ELEVATING VOICES FOR SELF-ADVOCACY: MAKING THE CASE FOR CHILDBIRTH AND ADVOCACY EDUCATION FOR BLACK PREGNANT WOMEN

By

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Abstract

Black women have the highest rate of maternal mortality in the United States. Racism, access to health care, lack of quality health care providers, and lack of childbirth and advocacy education are contributors to maternal mortality. Systemic and interpersonal racism significantly impact health experiences of pregnant women. Lack of access to health care and lack of quality health care providers can prevent pregnant women from receiving adequate care and keep their health concerns from being taken seriously. Childbirth education can prepare pregnant women for birth; and advocacy education can help patients understand their rights and how to collaborate in their care, especially for high-risk populations such as pregnant women. Because Dallas has a high maternal mortality rate, this study explores the experiences and impact for Black pregnant women after attending a childbirth and advocacy education course. The findings indicate that when Black pregnant women know their rights, confidence to advocate for birth is increased, and support teams can help ensure rights are respected in birth.

Keywords: maternal mortality, racism, self-advocacy, childbirth education

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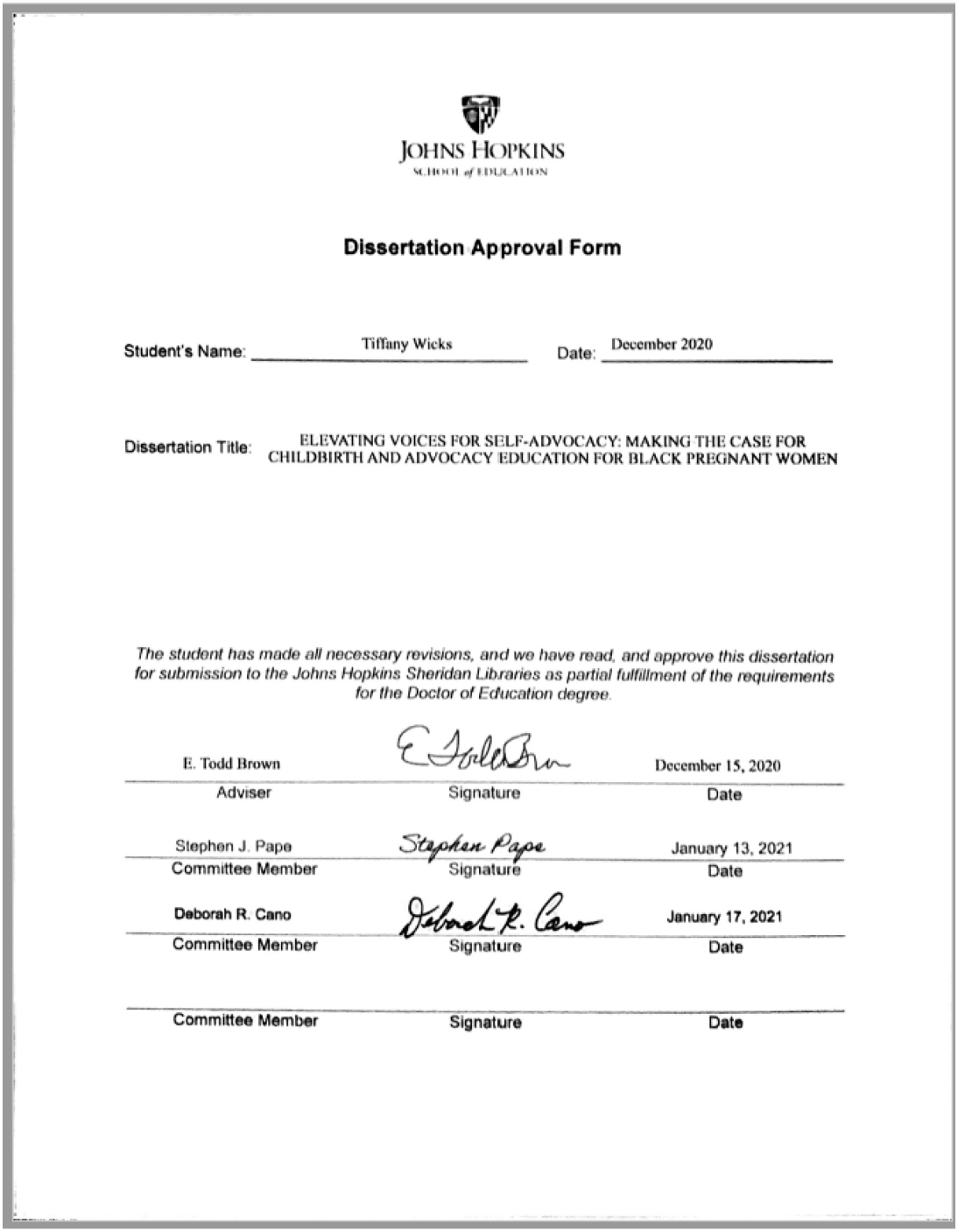

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The student has made all necessary revisions, and we have read, and approve this dissertation for submission to the Johns Hopkins Sheridan Libraries as partial fulfillment of the requirements for the Doctor of Education degree.

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Dedication

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To the women in this study and to Black mothers everywhere, may your voices always be heard, validated, and believed.

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Executive Summary

Research from the World Health Organization on maternal mortality in the United States notes that over 50% of maternal deaths are preventable (Agrawal, 2015). There are approximately 1,200 maternal related deaths in the United States each year and at least 60,000 serious complications due to childbirth. Black women are three to four times more likely to die in childbirth than White women (Center for Disease Control, 2017). Black women report less satisfactory experiences in their birth from their health care providers due to racism, quality of prenatal care, and implicit bias from their health care provider than any other race (Facione & Facione, 2007).

The obstacles discussed in the research that contribute to the high maternal mortality rates of Black women include a lack of education and advocacy (Ferguson, Davis, & Browne, 2013; Brashers, Haas, & Neidig, 1999). Research suggests there is a significant impact on improved birth outcomes after pregnant women attend childbirth education (Ferguson et al., 2013). Additionally, when patients feel confident in their ability to self-advocate with their provider, there is a significant increase of participation in health care decisions and assertiveness in their care (Brashers, Haas, Klingle, & Neidig, 2000). In the work that follows, the evaluation of a childbirth and advocacy education course was explored.

