Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world-wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

Michelle Anaba 04/11/2022

Date

A Qualitative Study on the C-section Experiences of Black Women in the Southeast United States

By
Michelle Anaba

Degree to be awarded: MPH

Behavioral, Social, and Health
Education Sciences Department

Dawn L. Comeau, PhD, MPH
Committee Chair

Whitney S. Rice, DrPH, MPH
Committee Member

Cam Escoffery PhD, MPH
Department Chair

A Qualitative Study on the C-Section Experiences of Black Women in the Southeast United States

By
Michelle Anaba

Bachelor of Science, Towson University, 2016
Master of Public Health, Emory University, 2022

Thesis Committee Chair: Dawn Comeau, PhD, MPH

An abstract of
a thesis submitted to the Faculty of the Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of Master of Public Health in Behavioral Sciences and Health Education
2022

Abstract

A Qualitative Study on the C-section Experiences of Black Women in the Southeast United States

By
Michelle Anaba

Black women face some of the greatest disparities in healthcare and healthcare access. These disparities often stem from racism as opposed to genetic factors. Black women face the greatest health disparities in maternal morbidity and mortality, and they have the highest c-section rates out of all other racial groups in the United States. These disparities stem from racism, providers' implicit bias, and providers not listening to Black women. Often, Black women are ignored when they express concerns during their prenatal, childbirth, and postpartum experiences. They may have issues that left untreated, could lead to adverse health outcomes or even death.

There is research that shows that c-sections may be overused in the United States. Physicians are typically paid more for c-sections than vaginal deliveries, and c-sections may be viewed as more convenient for a physician, since they can be scheduled. There are several reasons why the c-section rates for Black women may be higher than other races. Black women often do not have access to high-quality healthcare, and may only have access to hospitals with high rates of adverse health outcomes. Additionally, physicians may ignore Black women's symptoms and not find issues until later, if at all. There are some qualitative studies that provide data on why Black women face adverse maternal and child health issues, but there are not many qualitative studies that focus on Black women's perspectives on c-section experiences. This qualitative study will focus on the experiences of Black women in the Southeast who have had a c-section within the past 15 years. The aims of this study are to hear directly from Black women and find out what their experiences were, how they were treated by medical staff, and whether they felt their c-section was necessary.

A Qualitative Study on the C-Section Experiences of Black Women in the Southeast United States

By
Michelle Anaba

Bachelor of Science, Towson University, 2016
Master of Public Health, Emory University, 2022

Thesis Committee Chair: Dawn Comeau, PhD, MPH

A thesis submitted to the Faculty of the Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of Master of Public Health in Behavioral Sciences and Health Education
2022

Acknowledgements

I'm grateful to my family for providing encouragement and support throughout this process. I would like to thank Dr. Dawn Comeau for consistently checking in on my progress, providing invaluable feedback and encouraging me all the way to the finish line! I am grateful for Dr. Whitney Rice for providing helpful feedback and making herself available for questions. I am beyond grateful to my participants who bravely and candidly shared their stories with me. Without you, I could not have done any of this.

Table of Contents

Chapter 1: Introduction ***1***

Chapter 2: Literature Review ***3***

Physician Preference and Financial Pressure to Recommend C-Sections **5**

Health Disparities **6**

Disregard for Black Women's Concerns **10**

Chapter 3: Methods ***12***

Introduction **12**

Participant Recruitment **12**

Data Collection **13**

Interview Guide **13**

Data Analysis Methodology **15**

Chapter 4: Results ***17***

Introduction **17**

Sample Description **17**

Key Findings **19**

The Need for Medical Staff to Improve Communication with Black Women **19**

The Need to Improve the Healthcare System and Childbirth Process for Black Women **24**

The Need for Black Mothers to Self-Advocate or Identify an Advocate **27**

Summary of Findings **34**

Chapter 5: Discussion ***35***

Discussion of Key Results **35**

Public Health Implications **39**

Individual-Birthing Black Women **39**

Relationship/Interpersonal- Advocates and Birthing Support People **40**

Community & Institutional- Medical Professionals **41**

Societal- Society and Policies **42**

Future Directions **43**

Conclusions 45

References ***46***

Appendices ***54***

Appendix A- Interview Guide.....54
Appendix B- Demographics Table 56
Appendix C- Visual Framework of Key Themes.....57

Chapter 1: Introduction

Research Question: What are the attitudes and experiences on c-sections of Black women in the Southeast who have had a c-section within the past 15 years?

C-sections can be lifesaving in the event of a true emergency. However, the c-section rates in the United States are higher than they need to be, especially among Black women (March of Dimes, 2021). According to the National Center for Health Statistics (NCHS), the 2018-2020 average for c-section rates was 31.8% for all races. The c-section rate for Black women was 35.8%, 32.6% for Asian/Pacific Islanders, 30.9% for White women, followed by 28.9% for American Indian/Alaska Native women (NCHS, 2022). Additionally, between 2019 and 2020, the c-section rates increased for the three largest race and Hispanic-origin groups (NCHS, 2022). For Black women, rates increased from 35.9% to 36.3%, and for White women, rates increased from 30.7% to 30.8%. For Hispanic women, the rates increased from 31.3% to 31.4% (NCHS, 2022). In addition to Black women having the highest c-section rates among any other racial group, they also have the highest rates of maternal morbidity and mortality (Centers for Disease Control and Prevention (CDC), 2021). Black women are three times more likely than White women to die from a pregnancy-related issue. Black women are more likely to not be listened to by healthcare professionals, and also more likely to be pressured into having a c-section. Additionally, Black women typically have less access to quality healthcare than White women do (Hall et al., 2015). Financial incentives are among reasons why the c-section rates are high. Physicians are typically paid more for c-sections than vaginal deliveries (Oster &McClelland, 2019).

The aim of this qualitative research study is to examine the experiences of Black women who have had c-sections within the past 15 years. The researcher will examine women's

experiences, which will include overall hospital experience, experience with medical staff, perceived discrimination, and any other relevant information.

The Ecological Systems Theory (the overarching theory of the Social Ecological Model) can be used in the future to provide a framework to explore how women's birth experiences are impacted by several different factors. The Ecological Systems Theory was developed by Urie Bronfenbrenner in 1979 (Harkonen, 2007). The Ecological Systems theory supports examining how a person's development is influenced by the surrounding environment, as well as the social interactions within that environment. (Harkonen, 2007) This theory may be used in the future to inform analysis of factors related to a woman's childbirth experience.

Chapter 2: Literature Review

The Cesarean section (c-section) is the most commonly-performed surgical procedure among women in the United States (Edmonds et al., 2013). C-sections can be lifesaving procedures, but all too often, they are used when not medically necessary (Galvin, 2019).

The increase of c-sections started in 1996. “The c-section rate rose by 53% from 1996 to 2007, reaching 32%, the highest rate ever reported in the United States.” (Menacker & Hamilton, 2010). The most current Centers for Disease Control and Prevention data from 2019 show that 31.7% of all births were via c-section, and 25.6% were among women with low-risk pregnancies (Hamilton et al., 2020). Compared to mothers who give birth vaginally, mothers who have c-sections are at a greater risk of experiencing pregnancy-related issues such as postpartum cardiac arrest and the need to be admitted to the Intensive Care Unit (ICU) (Galvin, 2019). Other possible negative health consequences include damage to the bladder and kidney infection. (Hess, 2021). Additionally, women who undergo c-sections are twice as likely than women who have vaginal deliveries to experience hemorrhage, which is the leading cause of childbearing related death (Hess, 2021). While c-sections can cause adverse health conditions for women of all races, Black women experience higher adverse pregnancy outcomes, and have a higher rate of maternal morbidity when compared to other races. There is evidence that Black women have higher maternal mortality rates and higher c-section rates than White women, and they face various issues, such as chronic diseases like hypertension, poor quality of care, and provider’s implicit bias (Peterson et al., 2019). These issues contribute to pregnancy-related mortality and health disparities. According to the CDC, between 2007 and 2016, there were 42.8 deaths per

100,000 births among Black women, compared to 13 deaths per 100,000 births among White women (Peterson et al., 2019)

According to the CDC's 2018 National Vital Statistics Report, 36.1% of Black women delivered children via a c-section, compared to 30.8% of white women, and 31.9% of women overall (Martin et al., 2019). Additionally, Black women were more likely to undergo a c-section for fetal distress or failure to progress (Edmonds et al., 2013). Participants in this c-section study included both women who were considered high and low-risk. Data on low-risk rates was included to provide background on the possible overuse of c-sections. The high rates of c-sections among women considered low-risk may suggest that c-sections may be especially overused among "low-risk" women who do not need them. In general, low-risk pregnancies are pregnancies with one child, where the pregnancy occurs "at term", where the baby is in the vertex (head-down) position, and there are no other medical or surgical conditions Institute of Medicine (IOM) and NRC (National Research Council), 2013).

There are a few factors that could lead to higher rates of c-sections. An investigative journalism group found that women who deliver babies in for-profit hospitals are 17% more likely to have a c-section than women in non-profit hospitals, even after other maternal health factors were controlled for (Melnick, 2010). C-sections bring hospitals about twice the revenue of vaginal births, since, by nature, surgery is expensive and requires longer hospital stays (Holmes et al., 2020). On the other hand, evidence shows that some non-profit hospitals make a large sum of money from their patients. A 2016 Washington Post article showed that seven out of the ten most profitable hospitals in the United States are nonprofit hospitals (Sun, 2021). In a study conducted on hospital profitability, researchers found that hospitals that were part of a

system were more profitable because they were able to dominate in their local market (Bai & Anderson, 2016).

