtis, 2003). The maternal mortality rate (MMRate) is the “number of maternal deaths in a given time period per 100,000 women of reproductive age, or woman-years of risk exposure in the same time period” (Ronsmans & Graham, 2006). This measure is a cause-specific death rate that indicates the risk of maternal death among women of reproductive age (U.S. Census Bureau, 2015). The lifetime risk of maternal death (LTR) is the “probability that a 15-year-old woman will eventually die from a maternal cause (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). This measure signifies the cumulative risk of dying from complications of pregnancy and childbirth during a woman’s reproductive life, which also takes into account fertility and obstetric risk (Ronsmans & Graham, 2006) (Patel, Burnett, & Curtis, 2003). The proportionate mortality ratio (PM) is “the proportion of maternal deaths among all deaths of women of reproductive age” (usually defined as 15-49 years) in a given time period (U.S. Census Bureau, 2015) (Ronsmans & Graham, 2006).

These measures can be used for both maternal and pregnancy-related deaths (Ronsmans & Graham, 2006). For pregnancy-related deaths, the name of the measures slightly changes to indicate it is for pregnancy-related rather than maternal deaths (Ronsmans & Graham, 2006). For instance, when using pregnancy-related deaths, the maternal mortality ratio becomes the pregnancy-related mortality ratio (Ronsmans & Graham, 2006).

Definition and Measures of Maternal Morbidity

According to the WHO Maternal Morbidity Working Group, maternal morbidity is defined as "any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing" (Filippi, Chou, Ronsmans, Graham, & Say, 2016). Two relevant terms related to maternal morbidity are severe maternal morbidity and maternal "near misses". The CDC defines severe maternal morbidity (SMM) as "unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health" (CDC, 2021). For instance, women who experience eclampsia, hysterectomy, embolization, blood transfusion, or admittance to the intensive care unit for more than 24 hours would fall into the classification of severe maternal morbidity (Hirshberg & Srinivas, 2017). Some countries identify SMM using organ-system dysfunction criteria based on ICD codes for conditions such as renal failure, cardiac arrest, sepsis, pulmonary edema, and eclampsia (Hirshberg & Srinivas, 2017). The WHO defines a maternal "near-miss" (MNM), also referred to as severe acute maternal morbidity, as "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth, or within 42 days of termination of pregnancy" (WHO, 2011). Women who experience maternal near-misses often survive either by chance or the quality of maternal healthcare care received (Filippi, Chou, Ronsmans, Graham, & Say, 2016). The causes of maternal morbidity occur during pregnancy, but the subsequent disability or chronic illness may take a long time to manifest (Filippi, Chou, Ronsmans, Graham, & Say, 2016). Thus, capturing the impact of morbidities requires a longer reference period than maternal deaths (Filippi, Chou, Ronsmans, Graham, & Say, 2016). There is no standard definition or universal identification criteria for severe maternal morbidity or near-misses (Hirshberg & Srinivas, 2017).

Indicators commonly used to measure maternal morbidity include women with life-threatening conditions (WLTC), severe maternal outcome ratio (SMOR), maternal near-miss ratio (MNMR), maternal near-miss mortality ratio, and mortality index (WHO, 2011). Women with life-threatening conditions (WLTC) denotes "all women who either qualified as maternal near-miss cases or those who died" (WHO, 2011). This measure is the sum of maternal near-miss and maternal deaths, which represents a severe maternal outcome (WHO, 2011). The severe maternal outcome ratio is "the number of women with life-threatening conditions per 1,000 live births (WHO, 2011). This indicator represents the amount of care and resources that would be needed in a facility or area (WHO, 2011). The maternal near-miss mortality ratio is "the number of maternal near-miss cases per 1,000 live births" (WHO, 2011). This indicator also estimates the amount of care and resources that would be needed in a facility or area (WHO, 2011). The maternal near-miss mortality ratio is "the ratio between maternal near-miss cases and maternal deaths (WHO, 2011). For this indicator, higher ratios signify better care (WHO, 2011). The mortality index is "the number of maternal deaths divided by the number of women with life-threatening conditions expressed as a percentage" (WHO, 2011). For this indicator, a higher index indicates more women with life-threatening conditions (suggesting low quality of care), whereas a lower index shows fewer women with life-threatening conditions die (suggesting better quality of care) (WHO, 2011).

Even though the maternal mortality ratio is the primary indicator for measuring the quality of maternal healthcare care, maternal deaths are relatively rare events (Filippi, Chou, Ronsmans, Graham, & Say, 2016). However, experts argue that cases of severe maternal morbidity occur more frequently and share similar characteristics to maternal deaths such as many common risk factors (Filippi, Chou, Ronsmans, Graham, & Say, 2016). Thus, women who

survive severe complications during pregnancy, delivery, and the postpartum period can serve as surrogates to help gain a better understanding of the preventable factors and conditions that contribute to maternal deaths (Yemane & Tiruneh, 2020).

Trends in Maternal Mortality

Global Trends in Maternal Mortality

Globally, the total number of maternal deaths decreased by 35%, from 451,000 in 2000 to 295,000 in 2017 (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). In 2017, the global maternal mortality ratio was approximately 211 maternal deaths per 100,000 live births, which represents a 38% reduction since 2000, when it was 342 (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). This means the global maternal mortality ratio declined by 2.9% on average every year between 2000 and 2017 (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). In 2017, the global lifetime risk of maternal death was 1 in 190—nearly half the level of risk in 2000 (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). The overall PM was 9.2% in 2017, which is a 26.3% reduction since 2000 (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019).

Despite global reductions in the number of maternal deaths, maternal mortality remains alarmingly high in low-and-middle-income countries. Low-and middle-income-countries account for 99% of all maternal deaths worldwide (Filippi, Chou, Ronsmans, Graham, & Say, 2016). The MMR in low-and-middle income-countries is an estimated 415 maternal deaths per 100,000 live births, which is over 40 times higher than the MMR in Europe and nearly 60 times higher than

that of Australia and New Zealand (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). Further highlighting the stark disparities between high and low-and-middle-income-countries, a large majority (86%) of all maternal deaths in the world occur in two regions, sub-Saharan Africa and South Asia (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). Sub-Saharan Africa alone accounts for approximately 66% (196,000) of all global maternal deaths and has the highest MMR of 542 maternal deaths per 100,000 live births (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019). Southern Asia accounts for an estimated 20% (58,000) of all maternal deaths (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2019).

In 2013, the United States ranked 60th in the world for maternal mortality and was one of only 8 countries that had an increase in maternal mortality worldwide (Hirshberg & Srinivas, 2017). Among high-income countries, the United States has the highest estimates of maternal mortality (Tikkanen, Gunja, Fitzgerald, & Zephyrin, 2020). In 2018, the maternal mortality ratio in the U.S. was more than double that in most other high-income countries (Tikkanen, Gunja, Fitzgerald, & Zephyrin, 2020). According to a study by the Commonwealth Fund, a woman in the U.S. is almost 10 times more likely to die from maternal causes than a woman in the Netherlands, Norway, and New Zealand (Tikkanen, Gunja, Fitzgerald, & Zephyrin, 2020).

National Trends and Patterns in Maternal Mortality

In the United States, there was a dramatic decline in maternal mortality throughout the 20th century (M.Callaghan, 2012). Between 1935 and 1982, the maternal mortality rates in the United States were consistently decreasing at an average rate of 8.6% per year (Singh, 2010).

This decrease in maternal mortality occurred during a time when there were widespread improvements in the standards of living as well as, medical advancements such as antisepsis, blood transfusions, and antibiotics (M.Callaghan, 2012). However, in the last 25 years, the number of maternal deaths in the United States has been steadily increasing (Creanga, Syverson, Seed, & Callaghan, 2017). The number of maternal deaths in this country increased from 658 in 2018 to 754 in 2019 (Hoyert, 2021). In 2019, the national maternal mortality rate was 20.1 deaths per 100,000 live births, which is significantly higher than the rate of 17.4 it was in 2018 (Hoyert, 2021). Similarly, the number of pregnancy-related deaths in this country increased from 7.2 deaths per 100,000 live births in 1987 to 17.3 deaths per 100,000 live births in 2017 (Centers for Disease Control and Prevention (CDC), 2020). Reasons for this observation are unclear (Hoyert, 2021). Although the improvements in the identification of maternal deaths due to the use of computerized data linkages between death records and birth records by states, changes in the way maternal deaths are coded, and the adoption of a pregnancy checkbox on the standard death certificate may be contributing to the observed increase (Creanga, Syverson, Seed, & Callaghan, 2017) (Centers for Disease Control and Prevention (CDC), 2020).

The high maternal mortality rate in the U.S. conceals substantial variations by race and ethnicity. Over the past 6 decades, the risk of Black women dying from complications related to childbirth remained 3 to 4 times higher than that of White women (Singh, 2010). Between 2007 and 2014, Black women had the fastest rate of increase in maternal deaths and have maternal mortality rates 12 times higher than White women in some cities (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). In 2019, the maternal mortality rate for Black women was 44.0 deaths per 100,000 live births, which is 2.5 times higher than the rate for White women (17.9) and 3.5 times higher than the rate for Hispanic women (Hoyert, 2021).

Native Americans/Native Alaskans, Asians/Pacific Islanders, and certain subgroups of Hispanic women such as Puerto Ricans also experience higher maternal mortality rates (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018).

Maternal mortality rates also increased with maternal age (Hoyert, 2021). In 2019, the maternal mortality rate for women under age 25 was 12.6 deaths per 100,000 live births, compared to the rate for women aged 40 and over that was 75.5 (Hoyert, 2021). This means the maternal mortality rate for women aged 40 and over was 6.0 the rate for women under the age of 25 (Hoyert, 2021).

Medical Causes of Maternal Mortality

Approximately, 73% of all maternal deaths are attributable to direct causes (United Nations Children's Fund (UNICEF), 2022). Deaths due to indirect causes made up 28% of all deaths (United Nations Children's Fund (UNICEF), 2022). Hemorrhage is the leading cause of maternal mortality, accounting for 27% of maternal deaths (United Nations Children's Fund (UNICEF), 2022). Other causes of maternal mortality include hypertension (14%), sepsis (11%), unsafe abortion (8%), and embolism (3%) (United Nations Children's Fund (UNICEF), 2022). Most causes of maternal deaths are preventable—if childbirths are attended by skilled health professionals and women are referred to emergency obstetric care in a timely manner when complications are diagnosed (United Nations Children's Fund (UNICEF), 2022).

While hemorrhage continues to be a major cause of maternal mortality, its relative contribution as a proportion of all maternal deaths has decreased over time (Callaghan W. , 2012). In contrast, the proportion of deaths due to cardiomyopathy and pre-existing conditions has been steadily increasing (Howell, Reducing Disparities in Severe Maternal Morbidity and

Mortality, 2018). According to national data, when all deaths due to cardiovascular conditions are added together with deaths due to cardiomyopathies, diseases related to the heart and blood vessels become the leading cause of maternal mortality (Callaghan W. , 2012). Bowyer (2008) reported similar trends in the United Kingdom. The increased number of women who become pregnant at older ages as well as the rise in rates of obesity, hypertension, and diabetes in the United States may help explain this pattern in maternal mortality (Callaghan W. , 2012).

Black women have a higher risk of dying from every maternal cause, including hemorrhage, gestational hypertension, and pulmonary embolism (Anachebe & Sutton, 2003). Tucker et al (2007), found that even though the leading causes of maternal mortality for Black and White women are similar, Black women had higher case-fatality rates for those conditions (Callaghan W. , 2012). A national study that examined pregnancy-related mortality among Black and White women revealed that Black women had a case-fatality rate 2.4 to 3.3 times higher than that of White women for most pregnancy complications including preeclampsia, eclampsia, and hemorrhage (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Harper et al (2004), reported that after controlling for confounders such as maternal age, income, hypertension, and receipt of prenatal care, Black women had higher pregnancy-related ratios for cardiomyopathy, hemorrhage, and respiratory complications (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018).

Non-Medical Causes of Maternal Mortality

The three leading causes of pregnancy-associated deaths are homicide, suicide, and drug-related overdose (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). A recent study estimates that the pregnancy associated homicide rate ranges between 2.2 to 6.2 deaths per

100, 000 live births (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). It is reported that Black women have almost seven times the risk of homicide as White women (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). Previous studies have found that pregnant and postpartum women, particularly young women, have nearly twice the risk of homicide compared to non-pregnant women (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). Intimate partner violence contributed to approximately 33% to 66% of pregnancy-associated homicides (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). For women experiencing intimate partner violence during pregnancy, the risk of becoming a victim of homicide or attempted homicide is three times higher than that of women who are being abused but were never killed or almost killed (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). Additionally, studies have estimated that suicides account for approximately 20% of postpartum deaths (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021). Depression is one of the leading comorbid factors that contributes to pregnancy associated suicides (Campbell, Matoff-Stepp, Velez, Hunter Cox, & Laughon, 2021).

Trends in Maternal Morbidity

Global Trends in Maternal Morbidity

Due to the lack of standard definitions and identification criteria, the true global burden of maternal morbidity is unknown (Firoz, et al., 2013). However, the World Bank estimates that severe maternal morbidity is increasing over time (Geller, et al., 2018). It is projected that for every maternal death, 20-30 women experience acute or chronic morbidity (Firoz, et al., 2013). Like rates of maternal mortality, severe maternal mortality rates are higher in low- and middle-income countries than in high-income countries (Geller, et al., 2018). Previous studies suggest

the highest burden of severe maternal morbidity is in sub-Saharan Africa, where one study in Nigeria found SMM estimates as high as 198 per 1,000 live births (Geller, et al., 2018; Mbachu, Ezeama, Osuagwu, & al, 2017). Asia also has high rates of severe maternal morbidity, with one study in India finding a SMM rate of 120 per 1,000 live births (Geller, et al., 2018).

National Trends in Maternal Morbidity

Again, it is difficult to determine the true rate of severe maternal morbidity in the United States due to varying definitions and identification criteria (Hirshberg & Srinivas, 2017). However, in the United States, it is estimated that maternal morbidity affects more than 50,000 women every year, or about 0.5-1.3% of pregnancies (CDC, 2021; Hirshberg & Srinivas, 2017). For every maternal death, 100 women experience acute or chronic morbidity or undergo a lifesaving procedure during their delivery (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Between 1998 to 2011, the rate of severe maternal morbidity increased from 0.6% to 1.6% (Hirshberg & Srinivas, 2017). Callaghan et al (2014), reported that based on ICD-10 codes, severe maternal morbidity increased by 75% from 1998 to 2009 (Hirshberg & Srinivas, 2017; Callaghan, Grobman, Kilpatrick, Main, & D'Alton, 2014). Based on ICD-10 codes, the incidence of 13 SMM indicators, including renal failure, shock, and cardiac surgery, more than doubled between 1998 and 2009, with blood transfusion/hemorrhage being the most common indicator of severe maternal mortality (Hirshberg & Srinivas, 2017; Callaghan, Grobman, Kilpatrick, Main, & D'Alton, 2014). It is unclear why severe maternal morbidity is increasing but changes in the overall health of the population of women giving birth, such as increases in maternal age, obesity, pre-existing chronic conditions, and cesarean delivery, may be contributing to increases in pregnancy-related complications (CDC, 2021). The increase

in blood transfusions (a procedure in which a patient is provided donated blood usually to address excessive bleeding during or after delivery), may also largely be driving the increase in SMM since blood transfusions increased from 24.5 to 122.3 from 1993 to 2014 (CDC, 2021).

Similar to maternal mortality, racial and ethnic minority women experience disproportionately higher rates of severe maternal morbidity (CDC, 2021). Black women have the highest rates for 22 out of 25 indicators of severe morbidity, used by the CDC (CDC, 2021). Gray et al (2012), conducted a population-based case control study and found all ethnic minority women had an increased risk for severe maternal morbidity with Black women having the highest rate reported (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018; Gray, Wallace, Nelson, Reed, & Schiff, 2012). Another study that analyzed data from seven states revealed that Black women had 2.1, Hispanic women had 1.3, and American Indian/Alaska Native women had 1.7 times higher rates of severe morbidity compared to White women (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Similarly, a population-based study in New York City shows that severe maternal morbidity rates for Black women were 4.2% and for Hispanic women were 2.7%, which is much higher than that of White women (1.5%) (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018).