Problem Statement

Maternal mortality in the United States affects Black women more than any other ethnicity (Center for Disease Control, 2017). The average number of maternal deaths per 100,000 births across all races and ethnicities is 23.8; the average number of maternal deaths per year for Black women is 40.0, compared to 12.3 for White women and 17.6 for women of other races (Roeder, 2019). There are four prominent factors among many that contribute to maternal

mortality: (a) systemic racism, (b) access to health care, (c) quality health care providers, and (d) lack of childbirth and advocacy education (Ronsmans, Graham, & Lancet Maternal, 2006).

In the area of Fair Park, located in south Dallas,Texas, pregnant women face multiple obstacles that can hinder prenatal care and impact childbirth such as difficulties accessing health insurance, quality providers, and lack of transportation (City of Dallas, 2018), which may lead to difficulty accessing childbirth and advocacy education. Due to these barriers, there is a need to address the challenge of maternal mortality for Black pregnant women in South Dallas.

Statement of Purpose

In this study, childbirth and advocacy education were delivered to Black pregnant women in the Dallas area. The purpose of the study was to evaluate the experiences of participants in the education sessions and how they utilized the childbirth information provided to advocate for themselves during the birth of their child. The purpose of the intervention was to educate Black pregnant women in Dallas about childbirth and their patient rights to encourage self-advocacy during birth.

Research Questions

The research questions addressed in this study are as follows.

1. How do Black pregnant women in Dallas experience the childbirth and advocacy education course?
2. How do Black pregnant women in Dallas perceive their ability to self-advocate, if at all, during delivery after they attend a childbirth education class?
3. To what do Black women who self-advocated attribute how and why they advocated?
4. To what extent did the childbirth and advocacy education program contribute to their ability to advocate for themselves during childbirth?

Overview of the Methodology

The purpose of the study was to explore the outcomes of a childbirth and advocacy education course on pregnant women's ability to self-advocate. The education courses served as an intervention to inform women about their patient rights and how to advocate for themselves during birth. The study used qualitative methods through a descriptive single case study with embedded units. In this study, childbirth and advocacy education was delivered to participants that met the criteria as pregnant Black women. The qualitative data were collected in focus group and postpartum interviews with the participants after the education.

Abide Women's Health Services provided the venue for the study to host the childbirth and advocacy education course that aligns with their mission of serving pregnant women in South Dallas. The childbirth education course was created and delivered by childbirth educator Althea Hurd. I designed the advocacy session of the course and served in the role of researcher as insider participant. After the delivery of the course, participants were asked to volunteer to engage in a focus group and offered the opportunity to be interviewed after they gave birth. Data collected from the education and advocacy course was in the form of focus groups, field notes, and qualitative interviews. The study data was analyzed using a thematic analysis coding process. The expectation of the study was that the childbirth and advocacy education course would positively influence the birth experiences of pregnant women in South Dallas to advocate for themselves during their hospital birth.

Rationale and Significance

Researchers discuss the importance of training health care professionals to be culturally sensitive toward patients. Additionally, it is important to educate pregnant women about all the aspects of childbirth to prepare them emotionally and physically (Ferguson et al., 2013).

For the purposes of this study, the focus was on childbirth education. Education during childbirth can lead to lower rates of emergency medical intervention, reduced rates of anesthesia, increased rates of confidence during birth, and lower rates of premature birth (Ferguson et al., 2013). In this dissertation study, childbirth along with advocacy education was delivered to participants to evaluate the effectiveness of the education course on each participant's birth.

Role of the Researcher

Labaree (2002) discussed advantages of being an insider-outsider in qualitative research. An insider is defined as a researcher who has a connection or multiple connections to the participants in the study. An outsider is defined is someone who cannot relate to the participants of the study and serves the role as an observer. An insider has the advantage of establishing trustworthiness with participants. Additionally, insiders are able to gain more clarity and insight during the study because of their existing knowledge. Larabee (2002) strongly suggests that the researcher be mindful of ethical obligations, honest with participants about the researcher's connection to the study, and the importance of maintaining professional distance with the participants in the study. Another important part of insider-outsider research is reflective practices during data collection and analysis. These practices include reflective journaling and multiple reviews of field notes that may aid in minimizing bias.

In the education and advocacy course study, the practitioner researcher is both an insider and outsider. She works as a mental health provider for pregnant and postpartum women and frequently works with Black women during and after the birth of their child. The practitioner researcher is also biracial with a Black mother and White father and has a personal connection to the issue of the maternal mortality of Black women. Additionally, at the time of the study the practitioner researcher was pregnant and planning to give birth in a hospital similar to the

participants of the study. However, the practitioner researcher is White-presenting (someone who looks White and also has dark skin) and has not experienced the level of systemic and interpersonal racism compared to Black women who have darker skin. This is a factor of outsiderness (Labaree, 2002). While the insiderness of the practitioner researcher potentially will benefit the study due to the intimate knowledge of the issue of both childbirth along with advocacy education for pregnant women, it is important for the researcher to be reflective in practices and remain unbiased through field notes and observations.

Findings

Several key factors emerged from the data collected in this study. The knowledge of patient rights increases confidence in giving birth and increases a Black pregnant woman's ability to self-advocate during birth. A support team is not only an important factor during birth, but the use of the support in helping affirm rights but they can also help express the wishes of the pregnant woman in labor when she is not able to verbalize them herself. The patient-provider relationship is a significant aspect of successful birth outcomes. When Black pregnant women are heard and consent is gained with each medical decision made, the pregnant patient feels empowered in shared decision making.

Chapter 1

Problem of Practice

Malcolm X once said, “the most disrespected person in America is the Black woman. The most unprotected person in America is the Black woman. The most neglected person in America is the Black woman” (Emba, 2020, p.1). Maternal mortality in the United States is an issue facing Black women more than any other ethnicity (Center for Disease Control, 2017). Although the average number of maternal deaths per 100,000 births is 23.8, the average number of maternal deaths per year for Black women is 40.0 as compared to 12.3 for White and 17.6 for women of other races (Harvard Public Health, 2019). Many factors contribute to maternal mortality, four prominent factors for Black women are (a) systemic racism; (b) access to health care; (c) quality health care providers; and (d) lack of reproductive and childbirth education (Ronsmans et al., 2006).