There are several reasons why women who are considered low-risk may still undergo c-sections. These reasons can include physician preference, lack of access to alternative forms of care, a woman's perceived pressure to have a c-section, financial differences between vaginal deliveries and c-sections, and negative presumptions about Black mothers' health.

Physician Preference and Financial Pressure to Recommend C-Sections

Physicians may encourage women to undergo a c-section because it is more convenient for the physician's schedule. According to a study that examined the association of obstetric intervention with temporal patterns of childbirth, c-sections, especially first-time c-sections, spike around the morning, lunchtime, and the end of the day, which could indicate scheduling pressures that doctors face with getting to office hours, going to lunch, and going home (Clark, 2014). Additionally, the risk of a woman having a nonelective primary cesarean was one-third higher on a weekday than on a weekend (Clark, 2014). A physician may also decide to perform a c-section because of pressures in hospitals. There are often not many labor rooms available, so doctors may decide to alter birth choices because of either implicit or explicit pressure to avoid "taking too long", since other women will be waiting to get into the birthing room (Oster & McClelland, 2019).

Physicians may recommend unnecessary c-sections because of the financial incentive to do so. Physicians are typically paid 15% more for a c-section than for a vaginal delivery (Oster & McClelland, 2019). This is because a c-section is a major surgery, and a vaginal delivery has the possibility of being time-consuming and complicated. The payments for a c-section are fixed,

and reflect the mode of delivery, and not the amount of difficulty (McClelland, 2014). In essence, labor management may take longer and lead to doctors losing sleep, less time with other patients, and less time with family (Oster & McClelland, 2019).

Certain studies have examined whether c-section rates would be lower if the payment amount were the same as vaginal deliveries. Researchers conducted a study in Minnesota to evaluate the effect of the blended payment policy (same payment for both vaginal delivery and c-section). After the policy was instituted, Minnesota's pre-policy cesarean rate (the c-section rate before the blended payment policy was enacted) decreased a total of 3.24 percentage points, compared with control states. Although there were significant policy effects on maternal morbidity, after the policy, childbirth hospitalization costs continued to decrease in Minnesota as compared to control states (Kozhimannil, 2018). This research shows that c-sections may not be recommended as frequently if there were no financial incentives.

Another study examined whether Minnesota's blended payment policy had different effects on c-section use and maternal morbidity in white women versus Black women in Minnesota, compared to six control states. Black women's cesarean usage decreased by -2.88 percentage points, compared with -1.32 percentage points in white women. However, postpartum hemorrhage increased by 1.20 percent among Black women, compared to a 0.48 increase among White women (Snowden, 2020). The increase in postpartum hemorrhage may signify a consequence of c-section reduction.

Health Disparities

High c-section rates are only one of the many facets of health dipartites that Black women face. Black women have the highest maternal morbidity and mortality rates, and are three times more

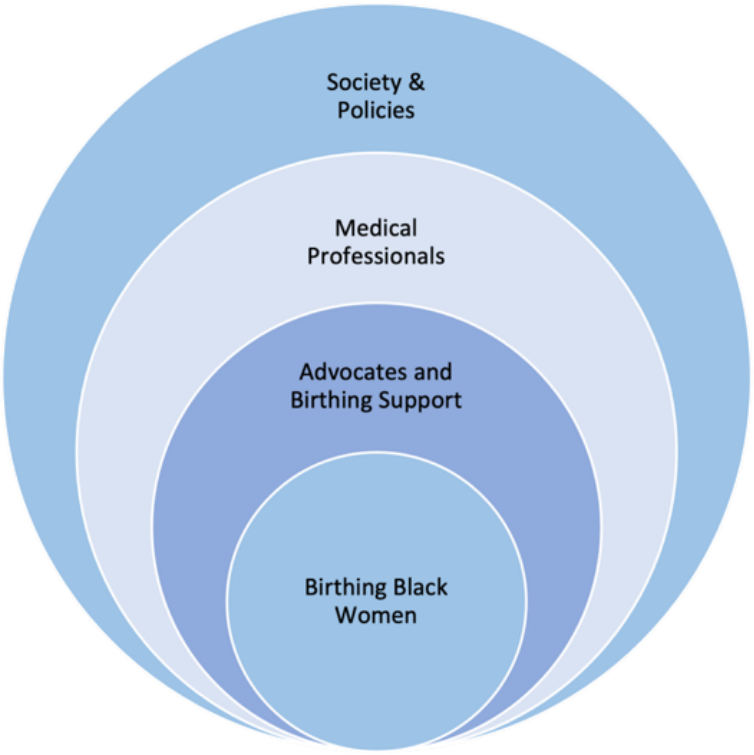
likely than White women to die from a pregnancy-related cause (CDC, 2021). There are several factors that contribute to Black maternal morbidity and mortality. Some of the reasons that Black women may experience disparities in care may be due to factors such as patient factors, community/neighborhood and provider factors, or system factors (Howell, 2018). Patient factors include poor patient-provider interaction among racial and ethnic minorities (Dahlem et al., 2015) such as Black women, variation in quality healthcare, one's underlying chronic conditions (CDC, 2021), demographic factors such as age, education and poverty level, as well as insurance and marital status. It also includes employment status, health behaviors, educational status, and literacy (Howell, 2018). Community and neighborhood factors such as a woman's social network, exposure to crime, poverty status, and housing status can also affect and exacerbate health disparities. Provider factors can include [quality of] communication, implicit bias, and cultural competence. Finally, system factors can include access issues such as access to adequate transportation and supportive health policies. System factors can also include interacting with structural racism and unfair policies (Howell, 2018). A study conducted on quality of hospitals in New York City found that Black women are more likely to deliver in a hospital with a higher risk-adjusted severe maternal morbidity rate (Howell et al., 2016). The study also found that there was a higher amount of Black low-birth weight babies delivered at hospitals with a high risk adjusted severe maternal morbidity rate.

In this thesis, the researcher planned on using Critical Race Theory (CRT) to inform and analyze data, but decided that using the Social Ecological Model was sufficient, and decided to only include CRT to describe future directions for public health research. In this thesis, the researcher used the Social Ecological Model (SEM) to inform and analyze the data, and the SEM

will be referenced in detail in the next chapter. The PI examined the factors of the SEM that can have an impact on a Black woman who has a c-section in the United States. The Social Ecological Model comprises four levels, individual, relationship, community, and societal (CDC, 2021). This c-section study incorporated a modified version of the SEM. The individual level was referred to as the patient level, and included women who have had c-sections in the past. The relationship level was referred to as the provider level, and included women's family, friends, and community advocates such as doulas and birthing support partners. The community level involved hospital staff such as obstetrician-gynecologists (OBGYN's), nurses, and anesthesiologists, and also included providers' implicit bias. Finally, the societal level included policies that affect a woman's ability to access adequate care. Additionally, the societal level included other barriers that prevent Black women accessing care, such as unfair policies and structural racism. The SEM analyzes the interplay between the four levels, and allows researchers and readers to understand how several aspects can impact a woman's childbirth experience. The researcher in this study incorporated aspects of this model to understand how a woman's individual, relationship, community, and societal factors affected her c-section experience. Birthing Black women made up the individual level, advocates and birthing support people made up the relationship level, medical professionals (and their implicit bias) made up the community level, and society and policies made the institutional level.

The following model showed how the PI adapted the traditional SEM for to fit this study.

Figure 1-Social Ecological Model for Black Birthing Women



The PI in this c-section research study observed a gap in research in relation to qualitative studies on c-section rates. However, the researcher did find research related to health disparities in maternal and childcare, as well as a cross-sectional study on prenatal care experiences of low-income women. A cross-sectional study conducted with Black women showed that positive patient-provider communication had a positive effect on a woman's trust in their provider and prenatal care satisfaction (Dahlem, 2015). Their findings suggested that quality patient-provider communication improves the prenatal care experience for Black women.

Black Women's Lack of Access to Care

Hospitals are still more likely to encourage women to undergo a c-section, since they know that their insurance companies can pay, and because Black women are less likely to be

listened to if they push back (Hess, 2021). Additionally, Black women do not have the same access to alternative birthing methods as white women. White women's c-section rates may be lower than those of Black women because they have access to home births and birthing centers (Hess, 2021). Birth centers are more common in higher-income areas, and Black women are more likely to be deemed to have a too much of a high-risk for an out of hospital birth. Additionally, white women are more likely than Black women to be able to afford a midwife or doula (Hess, 2021). Doula services are not covered by Medicaid, which significantly limits the amount of low-income or disadvantaged women that can utilize doula services. There are numerous studies that show that women who have access to doulas have better birth outcomes. When women using Medicaid received doula support, they had lower preterm and c-section birth rates (4.7% vs. 6.3% and 20.4% vs. 34.2%). This suggests that doula care would be cost-saving for Medicaid programs (Kozhimannil, 2016).

Disregard for Black Women's Concerns

Many Black mothers face unfavorable health outcomes because their doctors disregard their input. The California Health Care foundation funded a study that surveyed mothers about their birth concerns. The study found that health care providers often do not listen to women's concerns, and Black mothers were less likely to be listened to than all other races (Kritz, 2018). The California Health Care foundation disseminated a survey to 2,500 healthy women who gave birth to one baby in a California hospital in 2016. The survey results showed that 75% of women who felt pressured to have labor induced ended up having a c-section (Kritz, 2018). Additionally, 30% of Black women reported prenatal anxiety, compared to 20% of white women. Also, 20% of Black women faced prenatal depression, compared to 10% of White women (Krtiz, 2018).

These findings showed that there are several reasons why certain hospitals may have a higher c-section rate than others. While some research explains why c-sections may be prevalent, there is limited qualitative research on the perspectives of low-risk populations in particular, and even less qualitative research specifically centered on Black women's perspectives. This qualitative study examined the experiences of Black women who have undergone a c-section, in order to gain an understanding of their experiences, and the factors that resulted in them having a c-section. This project incorporated an "emic perspective" as the research is based on the perspective of the patient, and centered around the experiences of Black women who have had a c-section.