Medical Causes of Maternal Morbidity

The principal causes of maternal morbidity are similar to maternal mortality. The most common medical causes of severe maternal morbidities are hemorrhage and hypertensive disorders (Geller, et al., 2018). Transfusion is the most common severe maternal morbidity (48.4%), followed by eclampsia (14%) and hysterectomy (11.9%) (Gray, Wallace, Nelson, Reed,

& Schiff, 2012). Other factors associated with an increased risk of severe maternal morbidity include older maternal age (over age 35), obesity, nulliparity (a woman who has not given birth to a child before), prior cesarean delivery, induction of labor, use of forceps, cesarean delivery, and multiple gestations (Gray, Wallace, Nelson, Reed, & Schiff, 2012). Maternal morbidity is not limited to only physical injury or illness, it also includes psychological or mental health (Meaney, Lutomski, & O'Connor, 2016). Psychological maternal morbidities include depressive episodes/depression (especially during the postpartum period) and post-traumatic stress disorder (PTSD) (Meaney, Lutomski, & O'Connor, 2016). It is estimated that nearly 6% of women have severe PTSD symptoms during the weeks following childbirth (Meaney, Lutomski, & O'Connor, 2016).

Research suggests racial and ethnic minority women, particularly Black women, are more likely to experience maternal morbidities. Black women have higher rates of hemorrhage, preeclampsia (even for women without pre-existing hypertension), asthma, cardiac events, and infections (Meaney, Lutomski, & O'Connor, 2016). According to national data, Black women had higher rates of pregnancy-induced and chronic hypertension, asthma, placental disorders, gestational diabetes, pre-existing diabetes, and blood disorders compared to White women (Meaney, Lutomski, & O'Connor, 2016). Hispanic women also have elevated rates of postpartum hemorrhage, diabetes, and infection compared to White women, and experience 8 out of 11 co-morbidities more often than White women (Meaney, Lutomski, & O'Connor, 2016). Studies have shown that racial and ethnic minority women, especially Black women, develop these comorbid conditions at earlier ages, are less likely for these conditions to be managed adequately, and more likely to have mortality from these conditions (Meaney, Lutomski, & O'Connor, 2016). Similar to maternal mortality, most cases of maternal morbidity are

preventable if women receive timely diagnosis and quality obstetric treatment (Meaney, Lutomski, & O'Connor, 2016).

Maternal Morbidity and Mortality in Georgia

Between 2015 and 2017, Georgia had the highest maternal mortality ratio (25.1 pregnancy-related deaths per 100,000 live births) in the country (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021; Georga Maternal Mortality Review Committee, 2018). Currently, Georgia has the second highest rate of maternal mortality in the US with a rate of 48.4 maternal deaths per 100,000 live births (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). According to the Georgia Maternal Mortality Review Committee, 101 women in the state died from pregnancy-related deaths between 2012 and 2014 (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). In Georgia, it is estimated the number of pregnancy-associated deaths is 68.9 deaths per 100,000 live births (Georga Maternal Mortality Review Committee, 2018). Between 2017 and 2019, the severe maternal morbidity rate was 5.7 per 1,000 live births (United Health Foundation, 2022). The leading causes of pregnancy-related deaths and indicators of severe maternal morbidity are cardiomyopathy, cardiovascular diseases, hemorrhage, embolism, preeclampsia and eclampsia, and amniotic fluid embolism (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Between 2012 and 2014, nearly 18% of pregnancy-related deaths occurred during pregnancy and 82% occurred during the postpartum period (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). The Georgia Maternal Mortality Review Committee determined that the majority (87%) of pregnancy-related deaths that occurred between 2015 to 2017 were preventable, including 80% of deaths caused by cardiomyopathy and 100% of deaths

caused by hemorrhage (Center for Reproductive Rights, 2019; Georga Maternal Mortality Review Committee, 2018).

In Georgia, Black women have the highest rates of maternal mortality and morbidity. For Black women, the pregnancy-related maternal mortality ratio is 47 deaths per 100,000 live births compared to 14.3 deaths per 100,000 live births for White women (Center for Reproductive Rights, 2019). Between 2012 to 2014, approximately 60% of those who died from pregnancy-related causes were Black (Center for Reproductive Rights, 2019). This means during that time period, Black women were nearly 3.3 times more likely to die from pregnancy-related complications than White women (Maternal Mortality Review Committee, 2019). Black women are more likely to experience and die from all the six leading causes of pregnancy-related deaths in Georgia (Center for Reproductive Rights, 2019; Maternal Mortality Review Committee, 2019). Women who reside in rural counties in Georgia also have a significantly higher rate of maternal morbidity and mortality (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Rural women are close to 50% more likely to experience maternal mortality compared to women who live in urban areas (Delima, Engstrom, Michels, & Qiu, 2020). Additionally, the maternal mortality rate for Black women who live in rural areas is twice as high as that for rural White women (Cooper, et al., 2019).

Factors Contributing to Adverse Maternal Health Outcomes

Factors contributing to maternal morbidity and mortality are complex and multi-faceted. A 2018 report from 9 state Maternal Mortality Review Committees (MMRCs) identified 4 levels of factors contributing to maternal deaths: patient, provider, and systems of care (Ahn, et al., 2020). Based on recommendations from 13 MMRCs, a 2019 “Morbidity and Mortality Weekly

Report" provided a similar delineation of levels, but also added health system-level factors (Ahn, et al., 2020). For this literature review, state-level and societal levels were added as well.

Patient-Level Factors

Rise in Chronic Conditions

In the United States, the increasing prevalence of obesity and other chronic conditions among pregnant women may partially help explain the increasing rates of maternal mortality and morbidity (Ahn, et al., 2020; Agrawal, 2015). Several studies have demonstrated that obesity is associated with severe maternal morbidity (Saucedo, et al., 2021). Sucedo et al (2021), found that the risk of maternal death rises as BMI increases, escalating by 1.6 in overweight women and more than tripling in severe obese women compared to normal weight women (Saucedo, et al., 2021). Research has shown that obesity increases the risk of pregnancy-related complications and is a risk factor for certain chronic conditions including gestational hypertension, preeclampsia, and gestational diabetes (Saucedo, et al., 2021). Chronic conditions such as cardiovascular conditions and cerebrovascular accidents (strokes) are becoming the leading causes of maternal mortality, accounting for half of all maternal deaths in this country (Centers for Disease Control and Prevention (CDC), 2020; Admon, et al., 2017). Studies have shown that women with certain chronic conditions including chronic respiratory disease, chronic hypertension, substance use disorders, pre-existing diabetes, chronic heart disease, chronic renal disease, human immunodeficiency virus (HIV), and chronic liver disease have an increased risk of complications during pregnancy or the postpartum period (Admon, et al., 2017). According to Admon et al (2017), the number of women diagnosed with a chronic condition at the time of delivery increased almost 40% between 2005 and 2014 (Admon, et al., 2017). The study also

found that the prevalence of multiple chronic conditions increased from 4.7 in 2005 to 8.1 per 1,000 delivery hospitalizations (Admon, et al., 2017). Black women are more likely to have pre-existing chronic conditions such as obesity, chronic hypertension, and Type 2 diabetes, which increases their risk of cardiovascular disease and maternal death (Lister, Drake, Scott, & Graves, 2019)

Advanced Age and Cesarean Deliveries

Other individual-level factors contributing to the rise of maternal mortality and morbidity are increases in maternal age and cesarean deliveries (Creanga, Syverson, Seed, & Callaghan, 2017). Typically, when women become pregnant at age 35 or older it is considered advanced maternal age, and studies have shown women with advanced maternal age have an increased risk of certain pregnancy complications including pre-eclampsia, gestational diabetes, placenta abruption, pre-term delivery and cesarean delivery (Wang, Tanbo, Åbyholm, & Henriksen, 2011). Rates of maternal mortality also increase with advanced maternal age, as seen in 2019 when the maternal mortality ratio for women aged 40 and over (75.5 deaths per 100,000 live births) was 6.0 times higher than the MMR for women under age 25 (12.6 deaths per 100,000 live births) (Hoyert, 2021). For Black women aged 40 and over the pregnancy-related mortality ratio is more than 160 deaths per 100,000 live births (Callaghan W. , 2012; Callaghan W. , 2012). Additionally, in the United States, cesarean deliveries are becoming more common, rising from an estimated 1 in 5 births in 1996 to 1 in 3 births in 2006 (Leonard, Main, & Carmichael , 2019). Several studies suggest cesarean delivery is associated with a higher risk of severe maternal morbidity and maternal death, and thus the increase in cesarean delivery rates may be contributing to the observed trends in maternal morbidity and mortality (Leonard, Main, &

Carmichael , 2019). Huesch and Doctor (2015), revealed that Black women were significantly more likely to have a cesarean delivery compared with women from other racial or ethnic groups (Huesch & Doctor, 2015).

Substance Use and Mental Health Conditions

Several studies suggest substance use and mental health conditions among pregnant women may also be contributing to maternal mortality (Ahn, et al., 2020). One study showed the prevalence of maternal opioid dependence or abuse in the United States increased from 0.17% in 1998 to 0.39% in 2011 (Ahn, et al., 2020). The study also found that deliveries affected by maternal opioid dependence or abuse had four times the odds of maternal death than deliveries without opioid dependence or abuse (Ahn, et al., 2020). According to data from the National Survey on Drug Use and Health, pregnant Black women between the ages of 15 to 44 were more likely to have used any illicit drugs in the past month than pregnant White and Hispanic women (The National Survey on Drug Use and Health (NSDUH) , 2012).

Socioeconomic Status and Receipt of Prenatal Care

Research suggests lower socioeconomic status, lack of insurance, and lack of prenatal care also play a role in maternal mortality and morbidity disparities. Bertin et al (2015), revealed that women with low SES are more likely to lack knowledge of the possible association between not seeking or receiving timely prenatal care and adverse maternal health outcomes (Bertin, Viel, Monfort, Cordier, & Chevrier, 2015). Another study suggests women who receive late or no prenatal care are five times more likely to suffer a pregnancy-related death than those who receive prenatal care (Maternal Health Task Force, n.d.). In 2015, approximately 25% of all

women in the US started care later in pregnancy or did not receive the recommended number of prenatal visits; however, this rate increases to 34% among women who are African American and to 41% among women who are American Indian/Alaska Native (Maternal Health Task Force, n.d.). Other population-based studies reported that Black women are four times more likely to receive 0-5 prenatal care visits than White women (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018).

Social Determinants in General

Yet, socioeconomic factors alone cannot fully explain racial maternal health disparities. For instance, while educational advancement is usually a protective factor regarding health, that is not the case for Black women (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020). Education further exacerbates Black-White disparities in maternal mortality (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020). For example, Black mothers with a college education are five times more likely to die than White mothers with a college education (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020). Additionally, Black mothers with a college education have a higher rate of pregnancy-related deaths (40.2) than White mothers with less than a high school education (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020).

However, research demonstrates that a myriad of individual-level factors including higher prevalence of comorbidities and pregnancy complications, lower SES, and less access to prenatal care, contribute to but do not fully explain the significantly higher rates of maternal morbidity and mortality among racial and ethnic minority women (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018).

Provider Level Factors

Implicit Bias

According to Byrne and Tanesini (2015), "there appears to be a fundamental inconsistency between research which shows that some racial and ethnic minority groups consistently receive lower-quality healthcare and the literature indicating that healthcare workers appear to hold equality as a core personal value." (Howell, et al., 2018). One explanation for this paradox is that implicit or unconscious bias may be influencing clinicians' perceptions and medical decisions, which further contributes to racial disparities in adverse maternal health outcomes as well as patient-provider interactions (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Implicit bias is defined as, "the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner and cause us to have attitudes about other people based on personal characteristics including but not limited to age, race and ethnicity, body habitus, disability, gender, or sexual orientation. These biases are pervasive, subconscious, and activated involuntarily" (Howell, et al., 2018). Implicit bias is commonly measured or assessed using the Implicit Association Test (IAT), which is available online and involves a computerized, timed categorization task that measures implicit preferences by avoiding conscious processing (Saluja & Bryant, 2021).

However, many healthcare care providers fail to acknowledge how implicit bias affects their personal clinical practice (Saluja & Bryant, 2021). A study by the Society for Maternal Fetal Medicine reported that 84% of clinicians agreed that disparities impact their practice, but only 29% claimed that personal biases influenced how they care for patients (Saluja & Bryant, 2021). Another study in 2012 revealed that after adjusting for medically necessary cases,

cesarean deliveries were more commonly performed on Black and Hispanic women compared to White women (Saluja & Bryant, 2021). Given that cesarean deliveries are associated with more adverse maternal health outcomes, this finding suggests implicit bias may play a role in the higher rates of unnecessary C-sections among women of color.

Discrimination and Racism

Explicit biases such as discrimination and racism also impact the quality of perinatal care Black women receive, which further contributes to disparities in mortality and morbidity. In the United States, 30% or one in 10 Black women who delivered in a hospital reports they were mistreated by their provider due to their race compared to only 3 in 100 White women that report provider mistreatment (Siden, Carver, Mmeje, & Townsel, 2021; Saluja & Bryant, 2021). The Listening to Mothers III survey found that nearly one in five Black and Hispanic women experienced mistreatment from a provider during their hospitalization due to their race, ethnicity, culture, and/or language (Saluja & Bryant, 2021). In Georgia, approximately 21% of Black women experience some form of racism before, during, or after childbirth (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). According to Taylor et al, (2019), pregnant Black women in Georgia are often ignored or do not receive help from healthcare care providers when they are experiencing pain or discomfort throughout the perinatal period (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021; Taylor J, 2019). Overall, healthcare provider factors, such as delayed response to clinical warning signs and ineffective care, are the most common contributors to maternal deaths (Green, et al., 2021).

Patient-provider communication

Implicit and explicit bias also negatively affects patient-provider communication. Several studies have found that women of color are more likely to report lower satisfaction with medical provider interactions (Saluja & Bryant, 2021). Medical providers can express racial biases by engaging with patients using a condescending tone, which decreases the likelihood that those patients feel heard or valued by their providers (Saluja & Bryant, 2021). Also, biases can be expressed through providers recommending different treatment options based on assumptions about treatment adherence capabilities or deduced health conditions (Saluja & Bryant, 2021). Multiple studies indicate that medical providers who exhibit higher implicit bias display higher verbal dominance in their communication styles and less interpersonal approaches (Saluja & Bryant, 2021). As a result, patients of these providers report poorer satisfaction and greater difficulty understanding recommendations given by providers (Saluja & Bryant, 2021).

For Black women, in particular, poor patient-provider communication leads to medical providers ignoring their expressions of pain and discomfort (Taylor, Structural Racism and Maternal Health Among Black Women, 2020). Rust et al., found that women of color, specifically Black women, had significantly lower rates of epidural analgesia (Saluja & Bryant, 2021). Declercq et al., (2013) showed how Black women report worse experiences with pain management during the postpartum (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2014; Siden, Carver, Mmeje, & Townsel, 2021). Dismissals of Black women's pain and discomfort directly leads to delays in diagnosis and treatment of perinatal complications, which further contributes to maternal mortality and morbidity disparities.

Healthcare system Level Factors

Quality of Care

Multiple studies suggest that a considerable portion of racial disparities in maternal morbidity and mortality may be explained by variation in hospital quality (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Several studies have revealed that racial and ethnic minority women deliver in different, lower quality hospitals than White women (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Howell et al (2018), found that only 18% of White deliveries occurred in the same hospital as Black deliveries, and hospitals that disproportionately served Black pregnant women had significantly higher severe maternal morbidity rates for both Black and White women (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). In a population-based study in New York, the data suggests that Black women are more likely to deliver in hospitals with higher risk-adjusted severe maternal morbidity and mortality rates (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). 65.3% of White deliveries occurred in hospitals categorized in the lowest tertile for severe maternal morbidity compared to only 23.3% of all Black deliveries (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018).

Based off a simulation that quantified the impact of delivery location, it was estimated that if Black women delivered at the same hospitals as White women approximately 1,000 fewer severe maternal morbid events would occur among Black women and the Black SMM rate would be reduced from 4.2% to 2.9% (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). Creanga et al, (2014), found similar findings that Black serving hospitals performed worse than White serving hospitals on delivery-related indicators based on

data from seven states (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018; A.Creanga, et al., 2014). Structural racism may help explain why hospitals disproportionately serving Black women are of lower-quality (based on lower delivery-related performance indicators) and have a higher risk of maternal complications and death compared to hospitals serving more White patients (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019).

Discrimination based on insurance status

In one qualitative study, a large number of Black women discussed receiving differential treatment by hospital staff based on their insurance status (public versus private) (Lister, Drake, Scott, & Graves, 2019). Many Black women insured through Medicaid report prejudiced interactions with doctors and other healthcare care staff including being treated with disdain by medical professionals who knew or assumed that the women were uninsured or receiving Medicaid (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019). In Georgia, women on Medicaid discussed "feeling less worthy" to use or access services of the healthcare system (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019). One study found that in Georgia most pregnant women receiving Medicaid had to rotate between medical providers and wait long hours to receive care (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Many added that this was a disincentive for them seeking prenatal and postnatal care (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021).