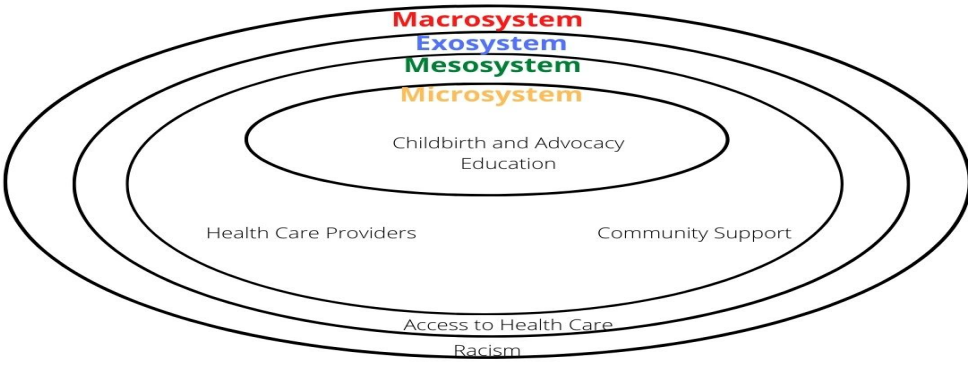
In Fair Park, located in South Dallas, Texas, pregnant women face multiple obstacles that can hinder prenatal care and impact childbirth. These obstacles include accessing health insurance and quality providers and a lack of transportation (City of Dallas, 2018). These barriers may lead to a difficulty in accessing childbirth and advocacy education. There is a need to evaluate possible interventions to address the issue of maternal mortality for Black pregnant women in South Dallas.

There are four consistent factors from the research that can impact maternal mortality. Foremost is the racial discrimination that women endure throughout their lifetime (Nuru-Jeter et al., 2009). Systemic racism, political and social systems designed to discriminate against people of color, significantly impact a Black woman’s experience during childbirth. The interpersonal experiences of racism may have a lasting affect and can create stress on an expectant mother.

Access to health care is another important factor in maternal mortality (Center for Disease Control, 2019). In neighborhoods with a high minority demographic, there is less access to hospitals and medical clinics resulting in decreased doctor visits and preventative care. (Center for Disease Control, 2019). Next are the socioeconomic disparities among Black women. There are lower rates of insured patients in urban areas of poverty, significantly impacting affordability of medical services (Morello-Frosch & Shenassa, 2006). Finally, minimal sexual and reproductive education is accessible to Black women, including medical rights in childbirth (Davis, 1982). The differences in access to education, as Davis (1982) noted, is about contraception, abortion, sexual diseases, and childbirth, all of which can contribute to higher risk of maternal mortality. These research-based factors contribute to higher maternal mortality rates among Black women as compared to any other race.

Theoretical Framework

Figure 1. Factors Contributing to the Problem of Maternal Mortality Organized around Bronfenbrenner's (1979) Ecological Systems Theory



Developmental Psychologist, Urie Bronfenbrenner, proposed the ecological systems theory of development as a perspective of how humans behave (Bronfenbrenner, 1994). This theory states that humans develop through frequent interpersonal, symbolic, and environmental encounters. Bronfenbrenner proposes this through a systems perspective as simultaneous interactions that independently contribute to life experiences (Bronfenbrenner, 1994). The ecological systems theory (EST) is a nested environment of systems, beginning with the innermost interaction and graduating to the outermost and least complex interaction (Bronfenbrenner, 1994).

Each structured system and the environment relate to the high mortality rate of Black women, the focal individual. The innermost circle, the microsystem, involves a direct interaction that is physical, social, or symbolic in nature. The context of the microsystem serves as the basis of the creation and maintenance of the individual's behavior (Bronfenbrenner, 1994). For this study, the microsystem is the childbirth and advocacy education a pregnant woman receives from birth professionals or hospital programs. The next layer, the mesosystem, consists of interactions between and among the focal individual in the microsystem, such as family support, socioeconomic status of individual, and health care providers. These factors not only interact with each other but also impact the pregnant woman before, during, and after childbirth. The exosystem contains several settings that are indirectly related to the individual, including access to quality health care based on transportation and insurance. In the macrosystem, the population, culture, or society structures the interaction with the individual (Bronfenbrenner, 1994). The macrosystem in this study is racism, and this impacts the other systems such as access to health care, and education for the individual. All these systems are nested within each other as contributing factors of the issue of Black maternal mortality.

Review of the Literature

There are several factors consistent in the research related to the issue of maternal mortality of Black women. In a review of the literature related to the focal individual, systemic and interpersonal racism, access to health care, health care providers, and childbirth education have been identified as barriers for Black women during pregnancy and childbirth (Nuru-Jeter et al., 2009; Center for Disease Control, 2019; Morello-Frosch & Shenassa, 2006). The review examined how these barriers increase the risk of complications and death during childbirth for Black women.

Macrosystem

The macrosystem impacts the population, culture, or society that interacts with Black pregnant women which, in this context, is the issue of racism. Racism in the context of understanding maternal mortality of Black women is both systemic and interpersonal, existing in institutions as well as personal experiences over the individual's lifespan. The macrosystem surrounds the other systems and relates to the impact of racism and traumatic experiences that indirectly and directly affect the individual (Bronfenbrenner, 1994).

Racism. Racism has existed since the founding of the United States and has infiltrated laws, education, health care, and interpersonal interactions (Feagin & Ducey, 2019). Both systemic and interpersonal racism significantly raise stress levels and impact the health of Black women during pregnancy and childbirth (Rich-Edwards et al., 2001). The Systemic Racism Theory (Feagin, 2010) defines five dimensions of national racism: (1) dominant racial structures, (2) comprehensive framing benefitting White culture, (3) individual and collective discrimination, (4) social production of material inequalities regarding race, and (5) racial institutions exerting power over minority Americans. The Systemic Racism theory provides a

review of the history of systems of racial oppression and evaluates current structures in the United States that exhibit White dominance and discrimination.

The history of systemic racism comes from the unjust benefits that White people gained from slavery and the oppression imposed from a White supremacist government (Feagin & Bennefield, 2014). Since the beginning of the establishment of American government to more current systems, Black people were recognized as three-fifths a person. In the 20th century, segregation limited students of color from receiving the same opportunities in the classroom. Since the 1950s, unfair housing practices and the housing crisis barred people of color from getting home loans in the suburbs (Taylor, 2012). Systems, such as housing and education, have primarily benefited White people while diminishing the value and rights of minority ethnicities. Black women in the South during the 1800s were used for medical experimentation and treated as if they were less than human to make scientific discoveries. In the first half of the 20th century, Black women were involuntarily reproductively sterilized after giving birth. Racism is still evident through the demographics of decision makers of various institutions (Feagin & Bennefield, 2014). One of the largest institutions rooted in systemic racism is the medical field.