Chapter 3: Methods

Introduction

A qualitative research design using semi-structured, in-depth interviews was used to explore the experiences and perceptions of Black women in the Southeast United States who have undergone a c-section within the past 15 years. The study was approved by the Emory University Institutional Review Board on September 13, 2021. When first introducing this study, the researcher had a hypothesis that Black women who had a c-section experienced discrimination and unnecessary c-sections. The hypothesis was developed when having informal conversations with other Black women, and by analyzing conversations on social media. The study was conducted to answer the research question: What are the experiences of Black women in the Southeast United States who have had a c-section within the past 15 years?

Participant Recruitment

Participants were recruited through convenience, snowball, and quota sampling. A flyer describing the study details was sent to the PI's network via email, social media (a Facebook group) and from there, interested participants contacted the PI to schedule an interview. The PI's network included a few non-profit and maternal and child health professionals in Louisiana and Georgia. Many of these professionals worked directly with populations such as doulas, mental health professionals, and Master of Public Health Professionals. Additionally, some of the people in the PI's network worked directly with Black women who had previously given birth. The study flyer was posted in two public health Facebook groups, and one Facebook group for Black women in Louisiana. The flyer included a summary of the research, the eligibility requirements, and the researcher's email and phone number to contact if interested. Eligibility requirements

were: participants needed to identify as a Black woman, be at least 18 years old, reside in a state in the Southeast US, and have had a c-section in the past 15 years. After the flyer was sent out via email and posted in Facebook groups, participants contacted the researcher via email or text to schedule an interview. The flyer was posted in a private Facebook group where comments were turned off, so participants were not able to directly share their email addresses in the Facebook comments. It was important to refrain from having emails posted publicly, so participants could remain as anonymous as possible. Participants were instructed to directly email the PI if they were interested in the study. Afterwards, the researcher sent participants a Zoom link and calendar invite for the interview.

Data Collection

At the beginning of the interview, the researcher read the consent script, then recorded the interview after receiving consent from the participant. The interview was saved to the researcher's laptop and imported to Emory One Drive, and subsequently deleted the recording from the computer. The researcher then imported the file into Otter.ai, then edited transcripts either in batches of two or three transcripts. After editing each transcript, the researcher made a list of potential codes and notes that would be helpful in developing the codebook. Interviews were facilitated by an interview guide that was semi-structured as identified below.

Interview Guide

The topics in the interview guide were determined by previous research developed using prior research articles. Questions focused on SES and other demographic questions, the women's c-section and birth experiences, and attitudes and perceptions towards hospital and medical staff. The PI went through interview questions and included probing questions when needed. Most of

the women who were interviewed provided great detail regarding their birth stories and experiences with medical staff. A copy of the interview guide can be found in Appendix A. The PI took written notes as needed. The PI adjusted the interview guide and questioning as the interviews progressed. As an example, she added more demographic questions after realizing that certain data were not being captured, and these demographic questions needed to be explicitly asked. As an example, she added questions that captured participant's sexual orientation and household income, when she realized that those questions may be helpful for context when performing analysis. Interview questions focused on eliciting feedback on how women felt when interacting with healthcare professionals, whether they felt pressured to have a c-section, and how effectively they felt that healthcare staff educated them on topics related to childbirth, c-sections, and overall pregnancy. The interview guide started out with demographic questions such as age, marital status, and occupation, and went into questions about family childbirth norms and pre-pregnancy ideas on childbirth. Later questions focused on the overall childbirth experience and interactions with healthcare professionals. One of the main questions was “Tell me about your childbirth experience”, which allowed women to freely share their birth story. There were also a few questions about women’s interactions with healthcare professionals and whether they felt discriminated against. Lastly, the final question asked women about what advice they would give to women (specifically Black women), based on what they wished they had known before becoming pregnant.

Data Analysis Methodology

The interviews were saved to the researcher's laptop and imported to Emory OneDrive, and subsequently deleted from the computer. The researcher then imported the file into Otter.ai, where it was transcribed. The researcher manually edited the transcript to ensure accuracy. Afterwards, the researcher made a list of potential codes and notes that would be helpful in developing the codebook. After transcription, transcripts were imported into MAXQDA software, and a codebook was developed using five transcripts. First, each transcript was coded individually, then additional codes were added when new themes were discovered. The researcher has completed, transcribed, and coded 11 interviews.

The researcher used aspects of the Social Ecological Model to analyze data. The SEM was applied to examine women's individual, relationship, community, and societal factors. The researcher included demographic questions in addition to race, such as age, income levels, marital status, and educational level to provide context to a woman's background. During the analysis process, the researcher explored the data and looked for themes surrounding how differences in demographic data relate to a women's hospital experience. As an example, the researcher paid close attention to experiences of women who had Medicaid and how their experiences may have differed from women who had private insurance. The researcher included interview questions on family norms to get a sense of how a woman's upbringing may have influenced the way she viewed childbirth, and any familial influences that may have impacted her experiences or mindset. Relationship factors were assessed to determine how different levels of support impacted a woman's childbirth experience. Additionally, the researcher assessed community factors such as a woman's neighborhood or workplace. As an example, a few women who were interviewed mentioned how they experienced stress at work during their pregnancies.

The researcher made a note of this and added a code related to stress at work, in case more women also mentioned the same thing. Regarding societal factors, the researcher included questions on how healthcare providers made the women feel, and whether the women felt that medical staff explained things to them. The researcher then analyzed the women's responses. As an example, the researcher made note of when women mentioned that they did not feel heard by medical staff.

Chapter 4: Results

Introduction

Three prominent themes were found in the research conducted among 11 mothers who were interviewed. The women had a wide variety of experiences, and there were several similarities among women's experiences. After demographic characteristics, results highlighted women's perspectives on the need for medical staff to improve communication with Black women, the need to improve the healthcare system in relation to the childbirth process, and the need for Black mothers to self-advocate and identify a person to advocate for them during the childbirth process. Additional themes that were explored included whether type of health insurance coverage plays a role in treatment, how more childbirth education can positively impact women, and how women's experiences can provide guidance to newly pregnant women on how to prepare for childbirth.

Sample Description

The sample consisted of 11 Black women with ages ranging from 25 to 41. The interview data were de-identified and participants were given pseudonyms after the transcripts were prepared. Pseudonyms were used to de-identify the participants, and similar cultural names were used for each participant, if relevant. Seven women reported being married, three reported being single, and one's marital status is undetermined. All the participants had a c-section within the past 15 years and currently resided in the Southeast United States, which consists of these states: Alabama, Georgia, Florida, Kentucky, Mississippi, North Carolina, South Carolina, Louisiana, Tennessee, and Virginia. Ten of the eleven women also gave birth in one of the aforementioned states, and one gave birth in a hospital in California. Six women reported undergoing at least one

emergency c-section, while five women reported having a scheduled c-section. Two women reported using just Medicaid, three women reported a combination of Medicaid and private insurance at the time of their birth, and six women reported using private/employee program insurance. The demographic data is displayed below.

Table 1

Variable	Overall Sample N = 11
Age (%)	
18 to 25	1 (9.09)
26 to 35	5 (45.5)
36 to 45	5 (45.5)
Type of C-Section (%)	
Non-emergency C-Section	6 (54.5)
Emergency C-Section	5 (45.5)
Pregnancy Risk Type (%)	
Non High-Risk Pregnancy	6 (54.5)
High-Risk Pregnancy	5 (45.5)
Highest Level of Education (%)	
High School	
Some College	
Graduated College	
Some Graduate School	3 (27.3)
Graduate Degree	6 (54.5)
Unknown	2 (18.2)
Type of Insurance (%)	
Private/ Employer Insurance	6 (54.5)
Medicaid	2 (18.2)
Multiple Pregnancies- Both	3 (27.3)
Medicaid and Private Insurance	
Uninsured	

Key Findings

Data were analyzed using thematic analysis. Three main themes emerged: (1) the need for medical staff to improve communication with Black women, (2) changes needed to improve the healthcare system and childbirth process for Black women, and (3) the need for Black mothers to self-advocate and identify an advocate during the childbirth process. Although each story was unique, the women in this study reported similar experiences such as not feeling seen or heard by their OBGYN's and other medical professionals, and not receiving enough education on the childbirth/ c-section process from their OBGYN's during the prenatal period.

Visual Framework Description

This visual depiction shows quotes from various participants that embodies the research project. The quotes provide an example for each of the three themes. The visual framework description is in Appendix C.

The Need for Medical Staff to Improve Communication with Black Women

Health Professionals Not Listening

Many women who were interviewed described not being heard or interacting with medical professionals who did not communicate effectively with them about the services they were receiving, as well as medical professionals who did not even simply provide an explanation of how things would go during their pregnancy or childbirth process. One participant mentioned that the hospital made decisions without her regarding her c-section and pregnancy. Ava is a 30year-old woman from Louisiana, and she had her son around age 19. She recalled that she did not receive a lot of pregnancy education, but her medical professionals did go over the possibility of having a c-section, although she planned on having a vaginal birth. She felt that she was not a

part of the conversation: “Um, and I kind of feel like, a lot of decisions were made amongst hospitals that which on their own, which, um, I don't know if that's like protocol, I don't know; it was my first delivery, my first ever C section.”