Medicaid Expansion

It is important to note that although the Patient Protection and Affordable Care Act (ACA) allows states to expand Medicaid coverage to uninsured populations, Georgia chose not

to expand coverage (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). This decision leaves nearly 240,000 Georgia residents uninsured including pregnant women with low SES (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). In Georgia, Medicaid funds between 50% and 60% of all births (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019). However, only 67% of OB/GYN providers in Georgia accept new Medicaid patients due to burdensome reimbursement processes and low reimbursement rates (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019; Center for Reproductive Rights, 2019). Furthermore, even though Georgia presumes Medicaid eligibility for all pregnant to speed up the enrollment process, it can still take several weeks for women to start receiving coverage, which results in delays in seeking prenatal and postpartum care and further contributes to racial disparities in maternal morbidity and mortality (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019).

Crisis Pregnancy Centers

Georgia also uses taxpayer funds to finance Crisis Pregnancy Centers (CPCs), which often do not provide accredited medical care or offer the information needed to access comprehensive pregnancy care (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019). Thus, CPCs can serve as a delay to perinatal care (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019). Georgia allocates $2 million annually in the state budget to fund CPCs through the Positive Alternatives to Pregnancy and Parenting grant program (Center for Reproductive Rights, 2019).

Rural disparities

Additionally, in Georgia, many hospital labor and delivery units have been closing over the last several decades, especially in rural areas (Center for Reproductive Rights, 2019; Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). In Georgia women living in rural counties are nearly 50% more likely to experience maternal mortality compared to women living in urban areas (Delima, Engstrom, Michels, & Qiu, 2020). This is largely due to their limited access to maternal care in rural Georgia (Delima, Engstrom, Michels, & Qiu, 2020). In 2015, only 46 of the state's 159 counties had labor and delivery units (Center for Reproductive Rights, 2019; Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). In 2019, 93 of Georgia's 109 rural counties lacked a hospital labor and delivery unit, 75 rural counties lacked an obstetrician-gynecologist (OB/GYN), and zero rural counties had a maternal-fetal specialist (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021; Delima, Engstrom, Michels, & Qiu, 2020). As a result, approximately 83% of women living in rural Georgia who once lived close to a birthing facility, now must travel long distances to access prenatal care and hospital delivery services (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Research shows that longer travel times are associated with poor birth outcomes, which may be further exacerbating racial disparities in maternal health (Center for Reproductive Rights, 2019). In Georgia, rural Black women have double the maternal mortality rate of rural White women and have a 30% higher rate of maternal mortality than urban Black women (Cooper, et al., 2019).

Societal Level Factors

Weathering and Stress

In the United States, Black women are exposed to a uniquely stressful experience due to their intersecting, stigmatized and marginalized racial and gender identities, which increases their risk for poor maternal health outcomes (Mehra, et al., 2020). The distinct combination of sexism and racism that Black women face is referred to as "gendered racism" (Mehra, et al., 2020). Studies have found that Black women report the highest number of stressful life events in the year before giving birth and Black pregnant women have higher levels of self-reported and biological measures of chronic stress than White pregnant women (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). This persistent exposure to chronic stress has a physical cumulative effect referred to as a "weathering effect" meaning Black women's bodies are aging and deteriorating faster than the average woman (National Partnership for Women & Families, 2018). Studies have shown that self-reported experiences of racism and discrimination over the life course are associated with adverse birth outcomes including higher rates of preterm delivery (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019).

Mistrust of Healthcare Care System

Black women also must grapple with this country's legacy of reproductive oppression and continue to experience reproductive coercion, which often leads to distrust of the healthcare care system. Previous adverse experiences and mistrust causes women to delay or a discontinue seeking perinatal care, which further exacerbates maternal health disparities (National Partnership for Women & Families, 2018). According to Becker & Tsui (2008), Black women are more likely to report having been pressured by a provider to use a contraceptive method

(National Partnership for Women & Families, 2018; Becker & Tsui, 2008). Additionally, some Black women may be forced to continue unwanted pregnancies due to cumbersome restrictions and a lack of health insurance that makes abortion inaccessible (National Partnership for Women & Families, 2018).

Structural Racism

Current efforts to identify and address root causes of maternal health disparities often focus on individual risk factors including clinical, behavioral, and sociodemographic factors; however, often not enough attention is placed on the historic, structural forces that created the social determinants of maternal morbidity and mortality in the United States (Crear-Perry, et al., 2021). According to the Aspen Institute, structural racism is defined, "as a system where public policies, institutional policies, and cultural representations work to reinforce and perpetuate racial inequity" (Taylor, Social and Structural Determinants of Health Inequities in Maternal Health, Structural Racism and Maternal Health Among Black Women). Redlining, mass incarceration, Jim Crow, and the GI Bill are prime examples of how structural racism harms Black people's health, by creating unequal access to resources and opportunities necessary for promoting optimal maternal health among Black people (Crear-Perry, et al., 2021). Structural racism also causes disparities in income, housing, safety, education, and other social determinants of health that are associated with increased rates of chronic conditions such as cardiomyopathy and hypertension (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020). This further increases Black women's risk of experiencing maternal complications and even pregnancy-related death (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020).

Adverse Maternal Health Outcomes in Georgia

In Georgia, 8.7% of women in Georgia receive delayed or no prenatal care (Baudry, Gusman, Strange, Thomas, & Villarreal, 2019). However, 11% of Black pregnant women in Georgia received late or no prenatal care (Center for Reproductive Rights, 2019). In Georgia, many women with low SES and rural women experience interruptions and inconsistencies in prenatal care due to a lack of health insurance (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Due to different social and structural determinants of maternal health, Black women are more likely to lack health insurance and face financial barriers, which leads to delayed or fewer prenatal visits (Lister, Drake, Scott, & Graves, 2019).

In Georgia, poor patient-provider communication is also associated with delays in seeking and discontinuation of prenatal care (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Poor patient-provider communication was also linked to delays in referrals of high-risk patients to specialists (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Hueston et al, reported that nearly all study participants stated that poor communication with their medical provider determined their continued utilization of prenatal care services (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021). Study participants shared that they became averse to care and disinterested in their medical providers when they felt like they were being ignored or unheard (Armstrong-Mensah, Dada, Bowers, & Muhammad, 2021).

A Call to Action for Respectful Maternal Healthcare Care

Most severe maternal morbidity events and maternal deaths are preventable (Howell, Reducing Disparities in Severe Maternal Morbidity and Mortality, 2018). In Georgia, 61% of

pregnancy-related deaths that occurred between 2012 to 2014 were deemed preventable, including 100% of deaths caused by hemorrhage and 80% of deaths caused by cardiomyopathy (Center for Reproductive Rights, 2019). Studies have shown that doulas can improve quality of care and most likely can help reduce racial maternal health disparities by serving as advocates for patients, providing culturally competent care, and bridging communication barriers between mothers and medical providers (Center for Reproductive Rights, 2019). Similar evidence has been demonstrated for midwifery-led care as well (Center for Reproductive Rights, 2019). However, these alternative care options, which are often more culturally acceptable, are not widely available in Georgia because the state's legal requirements for alternative options are stricter than other states (Center for Reproductive Rights, 2019). Certified nurse-midwives can practice but without full autonomy, home births must be done in cooperation with a clinician, and extensive regulations and requirements significantly restrict birth centers (Center for Reproductive Rights, 2019)

A growing body of research suggests disrespect and abuse of women seeking maternity care is becoming an urgent problem because it is one of the most significant barriers to women's utilization of facility-based maternal health services (Bowser & Hill, 2010). A 2010 landscape report for the US Agency for International Development identified seven major categories of disrespect and abuse women are subject to during pregnancy, childbirth, and after delivery: physical abuse, non-consented clinical care, non-confidential care, non-dignified care (such as verbal abuse), discrimination based on specific patient characteristics, abandonment or denial of care, and detention in facilities (The White Ribbon Alliance; Bowser & Hill, 2010). The report also states that the fear of receiving physical and emotional trauma inflicted by maternal

healthcare providers was a major deterrent for many women seeking proper skilled care in a healthcare facility (Maternity Today, 2022; Bowser & Hill, 2010).

Research suggests that ethnic minority women, especially Black women, have a greater risk of experiencing disrespect and abuse during hospitalizations (Center for Reproductive Rights, 2019). One study found that 22% of Black women report experiences of discrimination in the healthcare care setting (National Partnership for Women & Families, 2018). In a qualitative study conducted in New York City among women of color from low-income communities, many participants described different experiences of disrespect and abuse including experiences of racism and discrimination, verbal abuse (such as reported threats, judgments, and the use of condescending and rude language), poor communication with providers (women felt like they were being treated as less than human by providers, providers lack empathy and compassion, and felt that providers deliberately withheld information), and neglect (many women felt that providers did not listen/ignored them or did not respond with a sense of urgency when they shared that they were feeling pain or other concerns) (Freedman, McNab, Won, Abelson, & Manning, 2020). This supports key findings from the Listening to Mothers survey that, compared with White women, Black women are more likely to report being treated with disrespect and unfairly by providers due to their race (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020). The Listening to Mothers survey also highlights how, compared with women with private insurance women insured with Medicaid are more likely to report having no postpartum visits, forced to return to work at least two months after giving birth, having less emotional and practical support during postpartum period, and being treated with disrespect and receiving unfair treatment based on their insurance status (Declercq & Zephyrin, Maternal Mortality in the United States: A Primer, 2020).

Every woman deserves to receive respectful maternal healthcare (Shakibazadeh, et al., 2017). Respectful maternity care, including respectful prenatal, delivery, and postpartum care, is being increasingly acknowledged as a critical component of strategies to improve the quality of maternal healthcare and reduce racial disparities in maternal mortality and morbidity (Shakibazadeh, et al., 2017). Respectful maternal care can be defined as, "care provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth" (Green, et al., 2021). Respectful maternal care is globally recognized as a universal human right for every woman admitted to a hospital or any other healthcare facility (Shakibazadeh, et al., 2017). However, there is a lack of a common understanding of how respectful maternal care is defined, even though it is used similarly as the terms "women-friendly care" and "women-centered care" (Shakibazadeh, et al., 2017).

Due to the alarmingly high rates of maternal mortality and morbidity among Black women, there is an urgent need to understand the factors that may be driving these maternal health disparities in Georgia. Experiences of mistreatment and disrespectful care are powerful disincentives to seeking maternal healthcare in a hospital setting, which may be contributing to the Black maternal health disparities. This study aims to understand the facilitators and barriers to maternal healthcare care seeking in Atlanta, Georgia, specifically from the perspective of Black women (those who are most impacted by disrespectful care). In addition to filling this gap, this paper will also provide Black women-led recommendations for improving the provision respectful care in medical settings, which could be used to inform future interventions addressing racial disparities in maternal health.

Chapter 2: Methods

Study Design

We conducted an exploratory qualitative research study as part of a 12-month research supplement to the NIH Environmental Influences on Child Health Outcomes (ECHO) program. This approach was chosen because it is suitable for gaining a deeper understanding of Black women's lived experiences and identifying barriers and facilitators to maternal healthcare. This qualitative study used a community-based participatory research approach, which equitably involves community members and researchers at all stages of research with the aim of co-learning to improve community health and eliminate health disparities (Wallerstein & Duran, 2006). Researchers from Emory University collaborated with the Center for Black Women's Wellness (CBWW) as equal partners to develop the study design, collect, and analyze data, and present and disseminate findings.

This qualitative study sought to understand experiences seeking prenatal, delivery, and postpartum care by conducting focus groups among Black women with different insurance types (i.e private versus public insurance). This analysis sought to answer two major research questions: 1) What are the barriers and facilitators that Black women in Georgia face when seeking maternal healthcare care; and 2) What recommendations do Black women in Georgia have for providing respectful and equitable maternal healthcare?

Study Participants

This study is part of the NIH funded Environmental Influences on Child Health Outcomes (ECHO) program that brings together more than 70 cohort studies from across the nation under a common protocol to address five key pediatric outcomes with high public health impact: pre-, peri-, and postnatal outcomes, upper and lower airway, obesity, neurodevelopment,

and positive health (National Institutes of Health, 2021). The cohorts are made up of mother and their children referred to as "mother-child dyads" (National Institutes of Health, 2021). Most of the cohorts recruited participants prenatally and all cohorts are longitudinally following the children (National Institutes of Health, 2021). The Atlanta ECHO cohort study is one of the longitudinal studies that is conducting research on women and children in Atlanta, Georgia as part of the larger ECHO cohort consortium (National Institutes of Health, 2021).

This study recruited a purposive sample of 18 Black women enrolled in the Atlanta ECHO cohort who delivered their child at Grady Memorial Hospital (a public, safety-net hospital) or Emory Hospital (a private hospital) and experienced pregnancy complications due to hypertension or diabetes and/or experienced maternal morbidity. Eligible women were identified through data collected by the Atlanta ECHO cohort that documented pregnancy complications and delivery and postpartum outcomes. Eligible women were contacted and invited to participate by the ECHO investigator, Ann Dunlop. Participants were awarded a $50 gift card for their participation.

Data Collection

This study conducted 4 focus groups from May to December 2021 with 4-6 women in each. The composition of each focus group was purposively selected to include: two focus groups among women who delivered at Grady Memorial Hospital (one comprised of women who were insured by Medicaid, and one comprised of women who were insured by Right from the Start (pregnancy) Medicaid) and two focus groups among women who delivered at Emory Hospital (one comprised of women who were insured by Medicaid, and one comprised of women who were privately insured). The rationale for this organization was to enable the

examination of differences in women's barriers and experiences with perinatal care due to health insurance and variations in healthcare systems. All focus group discussions were done virtually via Zoom and were on average two hours long.

The focus groups were facilitated by two Black women skilled in qualitative research, one from the CBWW and the other a graduate student from Emory University's School of Public Health. The focus group moderator guide was developed and pilot-tested collaboratively with the Center for Black Women's Wellness. As seen in Table 2, the focus group guide explores domains centered around barriers and facilitators to seeking care during the prenatal, delivery, and postpartum experiences. Each focus group had a notetaker who took notes during the discussion and composed a summary report afterward.

Data Analysis

All focus groups were recorded and transcribed by a professional transcriptionist. To prepare for coding and content analysis, electronic transcripts were cleaned and de-identified by a member of the research team. For the preliminary analysis, the team developed a codebook using deductive codes derived from the focus group guide. Inductive codes were added to the codebook after rereading and coding the first transcript from the pilot focus group. A team-based approach, where two researchers review and code the transcripts with a lead analyst, was used to meticulously code each transcript. All textual data was organized and managed using MAXQDA qualitative data analysis software. One researcher conducted the thematic analysis, which includes identifying and analyzing themes, of the focus group data using MAXQDA data analysis software. Initial findings were shared with the CBWW to gain additional input.

Ethical Considerations

This study received ethical approval from the Emory University IRB. To ensure informed consent, participants signed a consent form that provided information about the study and explained the risk and benefits of participation. Researchers also received verbal assent from all participants to record the focus group. To maintain participants' confidentiality, all transcripts were de-identified and only members of the research team including community partners had access to the data. At the beginning of each focus group, participants were reminded that their participation is entirely voluntary. The IRB's approval demonstrates that the risk of undue influence from offering a financial incentive is reasonable.

Chapter 3: Results

Participant characteristics

A total of 18 women participated in the four focus groups. There was a range of between 4 to 6 participants in each group. As shown in Table 1, all focus group participants identified as African American/Black (100%). About one third of participants (38.9%) were young adults (18-24), while almost half (44.4%) were between ages 25-34 when they were pregnant and enrolled in the study. Most participants were unmarried (77.8%). However, 38.9% of participants were cohabiting with a partner and 27.8% of participants had a partner but was not cohabiting. Half (50%) of participants were privately insured, while about one-third (33.3%) of participants were insured through Right-from-the-Start Medicaid (Georgia's Medicaid program for pregnant women), and 16.7% of participants were insured through low-income Medicaid (traditional Medicaid based on income). Half of participant (50%) participants delivered at Emory Midtown Hospital and 50% of participants delivered at Grady Memorial Hospital, both located in metro Atlanta. Among participants, gestational hypertension and pre-term delivery were the most common perinatal complications.

Description of Topics

Participants identified a wide variety of barriers and facilitators when seeking and accessing maternal healthcare that were related to three topics: quality of interpersonal relationship and communication, adequacy of service, and sociocultural factors. Participants also provided recommendations to improve the provision of respectful maternal healthcare.