Black women have suffered from White framing in relation to their health care (Roberts, 1996). The medical field is an institutions where 75% of the providers are White and the majority of hospital governing boards are populated with White people (Castillo-Page, 2010). When White culture makes decisions from a monocultural lens based on the represented decision makers, it is referred to as White framing. In the 21st century, Black women are still dismissed when presenting real symptoms of health issues and suffer poorer quality health care than White women (Chin, Walters, Cook, & Huang, 2007). The poor health care for Black women not only impacts medical treatment and their comfort receiving treatment, but there is also a significant

impact on stress levels in pregnant women (Rich-Edwards et al., 2001).

Racism experienced in daily interactions takes a toll over time on Black women in a process called weathering (Geronimus, 2001). To evaluate the experiences of racism among Black women and understand the experiences of racism during pregnancy and postpartum, 302 Black female participants were studied in a large southeastern city (Jackson, Phillips, Hogue, & Curry-Owens, 2001). The authors defined racism as stressors during encounters due to racial oppression. Burden was defined as the impact of racism on birth outcomes such as birth weight, traumatic birth experiences, and health during and after birth. The participants were 167 college-educated women, ranging in age from 18-77 years old. Four scales of stress and depression measures were adapted: (a) NHIS Depression Scale (Pu, Bai, & Chou, 2013), (b) Spielberger State/Trait Anger Expression Inventory (Barnes, Harp, & Jung, 2002), (c) Spielberger State/Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970), and (d) John Henryism Scale for Active Coping (Stevens-Watkins et al., 2016). The adapted scale contained 71 items assessing the issues of racism, burden, personal history, and work environment and was administered twice within 30 days to the participants. In addition to the survey instrument, 36 participants agreed to participate in interviews. The results of the study reported that 37% of respondents stated that racism was a consistent problem in their lives, and 42% had to deal with racism affecting their children. In regard to burden, 46% of women felt as if they were a caretaker for those around them but did not feel taken care of, and 67% of women felt the burden to be strong for everyone around them. The research found no significant difference among women regarding age and income in responses pertaining to personal experiences, but women aged 25 to 34 were twice as likely to experience racism in the workplace than women 35 and older.

A similar mixed methods study examining the impact of racism on giving birth such as

preterm delivery and birth weight was conducted to predict outcomes in Los Angeles County, California (Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008). The researchers gave the Perceived Social Stress (Cohen & Williamson, 1988) survey to 294 women participants. The instrument contained items pertaining to general prenatal stress and psychosocial factors. Prenatal stress included anxiety and desire to carry the child to full term and stress due to racism. Women were recruited in pregnancy clinics by private physicians. Participants met entry criteria if they were at least 18 years of age and had no history of smoking or drug use. In addition to the survey data collected, the medical charts for 73 non-Hispanic White women and 53 Black women were reviewed noting pregnancy history, prenatal conditions, and weight gain throughout gestation. Researchers used regression analysis to pair analysis of the structured interviews for each category (general stress, pregnancy stress, and racism) with medical data from the participants by gestational age and race. The researchers found significant differences in pre-term delivery in Black women (16%) as compared to non-Hispanic White women (5%). A majority of the Black participants and non-Hispanic White participants reported experiences of racism which can contribute to stress and anxiety in pregnancy and birth (Dominguez et al., 2008).

A qualitative study designed to uncover differences in SES also explored the experiences of racism in pregnant and postpartum Black women. The study was conducted with 40 women divided into six focus groups to determine implications of racism in birth outcomes (Nuru-Jeter et al., 2009). Women of low socioeconomic status (SES) women were recruited from government programs and high SES women were recruited from professional organizations and local sororities. Participants were between the ages of 18 and 39, living in Oakland, Berkeley, Sacramento, and San Diego, California. Participants were either pregnant or had children

younger than 15 years old. Focus groups were utilized so participants felt more comfortable sharing their experiences of victimization and less vulnerable than in an individual interview. Questions involved experiences of racism throughout the participants lifespan, settings of racism, and the impact of racism during birth and parenting. Six themes emerged from the findings: (a) racism occurred throughout the participants' lifespan and had long-term effects; (b) racism was experienced directly and vicariously for the women and their children; (c) all women had experienced institutional, interpersonal, and internalized racism; (d) racism occurred in a wide variety of social settings; (e) the response to racism was active and passive; and (f) all participants were hypervigilant to anticipate and prepare for the possible future impact of racism. The researchers emphasized the need to address the lasting impact of interpersonal racism experienced by Black women before childbirth (Nuru-Jeter et al., 2009).

The three studies identified the stress of institutional and interpersonal racism in pregnancy and childbirth (Jackson et al., 2001; Dominguez et al., 2008; Nuru-Jeter et al., 2009). The Jackson et al. (2001) study and the Nuru-Jeter et al. (2009) study both evaluated the impact of racism on stress. Both studies found a significant impact of racism in daily life, such as the workplace; and the stress level reported was higher in Black participants than other races. In the Dominguez et al. (2008) study, the difference was the focus on participant concerns about the impact of racism on their children. Although stress levels were already high, researchers took a further look and found that interpersonal racism that Black women experience compounds when they have children. The research from the California studies indicate more work is needed to evaluate specific birth outcomes such as birth weight and severity of medical intervention for Black women.

The stress of racism is heightened for Black women in an effort to protect their children

from racism (Jackson et al., 2001; Dominguez et al., 2008; Nuru-Jeter et al., 2009). This heightened stress may have an impact on the labor of the pregnant Black woman, their health during and after childbirth, and birth weight and health of the infant. Racism influences Black women psychologically and physically throughout their life, especially in the childbearing years.

Exosystem

The exosystem encompasses the environments that indirectly affect the individual (Bronfenbrenner, 1994). In this work, it pertains to health care insurance and transportation. Lack of access to health care providers, because of the type of insurance a person has, can prevent pregnant women from receiving quality treatment. Sources of transportation can also prevent patients from consistent care. These barriers have a significant effect on birth outcomes for Black pregnant women.