Not Explaining Medical Procedures/Poor Bedside Manner

Bedside manner can refer to the attitude and conduct that a physician has when they are interacting with a patient. One participant mentioned the fact that healthcare professionals did not have proper bedside manner, and that healthcare professionals would just enter the room and start administering a health service, instead of first introducing themselves and communicating what they would be doing. Leslie is a 37-year-old woman from Georgia. She had her daughter at age 35, and was considered a high-risk pregnancy because of her age. When describing her interactions with healthcare professionals, Leslie said:

> “And I felt like other than saying hi, like, you're just giving me a vaginal exam, like, hold up? I don't know you like, can you say, “Hey, we're going to do... you know... “I'm just going to...Can you lie back? I'm going to check you know, your dilation...”, something, like, I don't..., we really don't know each other, even as a doctor-patient, you know, relationships.”

Leslie also described the healthcare professionals’ lack of proper bedside manner. She said:

> “...but next thing I know, she broke my water, and I didn't know that's what she was doing...she said she was just checking to see, you know, the progress with dilation...that last time she came in, she mentioned “scraping membranes”, but she didn't say what that meant. And I didn't ask because the way she said it, I didn't know that that would then mean she's breaking my water. Yeah. So, keep in mind, I hadn't had much progress with

> dilation at this point. So, when she did that, then it's like, oh, I broke your water. And I'm like, I didn't know that. And I also didn't know the downsides of that because now I'm exposed and my daughter's exposed because the sac you know, has now it's gone. And so, every time she's checking me there's a bonus, you know, there's the risk for infection. And yeah, [daughter's name] has no protection either. And that also put me on a time clock to deliver."

In this statement, Leslie describes how she was completely unaware that the nurse was going to break her water, which increased the possibility of infection. She knew that with her water broken, it would put her on the clock to deliver. Being "on the clock to deliver" meant that with her water broken, she and her baby were more prone to infection, so she would need to either go into labor, or have a c-section to reduce the risk of infection. Leslie mentioned that she was unaware that there was a certain amount of time that women must deliver the child once their water is broke, to reduce the risk of infection; and I did not know that once your waters they break, where there's naturally or they manually break it, then you have to deliver within a certain window because obviously the, you know, the risk for the baby and infection."

Leslie was upset because she did not want to have a c-section at all. She mentioned that in hindsight, she also wished that she had asked more questions, since she was unfamiliar with certain medical terms such as "sweeping the membranes." Certain scenarios such as this may indicate that doctors, nurses, midwives, and other healthcare professionals could improve communication if they explained what they were doing before proceeding, and the need to make sure that they explain technical terms that women may not be familiar with.

Another participant, Denise, described a time when her nurse was trying to find her son's heart rate. She first mentioned how some of the nurses who worked in the evening differed from the ones who worked during the day. Denise said that she could feel where her son was (the baby was moving around), but the nurse was not listening and instead kept scanning her stomach in another direction:

> "I don't know if there's a sort of personality to work in the evening day, I don't know. But they were less candid about what was going on. So, when the nurse came in to install the Cervidil or whatever, to get me dilated, she kind of sort of explained. And then once she put the monitor on me, it flipped a few times and she had to come back in and readjust it. And I remember telling her one time, "He's right here." "He's right here." Because I knew where my son always rested, because that's, you know where their head is, is closer to where the heart is. So that's where they put the monitors, so I was telling her, "He's over here." and she kept searching with the monitor trying to find his heart rate. And that's a scary feeling for a mom in those moments when they're trying to find the baby's heart you know... and I'm telling her "Hey here." And then she finally moves in that direction and sure enough, to get the heart rate."

Denise's nurse finally found her son's heart rate, but she described how it was a scary feeling of thinking that his heart rate could not be found. Another participant, Cassie, described what she experienced after her second c-section. When asked about being treated differently by medical staff due to being a Black woman, Cassie said that because she had a Black OB, she did not really experience racism or bias:

> “Yeah, I never, I'll say that and maybe because I did have a Black OB, I never experienced any type of bias or racism, okay. Or maybe I wasn't just looking for it any way...I will say- because I'm not a really hard person to aggravate, honestly, I let a lot of stuff slide. So maybe that's it too. But there was only one. One nurse that really aggravated me the second time. And I don't know, I don't I don't I don't I don't think it was a race thing. I don't know if she just didn't want to be at work that day. But she was just she pushed me to the limit, like the "call the manager" limit. And I never, that's the first time I ever had to do that in my life.”

A week after her c-section, Cassie went back to the hospital because her incision was infected. Her nurse told her that she may or may not need to be “cut open” again to clean the infection out. Cassie was nervous and scared because she did not want to be cut open again. Her nurse told her that she would let her know if she would need to undergo another surgery, but hours passed, and Cassie still had not heard anything:

> “And I'm waiting for her to come back and tell me whether or not that will be the case. And, you know, hours go by, hours go by, so I ended up having to call her and ask her, if that would be the case. That was the first strike. And she was like, "Oh, no, no, no, no, we're just gonna, we're just gonna do the -incoherent- antibiotics for two days, and, you know, we'll see where we're at from there." I'm like, I'm up in here losing my mind thinking I'm [going to be] cut open again.”

Cassie was upset because she was nervous and afraid of the possibility of needing to undergo another surgery, and the nurse did not seem to care in the same way. One participant,

Heather, described the experience where she was not dilating, and was told that she may need a c-section. She explained how she was afraid of having a c-section, and she felt that her second OB was "appeasing" her by telling her she "would be fine" instead of insisting that she would definitely need a c-section. Her main OB was Black, and the second one she saw while the first was off the schedule was White:

> "So um, that's why I like I get how we die in labor, and delivery; I get how it happens. And I also understand how easy it is for it to happen. Because if you are, if... the hospitals [are] overwhelmed [and] the OB and the staffing are people pleasers, -and I'm not I'm not attacking her-because I understand, and I appreciate her being nice to me. But I also understand that I could have died."

Heather also said:

> "Like I didn't know because at the time, I was a lay person. After I went to medical school, I realized I almost died in there. Like the lady was being nice to me and almost let me pass. And my OB is a Black woman, and the woman who let me almost die is not. And she wasn't she wasn't trying to almost let me die. She was appeasing me, but I didn't I didn't understand like, I'm literally I don't even have my medicine. I just know I don't want a C section and she's letting me in her letting me like I literally could like is fragile and I could have just slipped away."

Heather described how one of her OB's almost let her pass because she was appeasing her, and was not as adamant about insisting that she needed a c-section. She was not completely sure that this was related to her race, but she did clarify that the OB who did insist that she needed a c-section was Black.

The Need to Improve the Healthcare System and Childbirth Process for Black Women

Another theme that emerged was the need to improve the healthcare system and childbirth process for Black women. Many women faced discrimination during the childbirth process, as well as feeling uninformed about the childbirth process as a whole.

Perceived Discrimination

Participants described negative communication experiences that were tied to discrimination, and one participant acknowledged that Black women often have negative birth outcomes because of the way healthcare staff treat them. For example, one participant, Summer, described how her physician spoke to her in a demeaning way, because she was young (age 25) and because she was Black. Summer is currently pursuing a law degree. She had her first child when she was 20 years old, and her second child when she was 24. She had her first child at a small rural hospital in her hometown, and her second child at a more established health care facility. During her first pregnancy, the hospital in her hometown only had two OBGYN options, a White man and a White woman. She mentioned that her provider, the white female physician had "terrible bedside manner" as a White woman. She mentioned that before she had her first child, she never really thought about the risks that pregnancy presents. Summer described how she was anxious because of her son's low weight, and her physician was not effectively addressing her concerns:

> "And I was terrified, because I knew it was more real for me, as far as losing my life, because I knew that Black women were [dying] left and right, because doctors were not, you know, performing the proper tests to catch issues early, and also ignoring the signs when there's a problem. And so, I'm just like, I don't trust her judgment. She is making it clear that she doesn't care about me and I could die."

Summer described how she was even more scared during her pregnancy because she was aware of the increased risks that Black women face, and she felt that her physician did not care about her wellbeing. She also mentioned that she was treated differently because of her race and

age: “I remember having to have a conversation with her nurses because they kept talking to me in what I felt was a demeaning way, you know, call me sweetie this and, "ma'am" to the white patients.” Summer mentioned that she went as far as to talk to hospital administration training about cultural competency, but the doctors were not even aware of what that was.

Participants also described how they wished they were more informed on the childbirth and c-section process. One participant, Cassie described how she felt that she was ignorant to the risks that Black women faced, and the childbirth options that she had. She is 31, lives in Louisiana, and had her first c-section in 2010. Cassie said: “I was very ignorant to the risk, to the bias of Black women, and just to the options of delivery and labor and different. You know, I just wish I was more privy to the options I had.” She also stated, “Yeah, I just feel like education up on your actions is so important. I look back, I was so ignorant.” Other participants mentioned that if they did receive any education on childbirth, most of it was geared towards vaginal delivery. One participant, Hillary, described how much of the childbirth education was geared towards vaginal birth and not c-sections. Hillary is 31 and works as a social worker. Hillary said, “So I felt like it was kind of a lack of that part not knowing, like the recovery part of a section because everything was kind of geared towards vaginal [delivery].”

Making the Childbirth Process Easier for Black Women

Participants also had recommendations for what healthcare professionals can do to make the childbirth process easier for birthing Black women. Participants mentioned a desire for more accessible office visits (longer hours, etc.), more thorough appointments, the need to perform certain tests, and more classes and education on c-sections. Participants mentioned the desire for OBGYN offices to stay open earlier, so more women would have access. “So, I think education is a big part, but also umm. Like Georgia is, if you don't have a car, you're just out of luck. And I

feel like besides education, going back to access like, we are, there needs to be like OBGYN who are open late."

The Need for Black Mothers to Self-Advocate or Identify an Advocate

One of the main themes that emerged from this research was the need for Black women to self-advocate during the childbirth process. Participants emphasized the importance of asking questions, trusting their judgment, and preparing a "team" of support before giving birth.