Barriers to Seeking and Accessing Maternal Healthcare

Barriers were defined as factors that prevent or limit individuals from seeking maternal healthcare services. Barriers were categorized into three topics: poor quality of interpersonal relationship and communication, adequacy of service, and sociocultural factors.

Theme 1: Poor interpersonal relationships and communication with medical providers was a major barrier for Black women seeking and utilizing perinatal healthcare care services.

Within this broad theme, three significant subthemes emerged: poor patient-provider communication, provider's negative personality characteristics, and lack of an interpersonal relationship with provider.

Sub-theme 1: Poor patient-provider communication with maternity care providers was a significant barrier for Black women seeking future perinatal healthcare care services.

Many participants described instances of poor patient-provider communication. Several participants who delivered at Grady Memorial Hospital shared that when they expressed health concerns, such as pain or breathing issues, their providers did not listen to them. For instance, two participants stated:

> "*Last year, I actually I told him I know that the baby was coming. And he was like, "No, you're fine. You can go home." I went home and probably about an hour later, blood just started gushing out. I had to call 911 again. And when I got there, her foot was coming out. It was like the doctor didn't believe me. I'm like... I was telling him she's coming now. I know she's coming. I can feel it because these are not just regular pain. He really wasn't listening." (Pilot Participant 2)*

"I needed a new inhaler and they just pretty much kept telling me to exercise and walk it off pretty much. And I had to have my mom come down there with me. They listened to her, but they didn't listen to me when I was expressing my concerns about my asthma and me losing my breath so quickly." (Pilot Participant 1)

The participants also shared their beliefs about the consequences of their providers not listening to them:

"When I was telling the doctor that I was in pain and the baby's coming. He didn't listen and he sent me home. And I could have had a miscarriage when I went home because I was in labor then." (Pilot Participant 2)

"Because I'd say I was scared something's going to happen to me. That's why I had to get my mama involved. I couldn't walk a couple of steps without me losing my breath and they wouldn't take me serious enough about my asthma pump. I feel like they could have led to something real serious had it not been taken care of." (Pilot Participant 1)

Some participants discussed how when they expressed health concerns they had with their providers, their providers would listen but would either dismiss or not take their concerns seriously enough. For instance, one participant stated:

"…I'm sorry that you just finished, delivering a baby and you had a really long night, but I'm telling you that something is happening and she's like, well you're a first-time mom. You're probably not as far along. So I'm giving you this information, but yet you're still

giving me, you're kind of bypassing what I am literally saying to you. And you're going off of, I don't know, textbook knowledge or whatever." (Participant 7)

"I always felt they listened. I definitely felt like they listened. There's like a brushing off like, "Oh yeah, no, that's normal, that's fine", instead of truly like, "Oh, well let's dive into that". There were times that they were like, "Well, let us do a little research and, I want you to monitor it and come back next week when we meet and tell me what has happened." (Participant 12)

Several participants who delivered at Emory Hospital noted that providers did not take the time to "dig deeper" or inquire about symptoms further.

"I did my normal six-week follow up and I went back to my normal doctor, which was my OB. And after that, I didn't seek anything else. And there was a lack of them reaching back out to me, to be honest. After they saw me for six months... or six weeks, and they were like, "You're healed up. Good, go on about your business." They asked some questions about, "Do you feel suicidal?" Which no, I don't. But that doesn't mean I don't have other concerns or other... I'm not processing this first pregnancy and transition in life differently, but because it wasn't extreme, I don't feel like there was an urgent need for care, so they didn't offer much else." (Participant 12)

"That would've helped because I don't feel like there was much follow up. It was, "Okay, you're good enough to survive. Good luck surviving." And it would've been nice if there

was that personalized follow up that may have dug up deeper and asked more of what I needed or what I didn't know I needed." (Participant 12)

Other participants talked about how their providers withheld medical information and did not explain their medical decision or treatment well to the patient.

"Nobody explained to me what a [leep] procedure was. They just told me that I was going to have it done, and when I was going to have it done, and that was just the end of that. And I had to have my momma come…Yeah. I had to have my momma come because they wouldn't... No one explained to me. I didn't know what it was." (Pilot Participant 1)

"He's the one who told me that I had a cyst on my left ovary and the cyst was growing bigger than my babies. And so the plan was to go in and just remove the cysts, but it didn't work like that. So I didn't know that I can still have kids because my paperwork had said that they removed my ovary. So when I had got pregnant, I was not going back there." (Participant 14)

A few participants stated that their provider did not provide enough information about potential health concerns or resources, including mental healthcare care resources, during their pregnancy.

"That mental health was not offered postpartum." (Participant 12)

"I just feel like my first experience with my son, I feel like it wasn't the best. I feel like I see other moms and I'm like, they had the pictures took, I never took pictures with my son

at the hospital. Like he don't have any hospital pictures, just a lot of things that other moms did, I didn't do because I was never offered that. I didn't know about it. It's not like I went knowing like, so it wasn't even offered to me like, hey, maybe you should try doing this or we don't offer this here, but you can try to. I just feel like it should be a lot more…" (Participant 9)

Several participants emphasized how first-time mothers especially would have appreciate being provide more information.

"*But when I met the, the OB, she was nice, but I felt that she was a little cold and I like, you know, being a first time mom, I had a ton of questions and I just, I was expecting a lot more warmth and a lot more, you know, and like, I, not, I had questions, but then I was also looking for lots of information and I didn't feel like I got that." (Participant 7)*

Sub-theme 2: Providers' negative personality characteristics served as a barrier for future maternal healthcare-seeking behaviors among Black women.

Many participants described negative personality qualities in their providers such as having a rude or disrespectful attitude.

"*…the nurses would come in there with attitudes and I was telling the nurse one day I was in so much pain, I was like, "I need some medicine," she was like, "Oh well, you got to wait till this other nurse come in to give your meds." And I was like, "But I'm in pain, severe pain," and she literally made me wait until the other nurse came." (Participant 3)*

Several participants conveyed that they do not appreciate when members of their healthcare team have negative viewpoints.

> *"The team was just so negative, but I'm a very positive person. The faster they got her out because it was a C-section emergency. She said, "I'm not going to lie to you. Your baby's going to die." I was like, "Oh wow."...And I told her. I was like, "Oh, I don't believe you.". I said because I believe in a higher power. I don't believe my child is going to die." (Pilot Participant 2)*

Some participants who delivered at Emory Hospital reported that they believe the negative attitudes of the healthcare team could be attributed to the COVID-19 pandemic since the hospital staff was overworked and tired due to the increased caseloads and staff shortages.

> "*In my second experience, again, they were just must have been overworked because it felt as if we were bothering them. Not that anyone said anything per se, but there was a different level of sass from the nurses. And I never rang the buzzer. I didn't ask for anything. It wasn't that I was like bothering them. I just think they were tired." (Participant 12)*

Multiple participants also stated that members of their healthcare team did not respect their infant feeding preferences and pressured them to breastfeed. Participants who delivered at Grady Memorial Hospital and those who delivered at Emory Hospital both shared this sentiment.

"My only issue as far as cause I tried to breastfeed. Breastfeeding and it wasn't really working for me. So I kind of felt pressured that one of the nurses kept trying to pressure me into breastfeeding, even though I told her I didn't want to do breastfeeding anymore if she could just get a bottle, and she just kept trying to pressure me. No, continue to try, continue to try. But if I'm telling you that's not what I want to do then why are you trying to force me into breastfeeding" (Participant 13)

"So I had to end up giving her the formula and I ain't have no problem with doing that…But yeah, it was like they was trying to force breastfeeding, they try to make you do it." (Participant 1)

Sub-theme 3: The lack of an interpersonal relationship with maternity care providers negatively impacts the perceived quality of care and can serve as a deterrent for Black women seeking maternal healthcare.

Many participants described a lack of strong interpersonal relationships with their providers. Many participants criticized the lack of individualized maternity care and felt like their provider was making stereotypical assumptions about the care and resources that they would need.

"I would say that I think just, care is not individualized. I think it goes back to stereotyping and stuff. Sometimes they think that we all look alike or it's just a black woman walking down street or a black man walking down the street. I think when you get into healthcare they see you as that too." (Participant 7)

One participant added that the lack of individualized care can be attributed to medical providers who have been practicing medicine for a long time and do not continue to receive trainings on topics like non-discriminatory approaches to improve their care.

> *"And then I can understand people who have been doing this work for years like they do, I think we work in structures and organizations. It's really easy to categorize things. Over time, you can say, well, this mom seems that she fits in this category and stuff, but that's not really helpful because not every birth is the same, not every woman is the same." (Participant 7)*

Several participants stated that this lack of individualized care made them feel "like just a number" and feel like they were just being rushed or ushered through their appointments.

> *"I was just a number rather than a patient. My first one I felt very much like I loved the doctors that I always saw and it's the same group, but the second time I just felt like I was ushered through the process instead of the same care, if that makes sense." (Participant 12)*

> *"But I couldn't, I really did not leave that appointment feeling that I wasn't just going to be another number, you know? Like, were they really going to know me or anything like that?" (Participant 7)*

The lack of individualized care made one participant uncomfortable during her prenatal care visits and deterred her from seeking care in a hospital setting.

> *"But I don't, I don't want to go to a hospital. I was like, if I don't feel like I'm comfortable just in the appointments, I feel like I'm not going to be comfortable at birth, and that's really important to me" (Participant 7)*

One participant added that when providers closely follow guides and checklists, it makes her believe that her providers are not interested in learning about her unique needs or providing truly holistic care.

> *"However, I feel like it's more so because it's not individualized, I may say to you like, "Oh, I feel like I ain't got no help" and you have to go through the script or the guide that you're given and you're asking me all type of questions about suicidal thoughts and government assistance and all other programs and whatever else, because they're not individualizing it to me. They're going off a script that they have and they have to make sure they check off all the boxes and do all this other stuff to make sure I'm not going to harm myself, but that's not what I'm talking to you about." (Participant 11)*

Other participants talked about how not knowing or not having a relationship with the provider who will deliver their child caused discomfort.

"So, there was a panic there because I had spent the past 10 months essentially learning these group of people who would've been there, but neither of them were able to make it to the delivery. I had a completely different doctor who was at the hospital at the time. I did not know him, he came in, introduced his name as he was drying his hands that he had just washed, and he just kind of got down there and was like, let's go. So it made me feel very uncomfortable, I cried during that time because I felt like I didn't know him." (Participant 11)

Theme 2: Perceived inadequate medical care was another major deterrent for Black women seeking and continuing maternal health services throughout the perinatal period.

Within this theme, three significant topics emerged unequal treatment due to being on Medicaid, structural barriers, and perceived poorer quality of care.

Sub-theme 1: The perceived unequal treatment to women enrolled in Medicaid is a major barrier for Black women seeking maternal health services.

Many participants discussed how they believe patients insured with Medicaid receive unequal treatment compared to those privately insured. For instance, one participant shared a previous experience where the doctors did not provide treatment in a timely manner.

"I got a phone call at 6:00 in the morning, my sister had to rush my baby to the hospital. My baby was 20 minutes from dying. She was having an asthma attack and couldn't even breathe. They got her to the hospital, my sister only had her Medicaid card, but she had insurance too with her dad. Do you know, they treated my baby... they was moving so

slow with my baby. But when her dad came and was like, "Oh, she got Blue Cross/Blue Shield," that's when everything changed. They shifted gears, they had to rush her to Hospital 10. They did everything, they just went haywire then. But they was like, if he wouldn't have probably came with her insurance, my baby... ain't no telling what would have happened to my baby." (Participant 3)

"The nurse even told me this last time and I'm not supposed to tell you this, she said, "However you come in with whatever insurance you got, that's according to how we treat you." So if you got Medicaid, they basically just... shoot, they treat you when they treat you. And if you got health insurance, good insurance, they're going to make sure they take care of you really good." (Participant 3)

Participants also reported a large difference in the health-promoting resources provided to women enrolled in Medicaid compared to women privately insured.

"And I think all the resources come in based off of what a person has because once I started using my Blue Cross Blue Shield, I was getting phone calls, I was getting stuff in the mail. I was getting different packages or different resources. And I'm saying reliable resources versus on Pregnancy Medicaid, you didn't even hear from half that many people. It was the automated service calling out. But with my Blue Cross Blue Shield, you was getting live agent calling you. Even now, I still get it. (Participant 14)

Another participant added how she heard stories about people experiencing discrimination and stigma due to being on Medicaid.

> *"And another thing is, people have this thing where, "Oh, okay, you're on Medicaid," whatever, whatever, whatever. I feel like I don't care if it's Medicaid, Blue Cross/Blue Shield, Kaiser, or whatever, you're still a person, you're still a human. It doesn't matter if the government is paying for your medical benefits or if you paying for it out of your pocket at work, it's all still the same. It don't make you no better than me because you got Blue Cross/Blue Shield and I'm on Amerigroup, it doesn't matter. I didn't really experience, I just heard it. You know what I'm saying? I just heard a whole lot of stuff, but it's like people think that just because you're on Medicaid, you're supposed to be different from anybody else that's on whatever else health insurance. It's all the same. You're still a person, you're still supposed to treat me like a person." (Participant 1)*

Sub-theme 2: Structural barriers, such as lengthy waiting room times and difficulties scheduling appointments, were significant deterrents to Black women seeking maternal healthcare.

Many participants reported experiencing structural barriers such as long wait times and delays in treatment when seeking maternal health services.

> *"It was the worst experience ever. First, I got induced the night before. It took forever to get me in a room." (Participant 1)*

"First of all, I'm in the waiting room for an hour and a half before I even go back to triage." (Participant 6)

Several participants discussed how the COVID-19 pandemic exacerbated these issues and added the new challenge of not being able to schedule a cesarean delivery or pregnancy induction in advance

"Nonetheless, I called in every day and I believe it was like the third day they were like, okay, come on in, we can make it happen. So I drove myself to the hospital... And I think I waited in the waiting room for maybe two hours, for what I don't know because they said they had a bed, but they did not ask for any additional information, so I guess they did have everything on file as far as my health insurance and whatnot. So they were anticipating me, I guess it just took a while to get me into a room. (Participant 12)

"This second pregnancy with my daughter, and I continued to attribute it to COVID because that's just what I continued to hear from them, but during my delivery process, again, I was induced. It felt, I just felt like a number. I really felt like they were swamped and overwhelmed with their caseloads. And the doctors continued to say that so many people were having babies up until they couldn't. They kept saying, yeah, we need to go ahead and see if we can get you on the schedule, but they couldn't guarantee anything, because they're short staffed with nursing, or short staffed with doctors. But again, as somebody and at this point I have a child, so I need to secure care for him while I'm

delivering so that my husband could be with me. There were just some considerations that I don't think that they were given." (Participant 12)

The pandemic also resulted in an increase in pregnancies and an increase in the caseload in general, which further contributed to service delays.

"So I was at Hospital 2 for like five days because they had me there pushing my surgery back to tie my tubes because there was so many people in labor." (Participant 3)

"I'm in Hospital 2, I know it was that night was horrible. Somebody went in labor in the bathroom, somebody went in labor in the waiting room. It was horrible that night. It was so many people having a baby." (Participant 3)

A couple of participants also discussed have difficulties scheduling appointments for their postpartum visits.

"I actually missed my appointment and it was hard to get another one…I didn't get one for probably two months…Nobody was answering the phone. It was like, I would just call almost every day and try to get an appointment and they would always transfer me to the clinic, but it's like nobody was answering. So one day I just finally went up there and just and they were all sitting at the desk and I'm like, "You don't answer your phone?" (Pilot Participant 2)

Sub-theme 3: Perceived poor quality of clinical care, which includes providers' failing to meet professional standards of care and medical errors, was another significant barrier to maternal healthcare seeking for Black women.

One participant disclosed that a member of her healthcare team made a mistake and gave her the wrong medication, which could have caused severe negative health consequences due to the participant's health condition.

> *"I don't even think she had asked me for my first and last name on my bed. I think she just said, "Hey, they told me to come give you this medication.". And then I think later on, I came my... I think it was my mom that was with me that let them know that somebody had just came in and gave me some medicine. And they was like "What? Doctor didn't order any medication.". And that's how we found out that it was the nurse came into the wrong room and gave the wrong medication to the wrong person… Because they said that...it was a type of medication that a person with a heart condition couldn't have." (Pilot Participant 3)*

Another participant shared how the hospital staff did not regularly change her bed linens and exposed her newborn child to potentially contaminated water during her hospital stay.