Access to health care. There are racial barriers in access to health care (Brown, Ojeda, Wyn, & Levan, 2000). The type of insurance and transportation options play a significant role in health outcomes (Lillie-Blanton & Hoffman, 2005; Syed, Gerber, & Sharp, 2013). The critical issues, finding and obtaining resources for health care, have important implications for the maternal health of Black women. Care for women who are pregnant is a gateway for health care beyond childbirth and for the next generation (Facione & Facione, 2007). Health care experiences are important for prenatal women and impact their comfort with their health care provider and the women's knowledge about birth. In a review of published research pertaining to women's prenatal experiences, participation in and processes and perceptions of prenatal care were measured (Novick, 2009). The researchers used qualitative analysis to evaluate 22 studies, from the United States, England, Australia, Canada, Scotland, and New Zealand. Several themes emerged from the review of the studies.

The first theme, benefits and barriers, revealed that the barriers to prenatal care included transportation, lack of insurance, substance abuse, and lack of childcare. The second theme, the prenatal care setting, showed that cleanliness and play areas for children were important factors in respondents' satisfaction with prenatal care. The third theme, time spent in the waiting area and time spent with providers, revealed that the patient-provider relationship was negatively impacted the longer the patients had to wait for their appointment to begin. The fourth theme, continuity and comprehensive care, showed that many (the number was not specified) women did not often see the same provider nor feel they had much control throughout their prenatal care. In the fifth theme, relationships with providers, many women reported they felt dismissed by rude providers and felt as if providers stereotyped them and treated them with less respect because of their race. In the sixth theme, patients sought prenatal care information outside of their providers and the medical setting (i.e., doctor's office, hospital, clinic) and looked to midwives and nurse case managers for continued care. From the analysis of qualitative studies, the authors saw a need for personalized care and more training for health care professionals to create healthier social and emotional environments for minority pregnant women. The barriers to health care are compounded by the issue of quality insurance based on job and socioeconomic status.

Insurance. Limited access to health care may be the result of no insurance or limited coverage insurance. Poverty and lack of insurance are obstacles influencing the health of minority women with many different health issues including pregnancy (Brown et al., 2000). Approximately 36% of people living below the poverty level in the United States are completely uninsured and more likely to have higher rates of illness and health issues (Hoffman & Paradise, 2008). People who have health insurance are more likely to find a consistent source of care and a

97% chance of utilizing their health source for intervention and preventative care (Hoffman & Paradise, 2008). Black and Hispanic people represent the highest uninsured populations and are at twice the risk of not getting care for health issues (Lillie-Blanton & Hoffman, 2005).

There are disparities in affordable, quality health insurance between White Americans and minority populations (Lillie-Blanton & Hoffman, 2005). In a review of four studies (Weinick, Zuvekas & Cohen, 2000; Waidmann & Rajan, 2000; Zuvekas & Taliaferro, 2003; Hargraves & Hadley, 2003), researchers evaluated health care access across the United States among different races and ethnicities (Lillie-Blanton & Hoffman, 2005). The studies were chosen based on the following criteria: (a) access to health care between Whites and other minority groups, (b) measure of factors that contribute to disparities in health care, and (c) measurements of racial and ethnic differences in health insurance disparities. In the findings of the review, access to health care among Black Americans was found to be half the rate of White people. Before the Affordable Care Act (ACA) was passed in 2010, approximately 52.5% of Hispanic and Black people were uninsured in the United States. Since the implementation of the ACA, the percent of uninsured Black and Hispanic Americans dropped to 30.5% (Artiga, Orgera, & Damico, 2019). Among the uninsured, Black and Hispanic individuals are more likely to not have access to a consistent provider or seek care for health care for chronic conditions. Even with the decline in the percentage of Black and Hispanic uninsured since the enactment of the ACA, the Lille-Blanton and Hoffman (2005) review points out that there is a need for a continued national conversation about the disparities that still exist for quality health care for all.

Health insurance impacts provider care and access to preferred hospitals. In a study reviewing 5,539 United States hospitals that deliver more than ten babies a year, Howell, Egorova, Balbierz, Zeitlin, and Hebert (2016) evaluated the maternal mortality rates among

different ethnicities based on the demographic characteristics of hospitals and insured patients. Hospitals were categorized as high Black serving (n = 279), medium Black serving (n = 1,106), and low Black serving (n = 4,102). High Black serving hospitals had younger women giving birth, a high Medicaid population, a greater number of low-income patients and were located primarily in urban areas. Results of the review indicated that hospitals serving a high number of Black patients had a significantly more deliveries and greater number of patients served. At high Black-serving hospitals, the maternal morbidity and Cesarean section rates for Black women was 20.2 per 1,000 births as compared to low Black-serving hospitals at 12.3 per 1,000 births. Maternal morbidity was higher in hospitals with a combination of high Black-serving, low SES, low quality insurance. The authors noted that this was due to the pressure for doctors in poor quality insurance networks to see a high number of patients per day (Howell et al., 2016). The disparities in health coverage for minority Americans influence choice of providers, hospitals, and care for patients. For Black pregnant women, this disparity may impact birth outcomes and can lead to issues such as surgical intervention and maternal mortality.

Transportation. Reliable transportation to jobs, medical appointments, and childcare is a major barrier for low-income urban and rural populations (McCray, 2000; Hardy & Nitmeier, 2007). Care providers located in suburban areas are inaccessible without personal transportation as public transportation is often unavailable. Transportation challenges impact maternal prenatal care and childbirth because of the number of prenatal appointments and unpredictability of labor and childbirth (McCray, 2000). Despite the existence of public transportation, reliability of transportation limit patient choice in health care. Consistent prenatal care can be hindered by the lack of personal and public transportation for suburban and rural residents as well (McCray, 2000).

Lack of access to transportation poses challenges for those seeking preventive care and maintenance of health conditions (Syed, Gerber, & Sharp, 2013). Syed et al. (2013) reviewed 61 studies and assessments conducted from 1985 through 2012 to report the trends and effects of transportation as a barrier to accessing health care. All of the studies were conducted in the United States and examined barriers to ongoing care and chronic illness and included assessments measuring transportation barriers. Of the 61 studies, nine addressed transportation based on accessibility to a vehicle and modes of public transportation. Half of participants in each of the nine studies missed appointments because they did not own a vehicle or have reliable transportation. Two of the reviewed studies reported that over 50% of participants expressed the lack of consistent transportation as a reason for no-shows at doctor appointments. Along with not being able to get to appointments, the participants in five of the studies reported on average a 55% lower refill rates for medications due to transportation issues. There is a significant need for better assistance to expand transportation access in various communities (Syed et al., 2013). Although the Syed et al. (2013) review highlighted the issues for those seeking primary care and chronic illness medical care, transportation support for prenatal care is a prevalent challenge.