One participant, Faith, had two children: one in South Africa, and the other in the United States. She described how the childbirth process was vastly different. She is currently living in Georgia and works as the executive director for a major organization. She mentioned that her husband is a physician, and her father is as well. Faith described how important it was to ask questions and find another doctor if women did not feel like they were being heard by their health care professionals. She also described how important it was to ask questions and speak up if a woman felt uncomfortable, or if anything being explained was unclear. Lastly, she mentioned how important it was to research doctors beforehand.

Faith said:

> "Ask, ask, ask if you feel like you are not being seen or heard, or that your concerns are not being validated or responded to, go to somebody else. I would say, you know...try to find, you know, a Black care team if you possibly can, as a way of hoping, like as a way of potentially, like reducing some level of bias, but ask questions. Review, kind of do your own research and when I say that, by reputable sites. To understand- it's more not to kind of determine your care, but rather to understand the, you know, what the standard of care should be."

Faith also mentioned:

> "But all the while, I mean, I think that one of the things that helped me in general, was having the awareness of, you know, what I needed, and being able to ask myself for incoherent- questions. And just kind of like staying curious about the care that I was being offered. So that, you know, I just didn't assume that whatever was happening was the right way. I asked questions, I, you know, probed and, made sure that the care that I was being given, made sense for me as well, as you know, medically."

One participant described how her doctor broke her water too soon because he failed to check how far she was dilated, and she ended up needing an emergency c-section. Instead of being apologetic, he was angry with the nurse because she had given him incorrect information beforehand. Celeste's partner later informed her of a conversation he overheard while walking into the exam room. Her partner overheard her physician on the phone telling someone that he had a golf tournament, but he had to finish up with a patient first. At first, her partner did not realize that the physician was speaking about her case, but, and her partner realized that the physician may have viewed her c-section as something to simply check off his list, and not a priority. Celeste said:

> "He heard something like, "Oh, he's gonna basically have to go golfing. I was...I was impeding him ... it's weird, right? I was basically stopping him from a five o'clock appointment to go golfing with his friends. He heard the conversation when he was coming in. So that C section, like I said, was unnecessary."

Celeste also described how she later researched the doctor and found out that the uneasy feelings she had when interacting with the doctor matched the negative reviews she found online.

She also mentioned: “Um, it's okay to decline the service. If you feel uncomfortable with the doctor, like I said, I felt like I was.” She described how she got a bad feeling about the doctor when she first encountered him, and the conversation her partner overheard confirmed the negative feelings she had about him.

Participants in the research project also reiterated the importance of preparing a team to advocate during the childbirth process. One participant, Debra, is 41 and works as a policy analyst in Georgia. She has had three pregnancies (one of which was a miscarriage). She was flagged as high-risk because of her weight during her second birthing experience. Debra, said, “Yeah. But I would say also, being if you can't advocate for yourself, making sure that you have somebody to advocate for you for pain relief, number one.”

Participants mentioned being so “out of it” during their childbirth process, and how important it was to have other people there because they may have not been awake or completely aware of what was going on.

Another participant said, “...you know, you need someone there to kind of advocate for you. So that's another important thing, but I feel like sometimes, you know, we don't have...we don't have the resources, we're not listened to. So, we always get like the short end of the stick.” Cassie described how although she “should not have had a child at 19”, there should have been more resources available to her. She felt that she was ignorant to additional resources on the prenatal period or childbirth.

The women’s recommendations for the medical community included explaining the severity of childbirth complications, creating better access to OBGYN offices, and providing more education during the childbirth process. One participant mentioned how her physician told her that she would need a c-section because she had a small pelvis. Jackie is 32 years old and

lives in Virginia. She mentioned that she had a doula and really enjoyed it. She ended up needing a c-section because her baby was in distress:

> "And the end, I think that the doctor was like, oh, you know, you have a small pelvis. And I'm like, "How can we...Is there a way we can, you know, test for the things ahead of time or something like I don't know."

Jackie mentioned that towards the end of her pregnancy, around her 40-week mark, her doctor told her that she had a small pelvis. She felt that it would have been helpful to have some sort of testing beforehand. As a researcher, it seems that it may be beneficial for physicians to perform additional tests or conduct more research on how to deliver babies for women with small pelvises, since some White women may have a wider pelvis than Black women (Handa et al., 2008). Additionally, participants also had recommendations for what healthcare professionals can do to make the childbirth process easier for birthing Black women. Participants mentioned a desire for more accessible office visits (longer hours, etc.), more thorough appointments, the need to perform certain tests, and more classes and education on c-sections. Participants mentioned the desire for OBGYN offices to stay open earlier, so more women would have access. "So, I think education is a big part, but also umm. Like Georgia is, if you don't have a car, you're just out of luck. And I feel like besides education, going back to access like, we are, there needs to be like OBGYN who are open late."

Women described tips for childbirth in addition to recommendations for the medical community. One woman recommended setting up on the bottom floor of a house after giving birth, because it is difficult to walk upstairs after a c-section. Another woman recommended to prepare a team of people who can assist with the postpartum time period, because it is just as

difficult as the childbirth process. Further, participants recommended to have resources in order so women will have time to slow down and take care of their bodies and babies. One participant, Jackie described how in the U.S. people are pushed to work, and the parental leave policies are not ideal. Jackie said,

> "Have your resources as in order as you can to take the time you need to stop slow down, to do the best you can for your health and your baby's health...because that, you know, it's like I'm thinking about a future where Black women and children flourish. And we have to resist the system in some ways to do that. So, I just, you know, I'm grateful for not only what we can do individually, but also collectively, when I see organizations that are funding doulas, and midwives and night nurses. I'm just really excited for all that. I know it's so needed because it's such a special and tender time. Like we are bringing the future of society to bear we deserve all of that support and more."

Perceived Unnecessary C-Sections and the Role of Health Insurance Type

One other finding that emerged was the fact that some women believed that their c-section may have not been necessary and the fact that some women seemed to be underprepared for childbirth and the possibility of having a c-section. Ava described how she was told that she needed an emergency c-section because her son's heart rate dropped three times.

> "Now during, during my, like labor and delivery experience. I don't know, I kind of felt like.... (long pause-) I kind of felt like maybe I didn't need an emergency C section, because I honestly like I remember everything else so vividly. And I don't remember his heart rate dropping three times. And so, that always, I'm kind of always drawn back to

> that C section, because I'm like, Why did I actually need it like, and I always feel like it's because I have Medicaid."

It may be worth researching whether health insurance plays a role in quality of care and the likelihood of being recommended a c-section. Ava mentioned that she believed she was given a c-section because she was on Medicaid, and in addition, Celeste, the woman who found out that her doctor was known for performing c-sections was on Medicaid, which may or may not have made it more likely that she received a c-section. Contrarily, one participant who had private insurance mentioned that she found it strange when doctors were performing what seemed like unnecessary tests. She believed it was because the doctors knew she had private insurance that would cover the tests.

> "It's really hard to say no, because what I did start to wonder is, "Did they do all these extra ultrasounds and other stuff because they knew I had really good insurance that would cover it? Because they know what's a good plan and not a good plan. And so, I didn't necessarily attribute it to my race I attributed to just like insurance."

When asked if she felt that she was treated differently by medical professionals because of her race, Leslie mentioned that she could not say for sure, and it was a bit hard to gauge. She had a mix of both White and Black medical professionals who were tending to her. She mentioned that one of the doctors that she saw, was a White male that she did not care for. However, she only saw him briefly, so she could not get an accurate read on him. Leslie also mentioned that she had primarily White nurses, and while some of them had good bedside

manner, but she had better interactions with Black nurses. She felt that the White nurses gave her a “speech” about medications:

> “Yeah, like the Black nurses.... I'm not like trying to get high off medicine or just trying to, you know, take it haphazardly, but the black nurses seemed to be more accommodating versus I know, some of the white nurses. They gave me a speech. And I'm like, I'm not asking for it before it's time. So if I'm not asking for it before, it's time, why is.. why the speech? Like I'm within the, I don't know, if it was every four hours or six hours. I could see if I was asking for two hours later. But yes, they were giving me speeches, and I'm like, What's this about? So but that's, yeah, that that it's, it's hard to really say, and it wasn't anything that was very apparent. I'll say that.”

Summer also mentioned an instance where she felt that medical professionals were questioning her about her pain tolerance and asking for medications: “And so that was kind of my experience- just a lack of cultural competence from everybody on the staff, you know, people asking questions about my pain tolerance like "girl I do not want this medicine for nothing other than pain; believe me."

When asked about pre-childbirth norms, many women described not even considering the fact that they may need to have a c-section. They also mentioned not receiving prior education on c-sections. This may indicate that more education on c-sections is needed during the prenatal period.

Summary of Findings

Three key themes related to Black women's experiences after having a c-section emerged from the data. The three themes were: (1) the need for medical staff to improve communication with Black women, (2) changes needed to improve the healthcare system and childbirth process for Black women, and (3) the need for black mothers to self-advocate/ identify an advocate during the childbirth process. The first theme discussed issues with communication among Black women and their medical professionals. The second theme discussed changes that are needed to improve the overall childbirth process for Black women, such as more childbirth education and explanations in general. The third theme focused on the Black women's recommendations surrounding advocacy for Black women who would be pregnant in the future. Overall, the women who were interviewed each had unique experiences with some overlap.