> *"Yeah, and at the hospital, they didn't even change my bed sheets…I mean, well, if I was at Hospital 2 that many days, then they'd know I couldn't really get up. So I'm laying in the same sheets, I'm using... I think I did have a urine bag. No, but the fact that I really*

didn't have help to get up to go to the bathroom back and forth like that…" (Participant 3)

Other participants shared experiences with members of the healthcare team being more physically rough and neglecting pain management.

"*Or once again, they did the foley bulb, and the resident that they had come in was very rough, and I'm like, oh, okay. You're like, you have one hand in, and you're pushing on the other. It hurts. But it was just well; this is what we got to do instead of a care." (Participant 12)*

"*…the nurses would come in there with attitudes and I was telling the nurse one day I was in so much pain, I was like, "I need some medicine," she was like, "Oh well, you got to wait till this other nurse come in to give your meds." And I was like, "But I'm in pain, severe pain," and she literally made me wait until the other nurse came." (Participant 3)*

"*But once again, I think it was the next day I felt like I had to demand pain medication. I was hurting and I feel like I had to demand it. I asked a couple of times and "I'll be right back. I'll bring it right back. I'll bring it right back." "I'll asked the doctor "da da da". The doctor finally came. I pretty much had to demand it from him because like five nurses came in and was checking my stomach, press down on my stomach, making sure everything was in place. But wasn't nobody bringing no pain medicine back, so I had to pretty much demand it." (Pilot Participant 1)*

Several participants explained how their medical procedures were delayed due to their providers' deeming them of less of a priority. The quotes below exemplify participants' experiences with mistreatment.

> *"I think from my experience, we just get put on the back burner just because of what I went through with my second kid, I completely understand there are people having C-sections and I wouldn't say that they are more important than me, but just the way that they place importance" (Participant 6)*

Theme 3: A range of sociocultural factors was reported to inhibit Black women from seeking and accessing maternal health services.

Within this theme, three important topics emerged: psychosocial stress, social and cultural barriers, and social support. Black women experience acute and chronic life stressors, which negatively impacts their mental health and makes them more vulnerable to mental health disorders. Yet, having to identify and seek culturally acceptable mental healthcare care while suffering from a perinatal mood or anxiety disorders can be an onerous task for Black women. Given that Black women experience higher rates of depression compared to other members of the general population, social support is particularly useful to help cope with stress and lacking social support may further contribute to an unmet maternal mental health need among Black women.

Sub-theme 1: Psychosocial stress was a significant barrier to Black women seeking maternal health services, especially mental healthcare care, during the perinatal period.

Several participants expressed high levels of stress and anxiety, which can be typically expected when adjusting to life with a newborn.

> *"When I say I was like stressed out to the T, to the point where I almost left. I felt like, if it weren't for my kid, and having in the back of my mind, "Okay, I do got a kid, I do got something to live for, I do..." But I was so stressed out and so dead worried about am I going to be a good mother or is something going to happen, am I doing the best I can do, everything. And then with real life problems going on in life and then trying to take care of a child, you'll be so stressed out and so much overwhelmed to the point, where you getting ready to risk it all, just say, "Forget it," (Participant 4)*

Several participants also talked about how trying to balance returning to work earlier than anticipated caused them to feel stress and anxiety.

> *"They did prescribe me some anxiety meds at postpartum. And because of just how I had been feeling, I did get the pressure from my job to return back to work sooner than I had liked. Cause with the short-term disability, like everything was covered, but we only get a certain amount of time to readjust. And my job was like either come in part-time or don't come back at all. So I was forced into going back kind of early, which caused a lot of anxiety" (Participant 11)*

Several participants also added how it was stressful returning to work while breastfeeding due to struggling to find private places to pump the breastmilk and longer breaks in between pumping for breastmilk that affected milk supply

> *"That stress of going back to work, the stress of going back to work and then this schedule of being back at work and not knowing where I could pump and at home, we're feeding every two hours. I get back to work and it just wasn't functional for every two hours to dip away from my desk and spend 20 minutes on a machine, another 10 minutes cleaning the supplies, go back to work. And then I have to do it all again an hour later. That did not work so I found myself going longer periods, which was affecting my milk supply." (Participant 12)*

> *"I knew I wanted to do half and half because unfortunately, and even with me working for University 1 they're aren't all over places where I can freely pump. And I knew that. With my son, I pumped in a break room. Literally, I had to put a sign on the door, said, "Don't come in." There was no lock on it, so I had to do it with my back facing the door, God forbid, somebody did just swing open the door. But for my specific work area, there was no lactation room. I was definitely concerned about how I'm going to pump and get it back to him so, oh, that means I have to do half and half and send him to daycare with formula or whatever I was able to get the day before. And it was just... It was a lot." (Participant 11)*

Some participants described experiences of financial stress.

"Well, yeah. I'd been off work. I ain't have no money coming in… That was stressful." (Pilot Participant 1)

Several participants shared that caring for children, especially those who had a health condition was stressful.

"Well, when I first got home, I didn't get any sleep I didn't sleep at all because, my daughter, she was on the machines. And it beeps all the time. And I was just watching her the whole night. And I guess, for me, not getting any sleep, watching her all night, that's why I started to feel stressed." (Pilot Participant 2)

"So I always felt like my time was split and I always did feel very guilty because the second one was having these issues that I spent a lot more time with the second one than the first one. And it just didn't feel right, so I feel like thinking back on my second postpartum period, it just felt like I could never find a really good balance with anything. I really struggled with how to feel that I was giving adequate enough time and space and love to both of my sons and neither one of them never feeling like I'm spending more time than the other. And I think I harbored a lot of mommy guilt from that because I had heard and read that going from one to two is definitely challenging, but I felt that on so many levels it was difficult, going from one to two." (Participant 7)

One participant shared that experiencing multiple stressors such as financial stress and social isolation due to the COVID-19 pandemic may have contributed to her postpartum depression.

"Well, for me, mine was stressful. Because I was just ready to go back to work. I was happy. That was my second child, so I was happy that he was here and healthy and stuff. I was just ready go back to work and get some money, because I was like, "Oh my God." Then COVID had came, so it was like, that made it even longer. So I was depressed. I was like, I just need to get out the house." (Participant 2)

Many participants shared how they experienced postpartum depression, but many did not seek mental healthcare care services because they either were not referred to a mental healthcare care provider by their maternity care provider or found it burdensome to find culturally-appropriate mental healthcare care.

"I haven't actually gone to see a therapist. I really need to though. I really need to. She did give me a list of names, but I found that it was just, it was difficult to find out which one was going to work best. I tried to do that without, I guess I should have gone and saw for myself and had a few consultations, but me and my depression state didn't have the energy to do all that." (Participant 6)

Sub-theme 2: Social and cultural barriers were significant deterrents to maternal healthcare care seeking, including mental healthcare care during the perinatal period, among Black women.

Many participants described a cultural stigma around mental health illnesses in the Black community, which prevents many Black women from seeing menta.

"I mean, I tried, but in our community, within [the Black] community to be honest, it's really hard, when you talk about depression, anxiety, and stuff like that, people think you're crazy. So it's kind of hard. So you tend to cope with it within yourself or within close people that you feel like you can confide in. So it's not really like you have somebody, it's just something that you just have to deal with. And with us being Black, we just deal with it. Most the time we literally suck it up and we'll be okay. As long as my baby's good, as long as she's got a roof over her head, that's all that matters. We don't think about nothing else." (Participant 4)

"They're embarrassed about it because I was. I was like, "Oh my God, I'm going to a coocoo doctor." But, I needed the help. And honestly in Black communities, that's the problem, mental health, women. After having these kids, six, seven, eight, nine, ten kids. That's crazy. You need to talk to somebody." (Pilot Participant 2)

Several participants also directly and indirectly referenced the "strong Black woman" and "superwoman" schemas, which often results in Black women self-sacrificing for their children and their family while not prioritizing or taking care of their own health needs.

"Sometimes we need someone to say, "Hey, slow down and take care of yourself" because there is this cape that I feel we wear and it's just where everyone else comes first. Everything else comes first; your job demands, your family, your spouse, whether you're a daughter, a sister, whatever. All those other halves become paramount. And

sometimes it's nice to have somebody stop and say, "Wait a minute, what about you?" Or "We're going to do this for you." (Participant 12)

"I didn't seek any other counseling or help or anything like that. I can honestly now look back and see that it was that superwoman schema where as the black woman, you are only allowed to be vulnerable or down for only a short period of time, because you still have to get up and move forward with what you're doing, what you have to do and what you need to do. And there is no time for self care. I would say from the time I've conceived my first child, there has been little to minimum self care for me in all aspects. Their appointments come first, their needs come first, everything comes first and I'm an afterthought" (Participant 11)

One participant made a comment about increasing the accessibility of mental healthcare care services for Black women but then stated:

"Although, I can be honest that I doubt a lot of black women will actually take advantage of it because there is that schema of I got to be strong. I pray about it and keep going. Even though I would like to see more resources and more follow up, especially just knowing myself, I'm just speak on myself. I probably still wouldn't take advantage of it. Like, oh, I don't need that. I'll get through it. God ain't going to put me through nothing that I can't get through and just keep it moving. (Participant 11)

One participant discussed how cultural tropes of Black women prevent them for asking for help.

"We don't know how to ask for help. That's another thing about Black women too. It's the asking for help part too. Because it's something about very strong, dominant women, it's like asking for help is the worst thing in the world, but it ain't. Believe me it is not. It's okay to ask somebody… A lot of things we need to stop doing is thinking that we can take it all by ourself. That's why we break down the way we break down, and that's why I think that we die. Because we don't know how to let somebody else help us relieve all that." (Participant 1)

Several participants also discussed social myths and rumors about different local hospitals such as Grady Memorial Hospital, which prevents them from seeking care at specific health systems.

"So for me it was, everybody kept saying don't go to Hospital 2, but I'm a Hospital 2 baby. So that was 1980. So I was fine. I'm just fine. So I just figured I'd have my baby there too." (Participant 1)

"You hear Hospital 1 in the City 2 area. You hear that's a good hospital. You hear Hospital 2, you hear this is this, this, this is what happens at Hospital 2. I think it's the name thing. I don't think no one is actually doing the research of, you know what I'm saying? Until you get there and then you be like, okay, they're just like all the other hospitals. I could have went there. It's a name thing. Especially if you were raised up in City 2. No one wants to be a Hospital 2 baby. Nobody wants their kids born in Hospital 2. Everybody knows Hospital 2 is a trauma station. If you were born in Hospital 1, this,

this, this, this, this, this all a myth, everything is a myth. No one wants to go to Hospital 9 because that's why all the baby dies at. I was born and raised in City 2. These are the things that you hear, these are the things that you stick by. I think it's all the name thing. It's all a myth." (Participant 14)

"When I got here, hearing the conversations of people, saying that's a Hospital 2 baby, he's retarded. Cracking jokes and saying other stuff. To me, I later knew that was an unconscious thing for me. To choose Hospital 1 because of what others had said about the local hospitals and things of that nature." (Participant 11)

Sub-theme 3: Lacking social support from family and maternity care providers was a major barrier to maternal healthcare care seeking among Black women.

Several participants described a lack of support from family and their child's father during the perinatal period.

"No support from family or the fathers. I didn't have any support with my first child's father. I didn't. He actually just looked at my child and just said, "She's not mine.", and left." (Pilot Participant 2)

"I was forced to go back to work. My job was kind of like, "Hey, so you're protected for this long, but we need you to come back. The team needs you." Yada yada yada. And it's just myself and my husband out here, so we didn't have any additional support." (Participant 12)

"I don't have sisters. I'm the only child of my mom, so I don't have sisters and brothers and stuff to help. I only had her dad, me, and my mom. When I could see her. It was one on one thing with me and my baby, I was raising her. So it was something new to me, basically, it was just something real new having to raise a human being, it's hard." (Participant 4)

Several participants also emphasized that the lack of social support is particularly challenging for first time mothers.

"I don't know, maybe because I'm a first time mom, I had to figure out how to take care of a baby on my own. It was different from taking care of other people's kids and raising other people's kids than raising your own. So it was like, I had to learn everything on my own. It was kind of hard. It was. You got to have some support at home to take care of a newborn baby when you come home. Literally you got to, you're tired, you're exhausted from labor, it's ridiculous." (Participant 4)

One participant described how due to certain illness prevention protocols, that limit the number of visitors allowed in a hospital room, her husband was not able to support her in the delivery room.

"And to top it all off, I did this all by myself because they were doing flu protocols and I didn't have a babysitter that could watch my son. So my husband was with my first son

until his mom could come up. She lived out of town. So as soon as she heard I was admitted she started driving, but until she could get there, he walked in probably maybe two and a half minutes before the baby came out, like in the nick of time just to see him come out and cut the cord. So I did this whole process by myself. It was the worst experience ever." (Participant 6)

One participant explained that she had to return to work despite being instructed to be on bed rest due to the lack of social support.

"My problem was I just... I honestly think it's my fault because I don't listen, maybe. You have to work. What can you do? I believe that's why they both came early because I was supposed to be on bed rest and I worked...Yeah. I needed to work. I didn't have help so I had to work." (Pilot Participant 2)

Other participants added that it felt like they had limited social support when their partners had to return to work and when family members or other people were not physically there.

"I did have phone calls all the time with people just calling to check in family and distant friends and things of that nature. But being here with me on the day to day, no, cause this is my first child. This is his first child. We were just figuring it out. My mom came in town for the day of delivery, and she left out. She has her own responsibilities. I didn't have anyone. I could call someone, but no, I don't feel like I had support of someone showing me how." (Participant 11)

"I began to have a lot of anxiety from my fiancé and work. He still, of course, had to go to work. So I was at home a lot, of the times by myself, which did make me a little bit down. I wouldn't say depressed. It did make me a little bit down because it's just me and him, and I got to figure this all out on my own. My closest relative is like three hours away. So I had no one really, it was just me and him." (Participant 11)

A few participants also talked about desiring more support from their providers, specifically in terms of referring mothers to mental health services and following up to ensure their patients is receiving the mental healthcare care they need.

"But other than the six-week appointment and when they were like, you're good. That was it. At that appointment, that's when she prescribed the anxiety pills, which I never took, there was no follow up after that. There was no referral. I didn't seek any other counseling or help or anything like that" (Participant 11)

Facilitators to Seeking Maternal Healthcare

Facilitators were defined as factors that enable or promote the seeking of maternal health services. Facilitators were grouped by three topics: quality of interpersonal relationship and communication, adequacy of service, and sociocultural factors.

Theme 1: Strong interpersonal relationships and communication with providers were key facilitators for Black women seeking and accessing maternal health services.

Within this theme, the topics that were discussed were good patient-provider communication, good provider personality qualities, and strong interpersonal relationships. Good patient-provider communication and interactions helped participants build trust in providers and encouraged continuity of care, which facilitated more positive experiences and ensured that all the participants' preferences and needs were met.

Sub-theme 1: Good patient-provider communication facilitates greater patient satisfaction, which supports maternal healthcare care seeking among Black women during the perinatal period.

Many participants perceived their communication with providers favorable when their providers answered all their questions and addressed all their concerns.

> *"Cause the nurses were answering questions for me. They were helping me, the people that were in the NICU, they were amazing." (Participant 11)*

Several participants also enjoyed when their providers took their time and offered a lot of information.

> *"And so immediately I transferred my prenatal care to Birth Center 1 and from then on like, you know, my appointments with the midwives were, I don't know, like 60 to 70 minutes each time, like they spent a lot of time, gave me lots of information. And that was*

so helpful because as a first time, mom, I didn't even know, you know, like anything to ask or what to expect or anything like that. So they spent a lot of time, you know, like just with me talking about different things and like suggesting things that I had not even considered that would be important during prenatal care." (Participant 7)

"It was like I said, always attentive. Or if I had a question if I'm in the room, and I know Doctor 1 and Midwife 1 had other patients and I have concerns or whatever, I'm like, "Okay, I know you all have other patients to attend to, but I have this question" he was like, "No, go ahead this is your time. Ask the questions. It's no rush." So, when I was told to follow specific instructions, I followed, I showed up to all my appointments." (Participant 13)

Other participants discussed how they liked when providers made themselves easily accessible to answer questions.

"And, and they made it very accessible. If it were the wee hours of the morning and I needed to, I just sent them an email and they were very responsive via email." (Participant 12)

Several participants appreciated that their providers explained the medical treatment they were going to perform well.

"I do believe very early on, there was some concern about our son's head size and the possibility of there being fluid on his spine. But again, I think the care and the time that

was taken to explain everything in the process and what the possibilities were eased my mind in the process was there." (Participant 12)

Sub-theme 2: Providers' positive personality characteristics such as being nice and supportive served as a facilitator for future maternal healthcare-seeking behaviors among Black women.