Lack of transportation to provider visits can limit the health care a mother and her baby receives (McCray, 2000). A 1990 qualitative study was conducted with 211 Black, White, and American Indian women to identify barriers to prenatal care in low SES populations (Lia-Hoagberg et al., 1990). Participants were recruited from the 1980 census if they identified below the federal poverty line, which at the time of this study was $9,287 per year for a family of four. Several factors identified as barriers emerged from the interviews including demographic; financial; childcare; transportation; and psychosocial, emotional and social influences. Among all three populations of women who participated in the study, 46% of women indicated that

transportation was a major problem. More than 70% of the women interviewed did not own a car. Sixty percent of White women were able to borrow a car; 42% of Black women relied on someone to drive them to appointments; and approximately 33% of American Indian women walked to their nearest Indian Health Clinic provider. Of the women interviewed, 26% of them indicated they had missed prenatal appointments and did not reschedule them due to transportation issues, and 44% of the women reported having inadequate care due to inability to get to appointments. The researchers acknowledged the need to increase in transportation services for the low SES population (Lia-Hoagberg et al.,1990).

Among the many limits to accessing health care are unreliable transportation and low-quality insurance. Minority populations are less likely to be insured by their employers, and those uninsured often have less easily accessible health care providers (Lillie-Blanton & Hoffman, 2005). Additionally, low quality insurance also lowers the care provided by the health care system prenatally and during delivery (Howell et al., 2016). Researchers have found that hospitals that serve greater Black populations are linked to higher maternal mortality rates. Insurance, whether before or after the ACA in 2010, remains an issue for pregnant Black women. Lack of consistent public or personal transportation limits a pregnant woman's ability to attend all prenatal appointments or see her provider for other specialized preventative care (Lia-Hoagberg et al., 1990). Obstacles in quality health care are greater for Black women and may contribute to higher mortality rates during and after childbirth.

Mesosystem

The mesosystem consists of interactions among microsystems, such as health care providers and community support. These factors not only interact with each other but also affect the pregnant woman before, during, and after childbirth (Saha, Arbalaez, & Cooper, 2003). The

factors in the mesosystem can directly influence the individual's birth outcomes and contribute to the maternal mortality rate during birth (Facione & Facione, 2007).

Community support. Childbirth outcomes are positively impacted when community and social support are involved before, during, and after birth. A study of 125 women over the age of 18 sought to identify the psychosocial impact of social support during and after childbirth (Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993). The participants were asked about social support, frequency and quality of care, and involvement of the birth father. Of the 125 women, 80% were Hispanic and Black; 13% were White; and 7% indicated as other in ethnicity and race. Participants were interviewed once during each clinic visit and one postpartum visit. Results established that there was a significant correlation between larger social support networks with less difficulty in labor and higher birth weight of babies at delivery. The babies also had higher Apgar scores, which is the rating of the health of an infant immediately after birth. Participants who had lower social support reported higher rates of depression at their postpartum visit and mental health screening. The authors recommended a need for more direct intervention to impact birth and postpartum outcomes through social and familial support (Collins et al., 1993).

Labor, postpartum, and social support for birthing families to improve birth outcomes can include the use of doulas (Morton & Clift, 2014). A doula is defined as emotional, physical, and educational support during pregnancy and birth. A study of ~~predominantly Black~~ women evaluated differences in birth outcomes for women who did and did not use a doula for childbirth education and birth support (Gruber, Cupito, & Dobson, 2013). In their study of 225 pregnant women, with 50% of whom identified as Black had access to 47 doulas in Healthy Beginnings Doula Program (HBDP) and were trained and certified by the Doulas of North America (DONA) program. The doulas in the study provided ongoing support during pregnancy, labor support

during childbirth, and postpartum support briefly after childbirth to help initiate breastfeeding. Participants who chose to have doula support at their birth, roughly 56%, had higher rates of natural vaginal delivery (23%) without labor intervention and lower rates of cesarean section delivery (17%). Fifty-five percent of the participants that chose not to have a doula at their birth had higher interventions during birth such as epidurals to address pain relief during labor. The same group had 21% higher rates of cesarean section deliveries. The researchers emphasized the importance of labor support for pregnant mothers in childbirth for better birth outcomes in labor and birth weight for infants. Family, friends, or professional doulas support before and during birth can affect the type of childbirth, lower unnecessary medical intervention, and ease the anxiety and emotional discomfort of the pregnant woman. These improved outcomes may contribute to the reduction of maternal mortality of Black women as well (Morton & Clift, 2014; Gruber et al., 2013).

Health care providers. Birth outcomes and quality of health care between of Black and Hispanic women is frequently reported lower compared to White women (Saha et al. 2003). A study was conducted to understand the disparities in quality of care among various racial groups. Researchers analyzed the data from a phone survey conducted by the Commonwealth Fund's Quality Health Care Survey (Betancourt, Green, & Carillo, 2002) between April and November of 2001. Phone numbers selected at random located in largely Hispanic and Black neighborhoods were called over 20 times per household to ensure a higher chance of participation. A total of 6,722 people participated. The quality of patient-provider relationships, provider cultural sensitivity, and the racial similarity between patient and provider were analyzed. Results indicated that 25% of Black and Hispanic participants and 50% of Asian participants had a provider of the same race. Additionally, Asian, Hispanic, and Black participants reported lower

levels of satisfaction with their providers while approximately half of minority (i.e., Black, Asian, and Hispanic) populations surveyed felt their provider was appropriately, culturally sensitive during their health care. The authors reported overall lower levels of patient-provider quality of care for non-White populations. The quality of care that patients receive can impact their emotional well-being and physical health. In prenatal care, this quality of care could impact birth outcomes. The stress from lack of care or negative experiences in pregnancy can detract from the physical health of the mother, which can contribute to health risk factors in birth.

Prenatal care experiences for minority women play a significant role in their comfort and stress level during childbirth and postpartum (Facione & Facione, 2007). Researchers measured perceptions of prejudice in and personal experiences of bias in health care in a cross-sectional survey study of 817 women representing three racial categories: 37.6% Latino, 28.2% Black, and 34.2% White. The Habits of Health Care Utilization Scale (Facione, 1999) and the Perceived Access to Health Services Scale (Facione, Dodd, Holzemer, & Meleis, 1997) were used to design a single new survey measure. Among the 87.3% of the participants who reported personal experiences of prejudice, highly educated Black women had the highest scores of prejudicial experiences, followed by Hispanic women, and then White women. The authors recommend evaluating perceptions of prejudice and experiences as factors to improve future health care experiences especially for Black and Hispanic women (Facione & Facione, 2007). From this evaluation, further study is warranted as to what action can shape change provider care.