Chapter 5: Discussion

Public Health Implications, Recommendations, and Conclusions

Introduction and Summary of Study

The aims of this study are to find out the attitudes and experiences on c-sections of Black women in the Southeast who have had a c-section within the past 15 years. Through in-depth qualitative interviews, Black women shared their experiences with having a c-section, what they wish they had known before giving birth, and provided recommendations to healthcare professionals on how to improve birthing and c-section experiences for Black women. Through interviews, this study aimed to fill the gap in research in relation to qualitative studies on c-section rates, specifically among Black women. The intended purpose is to inform healthcare professionals in the Southeast of how to better serve Black women, and hopefully reduce the high rate at which Black women undergo c-sections. Additionally, research from this study can be used to improve the quality of care that Black women receive while in the prenatal, pregnancy, and postpartum stages of care.

Discussion of Key Results

The results from this study includes three main themes: (1) the need for medical staff to improve communication with black women, (2) changes needed to improve the healthcare system and childbirth process for black women, and (3) the need for Black mothers to self advocate/ identify an advocate during the childbirth process. These themes highlight the experiences Black women had during the childbirth and c-section process, as well as changes needed in the medical system, and recommendations that Black women mentioned.

The first theme, The Need for Medical Staff to Improve Communication with Black women, highlights changes needed to make the childbirth process more efficient for Black women. The theme highlights how Black women often felt ignored or unaware of the services medical professionals were providing while they were receiving medical care. Participant quotes are centered on not being fully aware of services they were receiving, not receiving enough education on the possibility of having a c-section, and being spoken to differently than White women. The literature shows that Black women undergo c-sections at disproportionate rates and often have less access to quality healthcare (Howell, 2018). All the women in the study expressed some sort of dissatisfaction regarding the care they received. Feelings of limited choices are often a factor in Black women's birthing experiences. One of the women from a small town only had access to two white physicians in her area, and she felt that the service that she received from them was poor. Additionally, the hospitals where Black women give birth are often of lower quality (Howell, 2016), and often have a history of higher life-threatening complications (Howell, 2016). In 2020, the national c-section average was 31.8% (National Vital Statistics Reports, 2020), while the 2020 Georgia c-section rate was 33.9% (National Center for Health Statistics, 2022). According to the Georgia Birth Advocacy Coalition, the 2019 Northside Hospital c-section rate is 40% (Georgia Birth Advocacy Coalition, 2019). Four of the eleven women in the study gave birth at Northside Hospital. Of those four, three had an emergency c-section. Two of the three women that had an emergency c-section had Medicaid. Two of the women had Kaiser Insurance, and one had Anthem/Blue Cross Blue Shield. A Boston University study found that insurance type plays a factor in how mothers are treated during their childbirth process, and the degree to which they can make decisions (Samuels, 2020). Additionally, the

Listening to Mothers in California found that after adjusting for demographic and health factors, mothers on Medicaid were three times less likely to feel that they had a choice in whether they had a vaginal birth or a cesarean (Samuels, 2020). One patient who had an emergency c-section and was on Medicaid actually stated, “I didn’t feel like I had a choice.” According to current research and data from interviews, Black women, especially those on Medicaid, may have less of a say in their healthcare experiences. This is a topic that will need to be researched further to determine a final conclusion.

The second theme found was changes needed to improve the healthcare system and childbirth process for black women. Looking back, many of the women were able to name what they wish had been different at the time of their c-section experience. Several participants mentioned that they did not receive much childbirth education, and if they did, it was mostly related to vaginal births and not the possibility of a cesarean birth. A lack of education and general feeling of not knowing what to expect during childbirth were common sentiments among the women in the study. Current research shows that in addition to being more prone to having c-sections, women of low socioeconomic status are less likely to participate in prenatal education (Howell, 2016). Additionally, a study in the American Journal of Obstetrics and Gynecology found that women who attended childbirth education (CBE) classes or had a birth plan had a greater chance of giving birth vaginally (Afshar et al., 2016). Another study that assessed the impact CBE had on birth outcomes found that less labor interventions were used in women who took a childbirth education class (Mueller et al., 2015). More research is needed to determine a conclusive outcome, but it may be that women who have access to CBE and are aware of birth

plans are more likely to be aware of birthing outcomes and what to expect during the childbirth process.

The third theme was the need for Black mothers to self-advocate or identify an advocate during the childbirth process. The mothers in the study described the importance of both self advocacy and creating a team of advocates for themselves during and after the childbirth process. The women mentioned the importance of advocating for oneself, "developing a team" of people to advocate during the childbirth process, and the importance of asking medical professionals if anything was unclear, even if it felt uncomfortable. One mom explicitly advised Black women to find a Black OBGYN. There were numerous instances found in firsthand accounts in articles and magazines/ blogs that supported the things that women mentioned. In a medically reviewed article online, a Black woman shared six things that she wished she had known about advocating for herself as a Black mom. She mentioned getting comfortable explaining how she felt, prioritizing relationship-building, talking to other doctors if necessary, asking as many questions as possible, educating herself, and planning for labor and support (Pierre, 2020). This was similar to what many women in the study mentioned. Glamour Magazine created a Black Maternal Health series where they shared various stories from Black women on the maternal mortality crisis. LaKisha Perkins shared her story in the Glamour article. She mentioned that her doctor kept missing things, and she felt that the information he was giving her about potential risks was insufficient. She ended up switching to a Black doctor that she felt more comfortable with

(Bahadur, 2021). Some of Lakisha's advice included planning as much as one can, researching the health provider, and speaking up if something does not feel right. Participants in the c-section

study mentioned all these points as well. Additionally, LaKisha mentioned the importance of gathering a solid personal and family health history.

Public Health Implications

This study aims to fill the gap of research of qualitative interviews with Black women who have undergone c-sections. There is research centered on the high c-section rates among Black women, but there is limited research on qualitative interviews on Black women's experiences. With the disproportional rates of Black women's c-section rates, as well as Black maternal morbidity and mortality, research is needed in order to improve outcomes. Results of this study can be used to understand Black women's experiences to improve them. This study could lead to better interventions and policies in hospitals and clinics, to improve outcomes for Black women. Health care professionals could use the study results to improve their communication with Black women during their childbirth process.

This research study has several public health implications that can be linked to the Social Ecological Model. The Social Ecological Model (SEM) can be used to depict the way relationships are connected between individual, relationship, community, and societal factors (CDC, 2022).

Individual-Birthing Black Women

This public health research has implications for individuals because women who become pregnant and may need a c-section in the future may use the advice from women in the study to inform how they take care of themselves before and after childbirth. Current qualitative research shows that Black women give birth in low-performing hospitals and often have poor interactions

with medical professionals, and have issues with obtaining adequate pre and postpartum care (Howell & Zeitline, 2017). These issues were echoed by women in the c-section study, as many of them discussed poor interactions with health providers. This level also exemplifies how it is essential for Black women to speak up for themselves. The Chicago Birthworks Collective describes birth equity as "the assurance of the conditions of optimal births for all people, with a willingness to address racial and social inequalities in a sustained effort" (Chicago Birth Works Collective, 2021). The Chicago Birthworks Collective suggests that Black women be clear about their expectations, have a plan, and educate themselves so that they can be informed enough to know whether their doctors are telling them the whole truth (Chicago Birthworks Collective, 2021).

Relationship/Interpersonal- Advocates and Birthing Support People

This research study has implications for women's relationships with their families and other women. Women who become pregnant may share their knowledge of c-sections and their recommendations with other women, which may lead to improved health outcomes. Black women's partners, doulas, or advocates may serve as interpersonal support during and after the birthing process. The Commonwealth Fund is a private foundation that supports independent research on health issues and creates grants to support healthcare. The Commonwealth Fund describes how community-based doulas can serve as patient advocates to Black women by serving as patient advocates and providing comfort and coaching (The Commonwealth Fund, 2021). Additionally, research suggests that doulas are especially helpful for women of color, women who have low income, and other marginalized communities (The Commonwealth Fund, 2021). Additionally in reducing maternal morbidity and mortality, current research shows that

doula support reduces the c-section rate. One study compared c-section rates between a doula-supported program vs a Medicaid program. After comparing for clinical and demographic factors, the odds of having a c-section were 40.9% lower for doula-supported births (Kozhimannil et al., 2013). A randomized control trial found that trained doulas helped to reduce the need for medical interventions among low-risk who were delivering at term (Fortier, 2015).

Community & Institutional- Medical Professionals

The results of this research study may also have a positive impact on the medical community. Results from the study and feedback from women can inform medical professionals on better ways to interact with the Black women that they serve. Additionally, one of the recommendations for this expand access to trustworthy medical providers. The National Partnership for Women and Families describes how critical it is for policymakers to maintain policies that improve healthcare outcomes for Black women, since their maternal mortality rates are three to four times higher than those of White women (National Partnership for Women and Families, 2018). Maintenance of policies can lead to better communication between Black women and hospital staff, and improved protocol for information-sharing, as well as a more informed basis on how to disseminate childbirth education classes on maternal outcomes and c-sections. A New York Times article that created a guide for medical providers and Black mothers suggested that medical providers should overcompensate for the fact that the medical system treats Black women poorly, and pay particular attention to the Black mothers they serve during the prenatal and laboring period (Chidi and Cahill, 2020). They also suggested talking to patients about why c-sections are performed.