Several participants liked when their providers were personable and nice.

"So I followed up with the OB at Hospital 1, which I love her. I really had a good experience with her. She was a black woman, but she was a very warm, she answered all my questions. Like she was very personable. It was such a good experience." (Participant 6)

"*Like I really like the staff, the ones that I had, they was all nice." (Participant 14)*

Other positive personality characteristics that were identified were being supportive and patient.

"Second time around with my daughter for the vast majority of the time, I was just in there it was just the resident and the nurse and they were so sweet and supportive the whole time, and my daughter was sticking her hand out to come first and the resident she just seemed so confident, and so chipper, she had the right personality for working with me, and so she just stuck it back up and it was just based on what I'd experienced the first time around. I mean, I was just kind of dreading things and she just knew exactly what she was doing, and I thought it was a great experience." (Participant 8)

"…but the nurse was really nice. She was really patient. She was really trying to help me. She could tell that I was getting frustrated. So she was just like, "Oh, you know, I'm here. If you need anything, if you go home and you decide, you want to try it again?" She was encouraging me, to keep on trying." (Pilot Participant 1)

Sub-theme 3: A strong interpersonal relationship with a provider is another facilitator to maternal healthcare seeking among Black women.

Some participants reported having strong interpersonal relationships with their providers.

"I had a great experience. I had a caring doctor. He was just so nurturing and any issues that I have, he made sure that he worked me in. We had a great relationship. I just think that he was the blow." (Participant 10)

Several participants felt more comfortable after meeting all the doctors who could possibly deliver their child.

"They were a great team. I got to meet each of them individually, because no one knew who were, who was going to be on call at the time of delivery. They were great throughout the entire pregnancy. They helped with any questions. I had any concerns that I had. There was a small introduction to the facility of where I would be so that I knew where I was going. I knew where I would be and, and I got to meet some of the staff members. So that was great, especially for a first time mom." (Participant 11)

> *"Likewise, I also had a team of doctors through Hospital 1, who I stayed with throughout the entire pregnancy period. Also being able to meet each of the doctors and the team was beneficial as a first time mother, just providing comfort through the process." (Participant 12)*

A couple participants also reported that the appreciated when providers respected their culture and values.

> *"I got a doula and I got private birth education classes, which were more aligned with kind of my beliefs…But they were able to offer classes that were helping you to understand, not just, you know, medically what's happening and biologically what's happening, but energetically and psychologically and spiritually what giving birth is. And I really appreciated that." (Participant 5)*

Other participants enjoyed when their providers shared similar religious or spiritual beliefs and was able to provide more holistic care that includes spiritual well-being.

> *"They always encouraged me, think positive. And my physician, he was always a man of God, Doctor 1, so he would always pray with me throughout the pregnancy. The prenatal care was good. And I had a successful pregnancy." (Participant 13)*

One participant discussed how she really appreciated how her provider followed her birth plan closely, which helped ensure that all her individual preferences were met.

> *"I mean, I was just kind of dreading things and she just knew exactly what she was doing, and I thought it was a great experience. They waited until the very last minute to have 10 people come in and then it was quite crowded, but I just really liked that it was just my husband and I, and the two of them, and they were just so supportive the whole time. And I could tell, they really read my birth plan and everything. Like my dad had passed away while I was pregnant, which was a really hard thing, and my nurse was like so supportive with that and everything and just I could tell they read everything and were trying to do everything that I'd wanted." (Participant 8)*

Theme 2: Perceived quality of care was another facilitator for Black women seeking and continuing to utilize maternal health services during the perinatal period.

Within this theme, two important topics were discussed: ease of access and high-quality of care.

Sub-theme 1: When maternal health services are perceived as convenient or easy to access, it facilitates maternal health seeking among Black women.

Some participants enjoyed how convenient it was to sign up for maternal health services in the hospital before being discharged.

> *"But the good part about it, it was easy to sign up for care. I did everything in one at Hospital 2. So for me it was, everybody kept saying don't go to Hospital 2, but I'm a*

Hospital 2 baby. So that was 1980. So I was fine. I'm just fine. So I just figured I'd have my baby there too, but everything was easy for me." (Participant 1)

"Mines was easy as well. How she said, at Hospital 2 you had everything right there. I signed up for WIC, all that stuff in one walk. So it was very easy." (Participant 2)

Several participants reported that they believe mental health services are becoming more accessible.

"Yes, very easy to get in touch with. I actually just Googled a couple of places in my area that would take my insurance and I just called around and I set an appointment (Pilot Participant 2)

"Not to cut you, but I know this now, it's more like they offer you more help now. They'll ask you questions like, "Are you okay emotionally? Are you..." it's said more now. It was hidden and something to be ashamed of back in the day. But now, it's more open and more out there where people don't have to feel ashamed that they need the help. And then it's more people that's willing to give you the help now. It's easier to find mental health or if you feeling anxious or... and stuff like that. Because my doctor asks me that all the time. They ask me that all the time, so now it's they ask you more than they would back in... 10, 15 years ago." (Participant 1)

Sub-theme 2: Perceived high-quality medical care, which includes care that either meets medical standards or more holistic care that ensures all their needs are met, is a key facilitator to maternal healthcare seeking among Black women.

Several participants reported that they considered the care they received high-quality.

> *"So I was constantly going to the hospital because I was scared. I don't know what's going on with my body, but they was pretty on point. When it come to that labor and delivery on the fourth floor at Hospital 2, they on point." '(Participant 4)*

Other participants shared that they believed they received quality care because it addressed both physical and mental health.

> *"Well, physical and mental because they... am I feeling like I want to hurt myself or other stuff like this. So I feel like they was taking care of the physical for you and baby and the mental for you while you was pregnant." (Participant 1)*

A couple participants who described receiving more holistic care stated that it was high-quality.

> *"They're really big on holistic care. So, they were encouraging me to go see a chiropractor and like even try like acupuncture, and all this other stuff. And then what was really helpful was not only did they do like these individual prenatal appointments, but they did like a group prenatal appointment. And so like the group prenatal*

appointment had, you know, all moms that were around the same weeks of pregnancy, but you had like first time moms, second time moms, third time moms, and that was so valuable because, you know, I was able to get a lot of information from like moms that had been there, done this, all of that. And it was, it was just so valuable. So, like since then I've definitely had like all my pre, like second kid, there was no question, I went back to the Birth Center 1. (Participant 7)

One participant explained how she appreciated feeling safe and heard.

"So, for me personally, that was really important. I really needed to feel like I was being listened to and understood and heard, and I needed to feel safe. Like, no, the statistics out there about black women and birthing are just, they're scary. And I just didn't feel like a hospital setting was the best option for me. And so changing that in the beginning for my first pregnancy, I think made the world of difference. And I was really happy that I found a place that I felt very safe and secure and like just very confident in their skills to help me have like, you know, the birth experience that I wanted." (Participant 7)

Some participants also shared how they appreciated that their providers thoroughly screened for possible risk factors during prenatal and postpartum visits, such as intimate partner violence and depression, using a checklist.

"For me, I thought it was crazy because of the questions they was asking, but then I'm saying to myself, just because I'm not going through these things doesn't mean somebody

else isn't going through these things. And one day I was in there and I actually overheard a woman saying that... they asked me like, "Are you getting beat? Are you..." They asking me all these questions, I'm saying to them, "No, I ain't getting beat. Nobody's hurting me." But they ask these questions and I actually overheard a young girl saying that these things was happening to her. So I think that Hospital 2 do a good job at making sure that you're okay during your pregnancy as far as when you go home and everything, because they ask me those questions every visit." (Participant 1)

"Yeah. They really had a little... a sheet of paper every time you went to the doctor, like a checklist, like make sure everything was okay. Each visit that you had at the hospital, they made sure you were okay. And if you need to talk to somebody, they would bring somebody yeah…They was on point at Hospital 2." (Participant 4)

Theme 3: Certain social and cultural factors, such as racial or gender concordance between patient and providers and social support, helped facilitate Black women's maternal healthcare seeking behaviors.

Within this theme, two significant topics emerged: preference for providers with shared identity and social support.

Sub-theme 1: Perceptions of a shared identity between providers and their patients is a major facilitator to maternal healthcare seeking among Black women.

Some participants revealed that they prefer to seek maternal health services from providers with a shared racial identity.

"Although, I specifically sought after physicians of color. My OB, my pediatrician, my dentist. I specifically do my research. Because I don't want to have to deal with those types of disparities. I picture in my head that, okay, a physician of color would dramatically close that gap I would have if I got care from a Caucasian physician." (Participant 11)

Several participants expressed that they prefer receiving maternal healthcare from providers who had the same gender identity as them.

"A woman that can relate to me as a woman. You say personal stuff without being uncomfortable. Or I can say what's going on with my body or if anything is going on down there uncomfortably, without feeling like I'm being judged or feeling like I'm uncomfortable speaking on it." (Pilot Participant 1)

"Actually, she was awesome. She was amazing. I could talk to her about anything and she was listening because she was pregnant as well." (Pilot Participant 2)

Sub-theme 2: Social support from family, providers, and technology was another key facilitator to maternal healthcare seeking among Black women.

Several participants stated that they felt supported by certain services offered by the Planning for Healthy Babies program, Georgia's family planning demonstration waiver.

> *"Yeah, Planning for Healthy Babies. I was in that program, so they would ask me questions about my mental and... postpartum and stuff like that, and they would give you numbers, actually give you 1-800 numbers to people that would call. And I still get text messages letting me know it's time for my daughter to get her teeth done or it's time for her regular shots or it's like a whole little program where they have all of your information where they know if she's taken a shot or not." (Participant 1)*

Another participant shared that a mobile application called "Baby Center" also provided valuable maternal health information and helped her feel supported.

> *"I used an app, Baby Center, and they helped me through everything. The only warning sign was just the feeding habit. If he's feeding less, pay attention to that. Everything else, I either learned from people around me or from Baby Center." (Participant 11)*

Several participants also talked about how having support from family and friends positively influenced their mental health.

> *"I've always had help around, so I guess that's why it doesn't physically bother me mentally, like a lot of people do. Because I've always had help with my kids."(Participant 3)*

One participant indicated that her provider referring her to mental health providers was perceived as a form of social support.

"But with that, it was just, the two weeks of baby blues turned into more of three months and I think it was, I did have some support from my OB, from Hospital 1 that I loved, she was really great. She knew my situation, what was going on. So she did refer me to some therapists to reach out, to talk to. But outside of her, it wasn't a lot of support. Definitely not with my first one." (Participant 6)

Another participant noted that she received informational support from her pregnant peers through her group prenatal appointments.

"And so like the group prenatal appointment had, you know, all moms that were around the same weeks of pregnancy, but you had like first time moms, second time moms, third time moms, and that was so valuable because, you know, I was able to get a lot of information from like moms that had been there, done this, all of that." (Participant 6)

Recommendations

Participants were also asked to provide recommendations for how to ensure that maternal healthcare providers deliver respectful maternity care. They offered a wide variety of suggestions with themes that fell under the following topics: quality of interpersonal relationship and communication, quality of service, and a culture of respect.

Theme 1: It is recommended that the quality of interpersonal relationships and communication with perinatal health providers improves in order to ensure respectful maternity care.

Participants offered many suggestions to improve the quality of interpersonal relationships and communication with perinatal health providers, which fell into three categories: patient-provider communication, providers' personality and approach, and social support.

Sub-theme 1: To ensure respectful maternal care, it is recommended that patient-provider communication between Black women and their maternity care provider improves.

One of the most common recommendations offered was to ensure that providers listen to their patients, especially those that identify as Black women, more.

> *"I think truly seeing a black woman as this is a new mom, a new birthing person that is here, I really need to listen to them. Let me take everything that they say and really kind of analyze what they're saying rather than just take everything that they're saying as not that big of a deal or just, oh, just face value, whatever." (Participant 7)*

Many participants recommended that providers' spend more time talking and getting to know their patients to enable them to provide more individualized care.

> *"Talk to them. Talk to them instead of showing them and treating them just like they just patients. Talk to them, see what they like, see what their preferences are. And don't just assume." (Pilot Participant 1)*

Several participants added that when Black women express health concerns, it should not be dismissed.

> *"A black woman has concern about giving birth or going into labor and delivery. It should be taken serious and not pushed to the side. It's a very alarming rate amongst black women. When they give birth, they express concerns and they get brushed off. Another means of support is reaching out. If like a doctor, a man, say a man doctor may not understand what a woman is going through. So maybe he can send it off to his colleague. "Hey, can you go and make sure she's okay?" And, get a feel for what she's going through maybe you can explain it to me in a better terminology than she can." (Pilot Participant 1)*

One participant recommended that pregnant patients should develop a birth plan with their providers to help improve patient-provider communication

> *"It needs to be a birth plan in place so I know who's going to help me deliver my baby. If you're not going to be there, who's going to be there? Who's the secondary doctor? Who's the nurse that's on call? The second nurse that's on call. I feel there should be a plan put in place. And if it happens to be a C-section, then who's that doctor or the secondary doctor. Just a whole birth plan. The whole birth plan. I know everything is not going to go how it on the birth pan, because it never does. But having some type of security in place, put a woman at ease." (Pilot Participant 1)*

Another participant recommended that providers make themselves more accessible to answer any questions they may have.

> *"But it's kind of like when I'm dependent on you to kind of hold my hand and guide me through this process; I just kind of wish you're more readily available for me. So for me, if I had any questions or anything, like sure, they were able to answer them, but at what timeframe kind of thing." (Participant 11)*

Several participants also suggested that providers should offer more information to patients, including resources and referrals related to mental healthcare care.

> *"I feel like even if you don't need the help, right then they could still give you referrals. But later on, I know you do have a postpartum checkup, like six weeks later. But what happens in between that six weeks? Like what if I get home and then I start to realize, well, now I'm really sad for no reason. Like the referral would really help me. "Oh, well, if you need to talk or someone to listen to you, here's a number that you can call." (Pilot Participant 1)*

Other participants recommended that Black women should advocate for themselves with providers and not be afraid to ask questions or communicate concerns with providers.

"For the mom, to put your foot down. Being pregnant, going to doctors is a scary experience because, your thought is just protecting my baby, what's going on, how is the child doing? You have so many questions, concerns, don't be afraid to ask those questions. If you feel like it's a stupid question, ask it anyway, because like she said, you can get on Google and go down a rabbit hole and think you're going to die giving birth and not really know what's going on. Especially those young moms that are early twenties and don't have that knowledge of the process." (Participant 11)

Sub-theme 2: It is recommended that maternity care providers' should have favorable personality qualities such as compassion, and practice esteemed approaches to care including more personalized care to ensure respectful care.

Many participants recommend that providers as well as staff at maternal and child health programs in general should have more compassion and empathy for their patients.

"As for providers, I do understand that a lot of times they are booking us on a 15 minute interval and they already came in the room five minutes late. And so it's a rush and things have to be moved along, but just take a little bit more care and concern when handling fragile people who may be diagnosed with something, have lost previous children, get to know the patient because we leave the situation feeling like... looking back years later, well, why didn't they do this? Why didn't they do that? And so I just want the providers just to be a little bit more caring as well." (Participant 11)

"You have some people who love what they do. But when you got these people in these places that don't love what they do and are not empathetic to people, it makes you... You have to have, when you working in service, and when I say service, I mean people who work in these DFAS office and people who work in doctor's offices and stuff like that. You're supposed to have some type of empathy for people." (Participant 1)

Many participants also recommend that providers take more time to get to know their patients and deliver more individualized care.

"...emphasizing the provider care and just... it's a short period of time, and I understand that they're booking and especially during COVID, everyone was pregnant, so their numbers and their caseloads have grown, but taking that time and that care to slow down and truly get to know your patients so that despite your caseload, you don't feel like just another number that their rushing in and rushing out, but taking the time to make each person still seen and heard is paramount." (Participant 12)

One participant suggested that providers should have continuous training to ensure that they are providing equitable and respectful care.

"And then I can understand people who have been doing this work for years like they do, I think we work in structures and organizations. It's really easy to categorize things. Over time, you can say, well, this mom seems that she fits in this category and stuff, but that's not really helpful because not every birth is the same, not every woman is the same. Kind

of breaking those trends of thinking and really looking at every person as an individual and not to throw them in these categories, I think will be really helpful because I think that you will not miss things that are important for moms. I guess I think that goes to training too. No matter how long you've been doing this 10 years or 30 years, I think the continuation of training and learning, just kind of reminding people who work in this area that you have to always be looking at these moms as a new patient and stuff would be really helpful." (Participant 7)

Sub-theme 3: It is recommended that Black women are offered more social support to ensure respectful maternity care.