Underlying provider bias and racism are significant influence in prenatal care. A meta analysis of research was conducted to evaluate the influence of implicit bias or the subconscious thoughts/beliefs that impact behavior of health care providers on their delivery of care (Hall et al., 2015). Fifteen studies included in the review studied health providers or health providers in

training and evaluations of implicit bias and attitudes toward racial groups. Of these, nine focused on implicit bias toward Black versus White patients, and six studies focused on bias toward Black and Hispanic patients versus White patients. Almost all of the studies used convenience sampling and cross-sectional design for data sampling and collection. Hall et al. (2015) used double independent data extraction to summarize and synthesis findings across all studies. Fourteen of the 15 studies found low to moderate implicit bias of health care professionals against Black and Hispanic patients, and 13 studies found that health care providers were more likely to connect negative words with Black patients than White patients. Four studies revealed that health care providers linked higher quality care with White patients than Black patients because Black patients were perceived as less cooperative and less responsible in their health care. Researchers measured implicit associations between the participant and topics such as minority races and vulnerable populations. Four studies indicated 80 different affiliations with bias and patient-provider relationships, and 33 of those relations were reported as significant or marginally significant correlations. Among the eleven connections between bias and health outcomes, three were considered significant indicating bias may contribute to poor health outcomes. Among the 84 links between general bias and health outcomes, 26 were significant. Although results did not indicate a majority of significant ties of bias and health care provision in every study; the authors reported concerns about the percentage of associations that impact care for Black and Hispanic populations. Researchers suggest training for health care providers in order to address issues of implicit bias and the need for cultural competence to improve patient health outcomes (Hall et al., 2015).

Among the studies discussed, patient-provider relationships and provider care are influenced by provider awareness of racial bias (Hall et al., 2015) and how patients perceive

provider prejudice (Facione & Facione, 2007). The contrast in the Hall et al. (2015) and Facione and Facione (2007) studies was the data collected from women experiencing prejudice as opposed to the small, implicit messages of bias and racism from providers. The studies differed in overt versus covert racism but still found that Black and Hispanic patients are experiencing discrimination from their providers at higher reported rates than White patients. The prevalence of implicit bias in patient care indicates that the impact of provider bias that need to be addressed (Hall et al., 2015).

Microsystem

The microsystem is the most direct interaction with the individual (Bronfenbrenner, 1994). One of the primary aspects of the microsystem is the education that a pregnant woman receives to prepare to give birth. Childbirth and advocacy education directly impact the knowledge and experience of a pregnant women to make informed decisions for birth options.

Education. Education in this study is divided into childbirth and advocacy education. Childbirth education provides knowledge about the details of labor and birth for pregnant women and their support systems (Riedmann, 2008). Advocacy education provides knowledge of patient rights and provider responsibilities to patients (Birth Rights Bar Association, 2020). Together, these educational opportunities aid in self-advocacy, confidence in birth, and informed birth choices (Ferguson et al., 2013; Brashers et al., 1999).

Childbirth education. Childbirth education classes are programs for birthing families that address various types of childbirth, labor interventions, and pain management techniques, which are important for informing birth plans and improving birth outcomes (Nolan, 1997). There are physical and emotional benefits to childbirth education. Australian researchers Ferguson et al. (2013) conducted a systematic review and meta-analysis of research studies that

evaluated the physical, emotional, and psychological benefits of childbirth education. Over 3,286 research articles from around the world, including countries such as Spain, Sweden, Canada, Australia, United States, Iran, United Kingdom, and Thailand, were related to the topic of childbirth; but only ten articles met the criteria correlating antenatal (childbirth) education and labor and birth. Four studies reported lower rates of women arriving at the hospital in false labor when participants had attended a childbirth education class. One of the studies conducted in Iran reported higher rates of vaginal labor without labor interventions when pregnant women attended classes before labor. The meta-analysis also examined emotional effects as well. Sixty-five percent of women who had attended classes reported decreased rates of anxiety compared to 45% of women who had not attended classes. A study from the United Kingdom found that partners were more involved in supporting the laboring mother if they had also attended the childbirth classes. The researchers reviewing the studies talk about the possible significant physical and emotional effects as a result of attending childbirth education. Although this review focused on biopsychosocial factors, there is a need to understand birth outcomes for pregnant women who attend childbirth education.

Childbirth education effects pregnant women biologically, socially, and emotionally (Ferguson et al., 2013); and education during pregnancy impacts birth outcomes (Hetherington, 1990). Hetherington (1990) evaluated the effect of childbirth education on birth outcomes: the type of birth, pain management, and health of the newborn. Eighty-three couples birthing at a large, urban hospital in the United States participated in the study; 52 couples completed the childbirth education class over a period of six weeks, and 31 couples who did not attend or complete the class. The components measured during birth were (a) the administration of anesthesia, (b) induction of labor versus spontaneous labor, and (c) premature versus full term

birth. Although there was no difference between the groups on the administration of anesthesia, couples who attended childbirth classes were induced or delivered prematurely less often than the non-attending group.

Among the participants who attended childbirth classes, 20% were induced in labor as opposed to 50% of participants who did not complete classes. Only 2% of the participants who attended the classes delivered prematurely versus an approximate rate of 13% of premature births for couples who did not finish childbirth education courses. The authors noted that childbirth education prepares birthing families for labor and delivery and helps pregnant women feel more confident in the birthing process. Equipping pregnant women for childbirth provides physical improvement in labor and important psychosocial outcomes that result from families who are prepared for birth. These two studies address the impact of childbirth education on birth outcomes for pregnant women, but there is still a need for more research on this issue, especially related to Black women.