Societal- Society and Policies

Finally, society may benefit from the results in this study. Structural racism is defined as "as a system where public policies, institutional practices, and cultural representations work to reinforce and perpetuate racial inequity" (Taylor et al., 2019). In the United States, Black people, and Black women especially, face greater health disparities because of racism. One of the main ways to improve health disparities among Black women is to improve the quality of care they receive. This can be done by building a more diverse workforce (Taylor et al., 2019). The Black women who have undergone c-sections had the ability to share their experiences while pregnant and during their childbirth experience. Their experiences and recommendations can serve as the starting point for much-needed policy changes. These policy changes can be related to policies on cultural competency training, and further inform medical professionals on how to better communicate and serve women. Additionally, better policies will decrease the c-section rate and lead to better health outcomes. Historically, because of racism, Black people have not had the same access to achieve academic success as other groups have, which means that they do not attend medical school as much as other races. Since Black families typically have about ten percent of a White family's net worth, and a Black student having the opportunity to attend medical school is often unattainable (Brownlee, 2020). Research shows that when Black women see providers of the same cultural background, they have better health outcomes (Taylor, 2020). Many women in the c-section study mentioned that they would advise pregnant women to seek out a Black OBGYN and/or Black care team. It is important for medical schools to recruit more Black students and make the process of attaining a medical degree in the United States more attainable.

Future Directions

Although this c-section study captured the unique experiences of various women, there are many stories that still need to be told. The women in this study were highly-educated, and many were well-informed on the disparities that Black women face. However, there are women from other socioeconomic and cultural backgrounds who may have different stories, but similar experiences. There are currently not many research studies that focus specifically on qualitative interviews with Black women who have undergone a c-section. Future studies could focus on qualitative research pertaining to experiences of Black women from all backgrounds. It may be helpful to also analyze factors that this c-section study did not, such as health history, physician reputation, and hospital policies or reimbursement.

In addition to using the socioecological model, the researcher used Critical Race Theory, or CRT, to explore future directions that CRT can be used in public health. The main way is the use of the Public Health Critical Race Praxis (PHCRP). The PHCRP is an empirical approach that is grounded in Critical Race Theory, and designed for public health studies (Ford, 2016). PHCRP can be used in four main phases. The first phase is Contemporary Patterns of Racial Relations, where researchers can explore how racism has changed over time and clarify how that is relevant to their current study (Ford, 2016). Phase 2 is the Knowledge Production Phase, where the researcher tries to understand the health disparities being examined (Ford, 2016). During this phase, the researcher analyzes the literature related to c-sections and researched relevant studies on Black maternal mortality, c-section rates, and related qualitative research studies. During Phase 3, which is Conceptualization and Measurement, the researcher develops constructs to measure the study constructs and health outcomes. This is done to reflect social or

political racial differences, but not biological differences, while keeping in mind power differentials between researchers and communities (Ford, 2016). Essentially, this means that the researcher will develop a way to analyze and publish the results of the study, and keep in mind racial equity issues and power dynamics between the community and the researcher, instead of the biological differences. The PI in a future study may choose to complete phase 3 by analyzing data on women's experiences with c-sections by incorporating racial, demographic, and political factors such as race, income level, perceived discrimination, and others. However, the researcher should exclude biological factors such as the fact that Black women are often told that they have a small pelvis and may be more likely to need a c-section (Handa et al., 2008), or because of other pre-existing conditions such as obesity and high blood pressure. Phase 4 is the "Action" phase. This may include the researcher sharing the knowledge gained from the study with individuals and communities who are currently working to change the social landscape, as well as "racialized power differentials" that contribute to health disparities (Ford, 2016). For example, the PI may choose to share the results with the women who were interviewed, as well as other Black women in the general community, and the general public health academic space. Additionally, the PI may share the study results more widely by publishing in a peer-reviewed public health journal, so that results will be shared widely to people who are committed to reducing health disparities among Black women.

Strengths and Limitations

One of the strengths of this study is that the researcher was able to capture the unique story of each women interviewed. Although the women had many similar experiences, each story was unique and presented in a way that captured individual experiences of each woman. Another

strength was the semi-structured nature of the interviews. This structure allowed the same base questions to be asked, but allowed room for women to introduce new topics. One final strength is that since all interviews were conducted either by phone or Zoom, more participants were able to take part in the study. The study included women all over the Southeast United States, and this would not have been possible if the study had taken place in-person. One limitation of the study is that the sample was relatively small. There were eleven women who were interviewed. Additionally, the sample was a convenience sample that was mostly derived from the Black Ladies in Public Health Facebook group, so the study does not equally represent all Black women in the Southeast United States. Also, since the sample mainly included women who were pursuing or who had a Master's or other advanced degree, so the sample did not include women from other socioeconomic or academic backgrounds. Another limitation is that the interviewer edited the interview guide during the interview process. Not all demographic information was captured for each participant, although the main questions remained the same.

Conclusions

Black women are often on the receiving end of poor-quality treatment from society and medical professionals. It is well-known that Black women have poor health outcomes such as higher c-section rates and higher maternal morbidity and mortality rates, not because of genetic factors, but because they are ignored and overlooked in the medical system. To improve these health outcomes, conducting research and hearing directly from Black women on their experiences and their recommendations on what needs to change is a key factor in improving these health outcomes. More research is needed to inform improved protocols and new policies.

References

Afshar, Y., Wang, E. T., Mei, J., Esakoff, T. F., Pisarka, M. D., & Gregory, K. D. (2016, November 15). Childbirth education class and ... - Wiley Online Library. Childbirth Education Class and Birth Plans Are Associated with a Vaginal Delivery. Retrieved April 20, 2022, from https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12263

Bahadur, N. (2020, August 14). How to advocate for yourself as a pregnant black woman. Black Maternal Health. Retrieved April 20, 2022, from https://www.glamour.com/story/how-toadvocate-for-yourself-as-a-pregnant-black-woman

Bai, G., & Anderson, G. F. (2016). A more detailed understanding of factors associated with hospital profitability. Health Affairs, 35(5), 889-897. https://doi.org/10.1377/hlthaff.2015.1193.

Brownlee, D. (2020, August 10). Why are black male doctors still so scarce in America? Forbes. Retrieved April 11, 2022, from https://www.forbes.com/sites/danabrownlee/2020/08/11/why-are-black-male-doctors-stillso-scarce-in-america/?sh=8a5747327c2e

Centers for Disease Control and Prevention. (2021, October 22). The social-ecological model: A framework for prevention |violence prevention|injury Center|CDC. Centers for Disease Control and Prevention. Retrieved January 4, 2022, from https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

Chicago Birthworks Collective. (2021, August 24). Birth equity for black families: Chicago birthworks collective. Chicago Birthworks Collective. Retrieved April 20, 2022, from https://www.chicagobirthworks.com/post/birth-equity

Chidi, E., & Cahill, E. P. (2020, October 22). Protecting your birth: A guide for black mothers. Protecting Your Birth: A Guide For Black Mothers. Retrieved April 20, 2022, from https://www.nytimes.com/article/black-mothers-birth.html

Clark, S. L., Perlin, J. B., Fraker, S., Bush, J., Meyers, J. A., Frye, D. R., & Garthwaite, T. L. (2014). Association of obstetric intervention with temporal patterns of childbirth. Obstetrics and gynecology, 124(5), 873–880. https://doi.org/10.1097/AOG.0000000000000485

Dahlem, C. H., Villarruel, A. M., & Ronis, D. L. (2015). African American women and prenatal care: perceptions of patient-provider interaction. Western journal of nursing research, 37(2), 217–235. https://doi.org/10.1177/0193945914533747

Edmonds, J. K., Yehezkel, R., Liao, X., & Moore Simas, T. A. (2013). Racial and ethnic differences in primary, unscheduled cesarean deliveries among low-risk primiparous women at an academic medical center: a retrospective cohort study. BMC pregnancy and childbirth, 13, 168. https://doi.org/10.1186/1471-2393-13-168

Ford, C. L. (2016). Public health critical race praxis: An ... - escholarship.org. Public Health Critical Race Praxis. Retrieved April 20, 2022, from https://escholarship.org/content/qt1kh2x0fn/qt1kh2x0fn_noSplash_e8d43603312e088f44341304057c0305.pdf?t=ooazv1

Galvin, G. (2019, September 25). U.S. News & World Report: The C-section capital of America. U.S. News. Retrieved September 25, 2020, from https://healthcostinstitute.org/in-thenews/u-s-news-world-report-the-c-section-capital-of-america

Georgia Birth Advocacy Coalition. (2019, January 9). Northside Hospital Labor and Delivery Review. Georgia Birth Advocacy Coalition. Retrieved April 20, 2022, from https://georgiabirth.org/hospital-reviews-1/2019/1/8/northside-hospital-labor-and-deliveryreview

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. American journal of public health, 105(12), e60–e76. https://doi.org/10.2105/AJPH.2015.302903

Handa, V. L., Lockhart, M. E., Fielding, J. R., Bradley, C. S., Brubaker, L., Cundiff, G. W., Ye, W., Richter, H. E., & Pelvic Floor Disorders Network (2008). Racial differences in pelvic anatomy by magnetic resonance imaging. Obstetrics and gynecology, 111(4), 914–920. https://doi.org/10.1097/AOG.0b013e318169ce03

Harkonen, U. (2007, October 17). The Bronfenbrenner ecological system theory of human development. Scientific Articles of V International Conference PERSON.COLOR.NATURE.MUSIC, Daugavpils University, Latvia, 1 – 17.

Hess, J. (2021, July 13). Why do black women in the US HAVE MORE C-sections than white women? Why do Black women in the US have more C-sections than white women?

Retrieved December 2, 2021, from https://www.opendemocracy.net/en/why-do-blackwomen-us-have-more-c-sections-white-women/.

Holmes, L., Jr, O'Neill, L., Elmi, H., Chinacherem, C., Comeaux, C., Pelaez, L., Dabney, K. W., Akinola, O., & Enwere, M. (2020). Implication of Vaginal and Cesarean Section Delivery Method in Black-White Differentials in Infant Mortality in the United States: Linked Birth/Infant Death Records, 2007-2016. International journal of environmental research and public health, 17(9), 3146. https://doi.org/10.3390/ijerph17093146.