Many participants recommend that Black women receive more social support.

"Definitely support. I feel like everybody portrays, a black woman. Like this strong woman who can just take it all and not have a break, but we need support too. We're not some brick wall that could just take anything that's thrown at us." (Pilot Participant 1)

"Just having support. You need that support. No matter what. No matter how old you are, no matter how many kids you got, you need that support." (Participant 4)

Several participants suggest that providers should support their patients more by following up with them and confirming that all their needs are being met during the perinatal period.

"By supporting your patients or supporting the client. Do follow-up calls, just to check to see how they're doing or is there anything that they need or if they're nervous about it. Just to be there." (Participant 10)

One participant suggested that there should be more peer support groups available for pregnant Black women.

"Or maybe a focus group on that, like a group with women who just had babies…like when we first had babies, like they had a little group where we can sign up first week get pregnant and stuff. So maybe it should be like a little group after that. It may be, but I don't know about that, but maybe that'll help out because it's like, everybody's going through the same thing. You know what I'm saying? You don't feel like you are alone at times. I guess we all feel like that sometimes." (Participant 1)

Another participant recommended that providers could support patients by getting a second opinion or asking another medical colleague with a shared identity as the patient to help explain the medical diagnosis and treatment.

"Another means of support is reaching out. If like a doctor, a man, say a man doctor may not understand what a woman is going through. So maybe he can send it off to his colleague. "Hey, can you go and make sure she's okay?" And, get a feel for what she's going through maybe you can explain it to me in a better terminology than she can." (Pilot Participant 1)

Other participants suggested that providers can support first-time mothers in particular by sharing a lot more information about resources and services available to them that may not be aware of.

> *"I just feel like my first experience with my son, I feel like it wasn't the best. I feel like I see other moms and I'm like, they had the pictures took, I never took pictures with my son at the hospital. Like he don't have any hospital pictures, just a lot of things that other moms did, I didn't do because I was never offered that. I didn't know about it. It's not like I went knowing like, so it wasn't even offered to me like, hey, maybe you should try doing this or we don't offer this here, but you can try to. I just feel like it should be a lot more…" (Participant 9)*

Theme 2: It is recommended that the quality of perinatal health services improves to ensure respectful maternity care.

Many participants recommended that hospitals should reduce the wait time for services. For instance, when asked "what suggestions would you make to improve prenatal care?" one participant said:

> *"Yeah, it was just the wait times. That was it. That was pretty much it, just the wait. Because it was a lot of people pregnant around that time, so..." (Participant 2)*

One participant recommended that patients insured with Medicaid should receive equal treatment and have increased access to healthcare services by expanding the number of health facilities Medicaid patients can receive care from.

> *"…about the Medicaid, I feel like you should be able to go wherever you want to go. That's why Hospital 2 be so full of people because all the low income people have no choice but to go to Hospital 2. You can't go to Hospital 5 and go see a doctor. You can't go to Hospital 1, unless you got something going on. You going to be at Hospital 2 for everything or some little side urgent hospital they got, that's low income." (Participant 4)*

One participant added that the overcrowding and long wait times at healthcare facilities that largely serve low-income populations should be addressed.

> *"The neighborhood clinic, that's overcrowded as well. If you notice all of our clinics, we have... they're overcrowded. If you're there, you going to see like 30 kids before you get seen. Before your baby gets seen, it's going to be 30 other women in there and 30 other children. And if she got more than one kid, that's more kids. It shouldn't be like that. They should make it better. It should be better. (Participant 1)*

Another participant recommended that hospitals should establish programs and policies that give Black patients additional time and attention to help address racial disparities in maternal mortality.

"Well, we know this is a phenomenon, right? We have the statistics and the research to show that there is a higher mortality rate. I would hope that that's followed up with the additional care and concern placed on that to remedy it. Meaning if we know that this is a concern, maybe put some other programs in place. Put that emphasis on care instead of painting it all with a broad brushstroke saying, we know that typically you guys have a higher mortality rate, we're going to dive deeper with your needs. We're going to dive deeper. Instead of having a 15-minute window, we're going to give you a 20 or 25-minute window for your appointments. Instead of keeping you in the hospital for two or three days, we're going to give you a full week. To rest, recuperate, and make sure there's no internal bleeding. I know that's going to be hard because we have outside responsibilities." (Participant 12)

Theme 3: It is recommended that respectful maternity care is promoted at both the provider and health system level.

These recommendations were categorized by three topics: respect and autonomy, community-based approaches, and self-care.

Sub-theme 1: It is recommended that providers show their patients more respect and maintain their patients' autonomy in order to ensure respectful care.

Many participants recommended that providers respect patients more.

"Respect me as a person. Respect me as a human being. Don't see color when you see me as your patient…Treat me as you would treat your family member. Don't mistreat me at my most vulnerable state." (Pilot Participant 1)

"And respect, if you care for me the way you supposed to as far as doing your job, I'm going to respect you enough to say thank you for caring for me. And when I show you respect, that'll make that person respect you, too. But you got to give respect to get respect." (Participant 3)

Several participants suggested that providers should respect patients' autonomy and practice more shared decision-making instead of solely making decision based on their clinical training.

"Can we actually have a conversation in this room before you just come down with, this is the one thing that I'm going to do and I knew that as I walked in the door? This is what I'm going to do and what I'm trained to offer you as opposed to stopping and being curious and listening to the whole of me and bringing any insight you might have into the culture, the ethnic practices. I think Participant 7 said it very well if you don't know, be willing to offer me options or be willing to say, I don't know." (Participant 5)

"…just pretty much being heard and not dismissed as an individual as, oh, you're just a patient you don't know. We know better than you type of attitude and just…realizing or admitting that, okay she might know what's going on with her own body or she

might actually have a point. You might actually be in labor and we're just not listening properly…I want to be a counterpart to you. Not just, doctor, patient." (Participant 6)

One participant suggested that provider trainings should teach providers how to be curious and inquire about patients' cultures to enable them to respectful of patients' cultures.

"Yeah, I'm just thinking, because I know that the doctors are trained to offer specific services based on their training and what is a board standard. But I'm curious how much they're trained to be curious. How much are you trained to ask questions, based on the cultural background of your patient, giving any kind of respect to, or, attention to ethnic makeup, cultural makeup? How much do you expose yourself to some of the traditions that a person comes from? They are bringing all of that into your operating room or to your session with them, your appointment with them. So having curiosity would really give me as a patient, a feeling that you are willing to accept whatever I bring, as opposed to what I feel like some of us have experienced. The doctor is coming with the answer and whatever you have is just an obstacle to me giving you the answer…" (Participant 5)

Sub-theme 2: It is recommended that community-based approaches, such as doula care and culturally acceptable alternative sources of care, are more accessible to Black women to ensure the provision of respectful care.

Several participants recommended that Black women get a doula to help advocate and support them. When asked "do you have any recommendations that you want to make, to make black women have respectful or equitable care", one participant said:

"A birth doula. I heard they're really good and I'm going to probably get one, my next pregnancy." (Pilot Participant 1)

One participant added:

"I think that's very helpful for women. Definitely us black women, anyway." (Pilot Participant 6)

One participant felt that some biomedical models of maternity care do not ensure that patients' cultural preferences are being met and suggested that people should seek providers that are more culturally acceptable and deliver more holistic care.

"…but I have seen that this Western medicine is very much trained to give you one answer and to not even nudge, like pressure you into one mold that not everyone wants to follow…I don't even go to doctors that much anymore, but to be honest…I go to a holistic doctor…She is ideal for me right now because I can go to her for one thing, but end up being able to talk about emotional, spiritual, professional subjects and all of that being brought into, and this is kind of a recommendation that I'm giving you based on all that you were able to bring, really just because she is open-minded and she is on a path that allows her to have different frameworks that inform her main practice of care. She is able to care for people in a more holistic way." (Participant 5)

Sub-theme 3: It is recommended that Black women prioritize self-care, which promotes advocacy that is essential for ensuring respectful maternity care.

Several participants recommended that Black women should practice more self-care during the perinatal period, especially to help cope with stress.

> *"Add those layers of self-care. Add those layers where it's okay to just sit back and allow our bodies to heal because we know that when we get home, we're still responsible for the meal prep and getting the children out the door in the morning. If we have more at home, and like you said, we'll be feeding. We're still responsible for feeding on both sides. If you have more than one child. And because we know that as soon as we step foot in the door, our responsibilities kick back up, allow us to have that time really where we can just rest, and you know recuperate." (Participant 12)*

Several participants recommended that self-care for Black women also includes not ignoring or denying the signs of stress, depression, and other mental health conditions and talking to someone (either a trusted family member, friend, or therapist) when you feel these symptoms.

> *"Yeah, just to speak out when you are going through it. To open up, just speak up on it, to not hold it in, if you're going through something. And if there is someone you can talk to, to just please talk to them so they can get you through it." (Participant 3)*

“I want black women to know it's okay to take a break. To take a load off. It's okay to not be supermom or superwoman. It's okay to cry. It's okay to feel down. It's been instilled in us that we are the glue. Yes, we're the glue. Yes, we have it all, but it's okay to be normal. It's okay to make mistakes. It's okay to feel like you want to give up. It's okay.”

(Participant 14)

Chapter 4: Discussion

This study identified a myriad of barriers and facilitators that Black women face when seeking maternal health services during the perinatal period in Atlanta, GA. This study also provided recommendations for ensuring respectful maternal healthcare. Many of the barriers, facilitators, and suggestions were related to how services are provided, both at the provider and broader health system levels, while others were linked to more social and cultural influences. Moreover, a large majority of the reported barriers, facilitators, and recommendations could be applied to all Black women regardless of insurance type and healthcare system.

Barriers

Provider level factors

Our findings indicate that Black women face many barriers when accessing maternal healthcare, which can often serve as a deterrent for seeking other perinatal health services in the future. The most common barriers cited by participants were related to provider factors such as poor patient-provider communication, dismissal of women's concerns, and poor staff attitudes. These findings are consistent with Johnson et al (2004), that revealed that African American patients experience poorer quality patient-provider communication compared to White patients during medical visits (Johnson, Roter, Powe, & Cooper, 2004).

Similar to other studies, several Black women in our study reported experiencing poor patient-provider communication during prenatal care, which even caused one woman to discontinue care at one health system and seek a non-hospital-based facility (Attanasio & Kozhimannil, 2015). This is consistent with Dahlem et al (2015) that demonstrated that patient-provider communication is associated with prenatal care satisfaction, perceived quality of care,

and trust in providers (Dahlem, Villarruel, & Ronis, 2015). Our findings support Raine et al, (2010), that argues that ineffective patient-provider communication is a barrier to prenatal care among pregnant Black women (Dahlem, Villarruel, & Ronis, 2015; Raine, Cartwright, Richens, Mahamed , & Smith , 2009). Given the importance of prenatal care for monitoring health, managing pre-existing conditions, and providing health information, it is essential that communication with providers improve during the critical prenatal period to reduce the risk of pregnancy complications among Black women (Peconic Bay Medical Center, 2019).

Contrary to previous literature, most Black women in our study did not explicitly report unequal treatment based on their race. However, Black women in our study noted that they often felt their maternity care providers did not listen to them and often dismissed their health concerns including complaints about pain and requests for pain medication. This not only causes Black women to mistrust providers but can also result in missed warning signs and delayed diagnosis (Alio, et al., 2022). It was also noted that Black women are subject to a lack of individualized care and stereotypical assumptions by providers, which supports previous studies that providers' implicit bias may impact assessment and management of pain as well as result in less attentive care and missed opportunities to prevent poor maternal health outcomes among Black women (Wang, Glazer, Sofaer, Balbierz, & Howell, 2020). This highlights the need for more training in implicit bias and cultural humility among providers.

Additionally, Black women in our study shared negative perceptions of providers' use of biomedical styles of communication (was perceived as impersonal or "cold") and medical paternalism, which results in providers assuming they know what is best for the patient without listening to their concerns or taking their lived experiences into consideration (Altman, et al., 2019). Through this power dynamic, Black women are not treated as equal partners in medical

decision-making (Altman, et al., 2019). Our findings support previous research that documents how this unequal power dynamic influences how providers share or withhold information (Altman, et al., 2019). Black women also reported providers and other members of the healthcare team (such as nurses) do not respect patients' feeding preferences and pressure them into breastfeeding.

Moreover, several Black women in the stated that their providers and other members of their healthcare team, such as nurses, talked to them with negative and rude attitudes, which led to discomfort and distrust of providers and the healthcare system. These findings support multiple studies such as Jacobs et al (2006) that suggest that poor interpersonal relationships with providers leads to distrust that inhibits maternal healthcare-seeking and can result in a change of providers as some women in our study did (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006).

Respectful care entails providers recognize their power in interactions with patients, emphasize effective patient-provider communication, and respect women's choices and preferences, which can improve patients' experiences with perinatal care as well as reduce preventable adverse maternal health outcomes related to provider-level factors (Altman, et al., 2019). This further underscores the need for more training on respectful care, communication, and interpersonal skills among providers.

Service and Health System Level Factors

Black women in our study identified barriers related to factors on the service and health system level that influence their maternal healthcare care seeking behaviors. Perceived poor quality of care, which includes unequal treatment due to health insurance type and service

delays, is another significant barrier to Black women seeking maternal health services during the perinatal period.

Our findings are consistent with the Listening to Mothers III survey, that found that women on Medicaid are subject to perceived unequal treatment or discrimination due to health insurance status (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2014). Like the Listening to Mothers in California study, we found that insurance type played a significant role in how Black women are treated and how much agency they have in deciding which providers and health systems to seek perinatal health services from (Samuels, 2020). Black women in our study reported that personally experiencing and witnessing unequal treatment to their children due to being on Medicaid made them dissatisfied and no longer seek care at one specific health system. However, it was noted that women on Medicaid and low-income women have limited choices in providers and health system options. This may reflect structural racism that results in Black women being more likely to be uninsured and face income inequality, which shapes their access to certain insurance types, providers, and delivery hospitals (Wang, Tanbo, Åbyholm, & Henriksen, 2011; Janevic T, 2020). Our findings indicate that more research is needed to understand the perinatal health experiences of Black women on Medicaid in Georgia and to further investigate the relationship between institutional racism and disparities in adverse maternal health outcomes.

According to our findings, many Black women face structural barriers when seeking maternal healthcare regardless of which hospital they deliver at (either Emory Midtown or Grady Memorial Hospital). These structural barriers result in poorer patient satisfaction and poorer perceived quality of care. Many Black women report long wait times and delays in service at Grady Memorial Hospital with one participant noting that this reflect larger systemic failures at

the health system level because the overcrowding at the hospital was attributed to Medicaid and low-income patients only having access to this public hospital for healthcare care. Black women who delivered at Emory Hospital also reported delays in service due to the COVID-19 pandemic. This suggests that the pandemic led to widespread health system constraints that may have also contributed to other barriers such as poor patient-provider communication and providers' rude and disrespectful attitudes since these communication issues are more likely to arise in stressful work conditions.

Only one Black woman in our study received care at a birth center, which is a community-based alternative source to prenatal and delivery care that is midwifery-led (Zephyrin, Seervai, Lewis, & Katon, 2021). This may be because birth centers are only recommended for low-risk pregnancies. However, it also may reflect how non-hospital-based care options such as birth centers and home births attended by midwives are largely inaccessible to women insured through Medicaid (Benatar, 2020). Previous studies have shown that non-hospital-based alternatives are associated with positive maternal health outcomes such as lower rates of C-sections, fewer maternal complications, and even no maternal deaths (Zephyrin, Seervai, Lewis, & Katon, 2021). Although the Affordable Care Act mandates that Medicaid covers services provided at birth centers, a recent study found that birth center providers struggle to participate in Medicaid due to low reimbursement rates and difficulties getting contracts with Medicaid managed care organizations (Benatar, 2020). Based on our findings, this study suggests that Georgia's Medicaid program should expand access to out-of-hospital care alternatives for women enrolled in Medicaid by improving reimbursement rates. This would help ensure more equitable treatment and improve maternal health outcomes for women enrolled in Medicaid.

Overall, most of the provider and health system level barriers that Black women face when seeking maternal healthcare care constitute disrespectful care. This underscores the importance of developing operational definitions and guidelines to promote respectful maternity care on the provider and health system level to help improve quality of care and address maternal health inequities among Black women.

Community/Societal Level Factors

A range of sociocultural factors was reported to inhibit Black women from seeking and accessing maternal health services, including mental health counseling, throughout the perinatal period. Many participants reported experiences of high stress and anxiety throughout the perinatal period, especially after returning home with their newborn. Two stressors that were commonly mentioned were financial stress and having to return to work too soon. This underscores the importance of maternity leave; however, the state of Georgia currently does not have a state law that mandates employers offer maternity leave.

Many Black women in our study shared how they experienced postpartum depression, but most of them did not seek mental health counseling, which indicates an unmet mental health need among Black women. Several participants also were not asked questions about their mental health or providers did not inquire enough to diagnose their depression and thus, these Black women did not have access to the mental healthcare care service they needed. These findings support the recent report published by the National Alliance on Mental Illness that stated that Black women have an increased risk of experiencing perinatal depression yet, Black women are underdiagnosed and less likely to seek mental health treatment due to many social factors

(National Alliance on Mental Illness, 2021). This underscores the need for providers to thoroughly screen for depression and other mental health disorders among Black women.

Black women in the study also acknowledged the cultural barriers to seeking and accessing mental health services within the African American community. Our findings support previous literature that states that mental health stigma in the African American community is a significant barrier for Black women seeking mental healthcare services (Ward & Heidrich, 2009). Our findings are also consistent with previous studies that suggests that the "strong Black woman" and "superwoman" schemas, often results in Black women self-sacrificing for their children and their family while not prioritizing or taking care of their own needs (Ward & Heidrich, 2009). These cultural tropes are often internalized by Black women, which prevents them for asking for help and leads to ignoring symptoms of mental health illnesses rather than seeking treatment (Ward & Heidrich, 2009). Our study supports findings from Ward & Heidrich (2009), that Black women often prefer to use religious coping or informal support to address mental health illnesses instead of seeking professional mental health services (Ward & Heidrich, 2009).

One Black women in the study noted that she did not seek mental health services because she feared mental health providers would not be able to relate and effectively treat her. This supports studies that suggests that poor access to diverse and culturally sensitive mental health care providers discourages Black women from seeking mental health services (NAMI, 2022). This highlights the importance of increasing diversity in the mental health provider community and the need for providers to consider patients' social, cultural, and socioeconomic context when deciding on referrals for psychosocial interventions.

Additionally, certain cultural myths deter women from seeking care at Grady Memorial Hospital. However, many participants had positive experiences at that hospital. This suggests the need for more tailored communication and assurance that hospitals that serve majority Black, low-income patients are still meeting hospital quality standards.

Many Black women in our study discussed how a lack of social support negatively influenced their delivery experiences as well as caused more feelings of isolation and stress during the postpartum period that may have contributed to poor mental health outcomes such as postpartum depression. Certain illness prevention protocols, such as those that limit how many visitors are allowed in the room, often prevents people from having valuable social support which negatively impacts patient satisfaction and their delivery experience in general (Haley & Benatar, 2020). One participant described how due to certain illness prevention protocols, that limit the number of visitors allowed in a hospital room, her husband was not able to support her in the delivery room which negatively impacted her delivery experience. Given the importance of social support especially during labor and delivery, it is critical that hospitals expand visitor policies even during the COVID-19 pandemic (when conditions are suitable) to ensure that Black women receive the social support they need during the perinatal period.

Participants also noted that it felt like they had limited social support when their partners had to return to work and when family members or other people were not physically there to support in terms of demonstrating how to care for their newborn or helping attend to other daily tasks. These findings support recent studies that demonstrate that Black women are more likely to report lower levels of social support, which further increases their risk for poor mental health (Liu, Setse, Grogan, Powe , & Nicholson, 2013). This highlights the need for increased

awareness and promotion of available community support programs that can help meet Black women's need for social support.

Facilitators

Provider level factors

It was reported that good experiences with patient-provider communication helped facilitate improved patient satisfaction, eased patients' anxiety, and increased adherence to provider recommendations. Good patient-provider communication was especially seen as helpful for first-time mothers. This supports findings from recent studies such as Korenbrot et al. (2005) that show the many benefits of good patient-provider communication (Dahlem, Villarruel, & Ronis, 2015).

Good patient-provider communication is commonly provided to Black women who receive care from midwives at non-hospital-based facilities and doulas. Several participants emphasized how they felt their midwives truly listened to them and one person transferred her care to a birth center because she found the midwives were able to have longer appointments and provide more information compared to those in a hospital setting. One participant shared similar sentiments about her doula. This highlights the importance of expanding access to community-based maternity care, including midwives and doulas, since research indicates that these providers help Black women feel listened to and meet all their needs and preferences, which has been shown to reduce the likelihood of adverse maternal health outcomes. It also highlights the need for increased access to doula care specifically through Medicaid coverage, because only one participant who had private insurance was able to receive this care.

Other important facilitators that were identified include desirable personality qualities in providers, such as treating patients with respect and compassion. These provider qualities helped facilitate positive experiences and continued use of maternal health services during the perinatal period. These findings are similar to those of Lori et al (2011) that found that treating patients with respect and providing compassionate care were desirable provider characteristics for Black pregnant women and having prenatal care providers with these qualities helped facilitate continuity of care (Lori, Hwa Yi, & Martyn, 2011).

Strong interpersonal relationships with providers were found to help facilitate positive experiences, build confidence in the providers' capabilities, and promote continuity of care according to participants. Many participants also reported that when providers respected their culture and values, it helped ease their anxiety and ensured trusting relationships. One participant cited this as her chief reason for seeking care with a doula. Another participant discussed how she really appreciated how her provider followed her birth plan closely, which helped ensure that all her individual preferences were met and led to a more positive birth experience. This is consistent with current studies that suggest that strong interpersonal relationships with maternal health providers helps improve the perceived quality of care and encourages maternal healthcare seeking behaviors (Dahlem, Villarruel, & Ronis, 2015).

Health system level factors

Another important facilitator that was identified among Black women was easy accessibility of maternal health services. Our findings are consistent with Heamon et al, (2015), that shows how the convenience of being able to sign up for maternal health services in the hospital before being discharged (following childbirth) and having no difficulties scheduling

appointments helped facilitate positive maternal healthcare experiences and maternal healthcare seeking behaviors during the perinatal period. This suggests that health systems should continue to ensure that perinatal healthcare services are easily accessible and convenient for Black women.

One participant shared how even though her doctor did not refer her to a therapist, she found it was easy to search and find mental healthcare providers on her own, which enabled her to seek and access mental health counseling. Several participants expressed that their providers did offer referrals to mental health providers and one participant noted that she believes some providers are inquiring about mental health more in recent years than they did in the past, which is contributing to increased access to mental healthcare. This further highlights the importance of the accessibility of maternal health services including mental healthcare. The findings may suggest there is a recent increase in awareness of mental health and mental health resources and information available online, which may be contributing to the perceived increased access to mental healthcare.

Perceived high-quality of medical care was also identified as an important facilitator to maternal health seeking behaviors. Many participants conveyed that they appreciated that their providers offered care for both physical and mental health that included thoroughly screening for intimate partner violence and depression at prenatal and postpartum visits. This reflects growing attention and new hospital and health system efforts to reduce or prevent pregnancy-associated deaths.

Another significant facilitator was the provision of high-quality medical care. Many Black women reported that they considered holistic care to be high-quality care. Nearly all of the participants who was provided holistic care received it from community-based alternatives such

as midwives at a birth center and a doula, which helped facilitate positive birth experiences where all their preferences were met, ensured they felt listened to, and was confident in their birth attendant's capabilities. In addition to the need to expand access to these culturally acceptable care options, our study suggests that these approaches of listening to patients and ensuring patients have their desired birth experience should be adopted by all providers and health systems using the model for respectful maternity care, which emphasizes all these desirable aspects of care.

Black women also identified that racial and gender concordance are important facilitators to maternal health seeking. Several participants expressed that they had positive experiences receiving maternal healthcare from providers who had the same gender identity as them because they could relate to their patients more and provide more compassionate care. Another participant reported that she specifically seeks providers of color to reduce the likelihood of experiencing adverse maternal health outcomes and discrimination. These findings support other recent studies that have found that racial and gender concordance among patients and providers is associated with improved patient satisfaction and birth experiences (Takeshita, Wang, & Loren, 2020). This further highlights the need to increase the diversity of providers.

Another important facilitator of maternal health seeking among Black women that was identified was social support. Some participants revealed that they received social support, such as informational support and emotional support, which enabled them to access and seek perinatal services. Several participants stated that they felt supported by certain services offered by the Planning for Healthy Babies program (Georgia's family planning demonstration waiver), which includes health education classes, case management, and a mobile application that had a list of affordable resources and health tips, sent reminders about important medical appointments

through texts, and had a symptom checker. This suggests that Georgia's Medicaid program should continue to provide these beneficial services to Black women.

Recommendations

It is important to center Black women voices when developing recommendations to ensure respectful maternity care since this population is disproportionately affected by disrespectful care, which may be contributing to Black maternal health disparities.

One recommendation that was offered by a Black woman in the study is that pregnant patients should develop a birth plan with their providers to help improve patient-provider communication. This will help clearly communicate who is expected to deliver the patient's maternal healthcare and help enable an interpersonal relationship is established with the provider delivering that care. Our findings suggest this will help improve patient satisfaction, especially for their delivery care, ease anxiety, and improve the perceived quality of care among Black women.

Another recommendation offered to ensure respectful maternity care was an increase in the social support provided to Black women. Several participants suggest that providers should support their patients more by following up with them and confirming that all their needs are being met during the perinatal period, especially when they referred patients to mental health providers for postpartum depression. There is an urgent need to adopt this recommendation given Black women's increased risk for mental health conditions and unmet need for mental health treatment (Kilgoe, 2021).

It was also recommended that a peer support program should be developed for Black pregnant women to help provide more social support. The positive experience that one

participant had with group prenatal appointments supports previous evidence that indicates that group prenatal care can improve patient satisfaction and is associated with reduced adverse maternal health outcomes such as reduced preterm births (Zephyrin, Seervai, Lewis, & Katon, 2021). Group prenatal care, which involves providers offering individual physical healthcare services as well as facilitating discussions on a range of maternal health topics among a group of pregnant women, is an innovative model to maternity care that warrants being explored and piloted among health systems in Georgia (Zephyrin, Seervai, Lewis, & Katon, 2021).

Other recommendations that were provided were related to improving the quality of patient-provider interactions, quality of perinatal health services, and addressing structural barriers such as long wait times for service. This suggests that providers and health systems need to continue to prioritize efforts to improve hospitals' quality of care in Georgia.

Strengths and Limitations

Our study had several strengths including the community-based participatory research approach and partnership with the Center for Black Women's Wellness (CBWW) who helped develop and refine the data collection instruments as well as co-facilitated the focus group discussions. Two other strengths were the focus group methodology and the ability to have two Black women conduct the focus group discussions. This allowed for honest, rich discussions that helped identify shared experiences and a range of nuanced perspectives on the issue, which may not be available through individual data collection.

However, one limitation of this study is that it did not include Black women from rural Georgia, which means their unique experiences and recommendations for maternal healthcare are not captured in this study. Another limitation is the relatively small sample size (N=18);

however, it is believed this study reached data saturation due to the repetition of themes and comments. Recall and sampling bias are other possible limitations. We tried to limit the recall period in this study to each participant's most recent pregnancy to minimize recall errors. However, it still may be challenging to recall accurate details of their prenatal care, birth experiences, and postpartum care experiences from over an extended period of time. There also could be sampling bias because the Atlanta ECHO cohort only enrolls women with livebirths, which excludes Black women who had stillbirths and neonatal deaths. These women may have unique experiences with maternal healthcare, particularly with postpartum care, which may make their needs and recommendations for respectful maternal healthcare different from those represented in the study.

Chapter 5: Public Health Implications

Respectful maternity care is not only crucial for improving quality of care; it is also a human right according to the WHO and the White Ribbon Alliance's Universal Rights of Childbearing Women Charter (Maternal Health Task Force at the Harvard Chan School Center of Excellence in Maternal and Child Health, 2022). The disrespectful care that Black women are subject to in medical settings violates their fundamental human rights to health and quality maternal health services free from discrimination. As non-hospital-based alternatives are limited in Georgia, it is important that all hospitals and health systems deliver respectful maternity care. The quality of care Black women receive has implications for future maternal healthcare-seeking behaviors, which directly affects their health and well-being.

Research suggests that the provision of respectful maternity care can improve maternal health outcomes and birth experiences among Black women (Taylor, The Importance of Respectful Maternity Care for Women of Color, 2021). When Black women seek and utilize timely, quality maternal healthcare, studies have shown it helps identify, manage, and treat health conditions that can complicate pregnancy, may reduce the risk of poor maternal health outcomes, and can reduce rates of maternal mortality and morbidity (Taylor, The Importance of Respectful Maternity Care for Women of Color, 2021). Studies in other countries have also indicated a direct relationship between respectful maternity care and positive childbirth experiences (Gebremichael, Worku, Abrha Medhanyie, & Berhane, 2018). Overall, evidence suggests respectful maternity care can help improve maternal health and reduce inequities in adverse maternal health outcomes among Black women (Crear-Perry, Green, & Cruz, 2021).

More research is needed to investigate the relationship between respectful maternity care and Black maternal health outcomes, which can inform health policy and hospital quality improvement initiatives. Also, the WHO has called for more research on how to define and

measure respectful care, which will enable providers and health systems to have specific guidelines to follow and reduce disrespectful care practices (Green, et al., 2021). Additionally, this study reveals the need for more research on strategies to improve the provision of respectful care. It is important that these strategies are centered around the lived experiences and needs of Black women who are most affected by disrespectful care to effectively create systemic change and reduce persistent maternal health disparities. By sharing Black women's perspectives of barriers and facilitators they face when seeking perinatal care, as well as their recommendations for improving respectful care, this study provides the foundation for developing operational definitions and a framework for respectful maternal healthcare.

Appendix

Table 1. ***Sociodemographic characteristics of focus group participants***

Characteristics	***Participants (N=18)*** *No. (%)*
Race/Ethnicity	
Non-Hispanic Black	18 (100%)
Age groups	
18-24	7 (38.9%)
25-34	8 (44.4%)
35 and over	3 (16.7%)
Relationship Status	
No partner	2 (11.1%)
Partner-not cohabiting	5 (27.8%)
Partner-cohabiting	7 (38.9%)
Married partner-cohabiting	4 (22.2%)
Highest Level of Education	
Some high school	1 (5.6%)
Completed high school	5 (27.8%)
Some college	4 (22.2%)
Completed college	4 (22.2%)
Some graduate school	0 (0%)
Completed graduate school	4 (22.2%)
Type of Health Insurance	
Low-income Medicaid	3 (16.7%)
Right-from-the-Start Medicaid	6 (33.3%)
Private	9 (50%)
Healthcare System	
Emory Healthcare	9 (50%)
Grady Health System	9 (50%)
Perinatal Complications*	
Preeclampsia	3 (16.7%)
Gestational diabetes	4 (22.2%)
Gestational hypertension	7 (38.9%)
Postpartum hemorrhage (requiring transfusion)	3 (16.7%)
Uterine fibroids	1 (5.6%)
Severe asthma	1 (5.6%)
Prolonged labor	1 (5.6%)
Precipitous labor	1 (5.6%)
Early birth	7 (38.9%)
Intrauterine growth restriction	1 (5.6%)

Domestic violence/trauma during pregnancy	1 (5.6%)
Fetal distress during labor	1 (5.6%)
Chorioamnionitis	1 (5.6%)

It is important to note that some participants had multiple perinatal complications

Table 2. ***Domains and Subdomains of Focus Group Guide***	
Domains	**Subdomains**
Background	Personal information
	Health condition during pregnancy
Prenatal Care	Experiences with prenatal care
	Community supports/programs
	Recommendations for improving prenatal care
	Unmet need
Delivery Experiences	Experiences with delivery
	Discharge/readiness
	Recommendations for improving delivery care
	Pre-term delivery
	Breastfeeding and lactation support
Postpartum Care	Experiences once home with baby
	Experiences with postpartum care
	Help with questions/concerns
	Recommendations for improving postpartum care
	Understanding of warning signs
	Reasons why Black women are more likely to die in childbirth
	Unmet need
Respectful Care	Define respectful care
	Experiences of respectful care
	Consideration of cultures
	Recommendations for ensuring equitable/respectful care
Bias	Unequal treatment based on race/ethnicity
	Unequal treatment based on characteristic other than race
Ideal provider	
Doula	
Midwives	
General perceptions of mental health	
Patient-provider communication	Good patient-provider communication
	Bad patient-provider communication
Social support	
COVID-19	

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