Howell E. A. (2018). Reducing Disparities in Severe Maternal Morbidity and Mortality. Clinical obstetrics and gynecology, 61(2), 387–399. https://doi.org/10.1097/GRF.0000000000000349

Howell, E. A., Egorova, N. N., Balbierz, A., Zeitlin, J., & Hebert, P. L. (2016). Site of delivery contribution to black-white severe maternal morbidity disparity. American journal of obstetrics and gynecology, 215(2), 143–152. https://doi.org/10.1016/j.ajog.2016.05.007

IOM (Institute of Medicine) and NRC (National Research Council). 2013. An update on research issues in the assessment of birth settings: Workshop summary. Washington, DC: The National Academies Press.

Kozhimannil, K. B., Graves, A. J., Ecklund, A. M., Shah, N., Aggarwal, R., & Snowden, J. M. (2018). Cesarean Delivery Rates and Costs of Childbirth in a State Medicaid Program After Implementation of a Blended Payment Policy. Medical care, 56(8), 658–664. https://doi.org/10.1097/MLR.0000000000000937

Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the Cost-Effectiveness of Doula Care Associated

with Reductions in Preterm Birth and Cesarean Delivery. Birth (Berkeley, Calif.), 43(1), 20–27. https://doi.org/10.1111/birt.12218

Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C., & O'Brien, M. (2013). Doula care, birth outcomes, and costs among Medicaid beneficiaries. American journal of public health, 103(4), e113–e121. https://doi.org/10.2105/AJPH.2012.301201

Kritz, F. (2018, October 10). Doctors often fail to listen to black mothers, complicating births, survey finds. California Health Report. Retrieved April 2, 2022, from https://www.calhealthreport.org/2018/09/20/doctors-often-fail-listen-black-motherscomplicating-births-survey-finds/

Martin, J. A., Martin, B. E., Osterman, M. J. K., & Driscoll, A. K. (2019). National Vital Statistics Reports. Retrieved September 25, 2020, from https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf

Melnick, M. (2010, September 13). Survey: Cesarean sections are more likely at for-profit hospitals. Survey: Cesarean Sections Are More Likely at For-Profit Hospitals. Retrieved September 25, 2020, from https://healthland.time.com/2010/09/13/survey-c-sections-aremore-likely-at-for-profit-hospitals/

Menacker, F., & Hamilton, B. E. (2010). Recent trends in cesarean delivery in the United States. NCHS data brief, (35), 1–8.

Mueller, C. G., Webb, P. J., & Morgan, S. (2020). The Effects of Childbirth Education on Maternity Outcomes and Maternal Satisfaction. The Journal of perinatal education, 29(1), 16–22. https://doi.org/10.1891/1058-1243.29.1.16

National Center for Health Statistics, final natality data. Retrieved April 2, 2022, from www.marchofdimes.org/peristats.

National Center for Health Statistics. (2020, May). Vital Statistics Rapid Release. Retrieved October 8, 2020, from https://www.cdc.gov/nchs/data/vsrr/vsrr-8-508.pdf

National Partnership for Women and Families. (2018). Black women's maternal health. Black Women's Maternal Health: Retrieved April 20, 2022, from https://www.nationalpartnership.org/our-work/health/reports/black-womens-maternalhealth.html

Office of Minority Health and Health Equity (CDC). (2021, April 9). Working Together to reduce Black Maternal Mortality. Centers for Disease Control and Prevention. Retrieved January 4, 2022, from https://www.cdc.gov/healthequity/features/maternalmortality/index.html

Oster, E., & McClelland, S. (2019, October 17). Why the C-section rate is so high. The Atlantic. Retrieved December 2, 2021, from https://www.theatlantic.com/ideas/archive/2019/10/csection-rate-high/600172/.

Osterman, M. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., & Valenzuela, C. P. (2022, February 7). National Vital Statistics Reports - cdc.gov. National Vital Statistics Reports:Births: Final Data for 2020. Retrieved April 20, 2022, from https://www.cdc.gov/nchs/data/nvsr/nvsr70/NVSR70-17.pdf

Petersen, E. E., Davis, N. L., Goodman, D., Cox, S., Syverson, C., Seed, K., Shapiro-Mendoza, C., Callaghan, W. M., & Barfield, W. (2019). Racial/Ethnic Disparities in Pregnancy-Related Deaths - United States, 2007-2016. MMWR. Morbidity and mortality weekly report, 68(35), 762–765. https://doi.org/10.15585/mmwr.mm6835a3

Pierre, R. (2020, October 28). 6 things I wish I knew when advocating for myself as a black mom-to-be. Healthline. Retrieved April 20, 2022, from https://www.healthline.com/health/parenting/6-things-i-wish-i-knew-when-advocating-formyself-as-a-black-mom-to-be

Samuels, M. (2020, July 27). Medicaid-covered mothers have less say in birthing experience. Medicaid-Covered Mothers Have Less Say in Birthing Experience. Retrieved April 20, 2022, from https://www.bu.edu/sph/news/articles/2020/medicaid-covered-mothers-haveless-say-in-birthing-experience/

Snowden, J. M., Osmundson, S. S., Kaufman, M., Blauer Peterson, C., & Kozhimannil, K. B. (2020). Cesarean birth and maternal morbidity among Black women and White women after implementation of a blended payment policy. Health services research, 55(5), 729–740. https://doi.org/10.1111/1475-6773.13319

Sun, L. H. (2021, October 26). These hospitals make the most money off patients - and they're mostly nonprofits. The Washington Post. Retrieved December 7, 2020, from https://www.washingtonpost.com/news/to-your-health/wp/2016/05/02/these-hospitalsmake-the-most-money-off-patients-and-theyre-mostly-nonprofits/

Taylor, J., Novoa, C., Hamm, K., & Phadke, S. (2021, December 3). Eliminating racial disparities in maternal and infant mortality. Eliminating Racial Disparities in Maternal and Infant Mortality:A Comprehensive Policy Blueprint. Retrieved April 20, 2022, from https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infantmortality/

Zephyrin, L., Seervai, S., Lewis, C., & Katon, jodie G. (2021, March 4). Community-based models to improve maternal health outcomes and promote health equity. CommunityBased

Models Improve Maternal Outcomes and Equity | Commonwealth Fund. Retrieved April 20, 2022, from https://www.commonwealthfund.org/publications/issuebriefs/2021/mar/community-models-improve-maternal-outcomes-equity

Appendices

Appendix A- Interview Guide

This qualitative study will explore the experiences and attitudes of Black women in the Southeast United States who have undergone a section within the past 15 years. The study will gain information on the women's experiences with hospital staff, attitudes towards hospital staff, experiences during childbirth, thoughts on why they were recommended to have a c-section, and overall experience with having a c-section. The study will also cover cultural norms and women's backgrounds. Participation in this study is completely voluntary, and you have the right to withdraw from the study at any time.

Thank you for agreeing to participate in this study. I'll be asking you a few questions about your childbirth and c-section experience. You will remain anonymous, and your information will remain confidential. Only I will have access to this recording, and the recording will be deleted after 1 year, after the study is complete.

I'll start off the interview with a few general questions to get some more background information.

1. What ethnicity do you identify as?
2. What is your age?
3. What sexual orientation do you identify as? (Heterosexual, homosexual, etc) 4. What is your highest level of education?
5. What is your marital status? (Single, married, etc)
6. What is your income/ income range? (25-50k, 50-100k, etc)
7. What is your occupation?
8. What state do you live in, and how long have you lived there?
9. What was your family like growing up?
10. What were your ideas on childbirth and pregnancy before you first became pregnant, and how have they changed?
    a. Possible probe: Is there anything that took you by surprise regarding pregnancy and childbirth?

Now we will discuss a little bit about your background

11. What was your family's views on childbirth, or some norms that you are familiar with?
    a. Possible probe: Are there any beliefs related to childbirth or pregnancy that your family or community have/had?
12. How many pregnancies have you had?

13. Did you have insurance for each of your pregnancies?

Now, I'd like to discuss a bit about your childbirth experience overall.

14. Were you considered a "high-risk" pregnancy for any of your pregnancies?
15. Tell me about your childbirth experience.
    a. Where did you have your first child (home birth, hospital, etc) 16. Tell me a bit about your experience with medical staff, doulas, etc?
    a. Possible probe: Did the medical/hospital staff make you feel comfortable?
17. What was the reason for your c-section?
18. Was your c-section considered an "emergency" c-section?
    a. Did you feel that it was actually an emergency?
19. Did the doctors or medical staff explain things to you?
    a. Possible probe: Childbirth education, c-section details, etc

We are nearing the close of this interview. I'd like to know about any tips you may have for people who are newly pregnant. (Black women who are

20. What are some things you wish you had known before giving birth via a c-section?
    a. Possible probe: Any tips for any new pregnant people?

Appendix B- Demographics Table

Table 1

Variable	Overall Sample N = 11
Age (%)	
18 to 25	1 (9.09)
26 to 35	5 (45.5)
36 to 45	5 (45.5)
Type of C-Section (%)	
Non-emergency C-Section	6 (54.5)
Emergency C-Section	5 (45.5)
Pregnancy Risk Type (%)	
Non High-Risk Pregnancy	6 (54.5)
High-Risk Pregnancy	5 (45.5)
Highest Level of Education (%)	
High School	
Some College	
Graduated College	
Some Graduate School	3 (27.3)
Graduate Degree	6 (54.5)
Unknown	2 (18.2)
Type of Insurance (%)	
Private/ Employer Insurance	6 (54.5)
Medicaid	2 (18.2)
Multiple Pregnancies- Both	3 (27.3)
Medicaid and Private Insurance	
Uninsured	

Appendix C- Visual Framework of Key Themes

Figure 2

This visual depiction displays some quotes that exemplify the themes that emerged from the research.