Advocacy education. Searching for general advocacy education during health care treatment and the relationship with health care providers, revealed little scholarly work. The research focuses on the impact of advocacy education for high-risk populations. The high number of uninsured and underinsured pregnant Black women place the minority population at high health risk (Lillie-Blanton & Hoffman, 2005), similar to those populations who have chronic health needs. Research focused on patients living with HIV and AIDS during diagnosis and treatment. Brashers, Haas, Klingle, and Neidig (2000) evaluated the impact of self-advocacy education for HIV and AIDS issues focusing on communication with health care providers and perceptions of effectiveness. A sample of 174 patients with HIV or AIDS were gathered from AIDS service organizations, activist groups, and clinical trials. The average patient had been

diagnosed with HIV or AIDs for four or more years. There were 155 male and 16 female participants in the study. Participants were asked to submit written responses to open-ended questions about how they communicated with their providers since their diagnosis and their perceptions and experiences with the communication. The researchers conducted a thematic analysis of the participants' answers to determine patterns of communication strategies with health care providers and approaches to self-advocacy. The results pertaining to approaches for patient self-advocacy addressed the need for education about the illness and treatment options from providers and social activists, promotion of mindful non-adherence, and encouragement of assertive attitudes during the discussion of health care options. The major theme resulting from the communication and perceptions of communication with health care providers reported that patients felt their self-advocacy was met with some hesitance and at times resistance from their provider. However, patients reported that the more knowledge they had about their treatment options, they more they were able to give reasons for their mindful consideration and non-adherence to provider mandates. The authors conclude that education on patient self-advocacy can benefit patient interpersonal health interactions and allow patients to make sound decisions in which they have an active role (Brashers et al., 2000).

Although the Brashers et al. (2000) study addressed patient self-advocacy, the interviews lacked depth and standardized instrumentation. However, another study created a specific scale for patient self-advocacy with an aim to address the reliability of measuring patient activism in health care. The researchers (Brashers et al., 1999) developed the Patient Self-Advocacy Scale (PSAS), which contained twelve Likert-scale items randomly placed within an 89-item questionnaire. The items contained statements evaluating provider interactions after patients self-advocated, the perceived value of being educated about their treatment options, and the

importance of being assertive in their health care decisions. In the Brashers et al. 1999 study, two sample populations were involved: participants living with HIV or AIDS and the general population. The purpose of two samples established reliability of the instrument and compared themes among HIV-AIDS patients and the general public. Participants were recruited from HIV-AIDS organizations and from faculty, students, and staff at a midwestern university. The first sample contained 174 participants who were diagnosed with HIV-AIDS. The second sample of the university population had 218 participants. Factor analyses was used to establish reliability and validity of the measure. The researchers concluded the instrument was a valid measure of patient self-advocacy. Additionally, the researchers looked for themes and suggestions that needed to be addressed on the issue of patient self-advocacy. The participants living with HIV and AIDS had higher rates of self-advocacy, involvement in health care treatment options, and educating themselves on their disease more than the sample of the general population. The authors recommend more investigation as to why some patients choose to advocate and others do not and a longitudinal look at patient communication with their health care provider. The study did not provide specific data on participant answers related to the twelve items for an in-depth comparison since the study's purpose was to evaluate reliability and validity of the PSAS (Brashers et al., 1999). The two (Brashers et al., 1999; Brashers et al., 2000) studies indicate the need for more research on patient self-advocacy and the type of education patients in other medical populations such as pregnant women need in order to feel confident to advocate for themselves and take an active role in decision making.

Summary

Many factors contribute to maternal mortality and birth outcomes of Black women. These

factors include racism, access to health care, health care providers and family support, and education before labor (Feagin & Ducey, 2019; Brown et al., 2000; Soet, Brack, & Dilorio, 2003; Ferguson et al., 2013). Racism, both systemic and interpersonal experiences, negatively impacts the emotional well-being and stress level of Black pregnant women leading to premature birth, difficulty in labor, and low birth weight babies (Dominguez et al., 2008). The high number of uninsured and underinsured minority patients are correlated with high maternal morbidity rates (Howell et al., 2016). Additionally, transportation is a major obstacle in accessing consistent medical care and receiving complete prenatal care for the recommended number of appointments, which impacts the health of the mother and the baby (Lia-Hoagberg et al., 1990). Issues such as community support and a quality health care provider directly impact the mother during birth (Gruber et al., 2013). Health care providers who have indicated implicit bias against Black patients explicitly impact the quality of care for birthing mothers and their families. Black patients of the providers with implicit bias have higher reported rates of the risk of maternal mortality (Hall et al., 2015). Childbirth education can be effective in helping pregnant women physically and emotionally in labor and influence vaginal, unmedicated labor and delivery rates, and the birth weight of the baby (Hetherington, 1990). All these factors critically affect maternal mortality of Black women. Therefore, the issue of maternal mortality needs to be addressed through intervention, using childbirth and advocacy education to positively impact confidence of pregnant Black women to improve their birth outcomes.

Chapter 2

Review of the Literature

Approximately 700 women die each year in childbirth from pregnancy related complications (Petersen et al., 2019). Black women have the highest percentage of maternal mortality, which is three times higher than any other race (Center for Disease Control, 2017). There are many contributing factors to the high rate of maternal mortality including but not limited to systemic and interpersonal racism, lack of access to health care, lack of access to quality health care providers, and lack of childbirth and advocacy education (Dominguez et al., 2008). The Center of American Progress conducted research to illuminate the issue of racial disparities in maternal health. Increased community education related to pregnancy health was among many of the suggested strategies to reduce the rate of maternal mortality (Taylor, Novoa, Hamm, & Phadke, 2019). Community education was defined in the Taylor et al. (2019) context as prenatal education including tools for advocacy as well as education for pregnancy and birth. The chapter will address the research on different models, impact, and cultural competency considerations of childbirth and advocacy education.

Childbirth Education

Childbirth education is a class or set of classes that provide preparation during pregnancy for labor and birth (Koehn, 2002). The goal of childbirth education is for pregnant women to have an informed, natural childbirth with little to no medical intervention. There are varied models for the delivery of the childbirth education, but there are consistencies throughout the components of the courses (Bailey, Crane, & Nugent, 2008). The main components of childbirth education include: (a) normal labor and birth process, (b) coping with the pain of labor, (c) medical interventions, (d) expectations for chosen delivery location, (e) when to call a care

provider, (f) danger signs, (g) breastfeeding care, (h) newborn care, and (i) postpartum care. Lamaze, The Bradley Method, Hypnobirthing, Family-Based Maternity Care, Mindfulness Childbirth, and Birthing from Within are the most frequently used models of childbirth education (Bailey et al., 2008). These models of childbirth education are used to prepare families for labor and birth.

History of childbirth education. Childbirth education has evolved over the last few decades. Formal childbirth education began in the 1960s to help pregnant women give birth in a hospital (Walker, Visgar, & Rossie, 2009). In the mid-twentieth century more women began to give birth in hospital, but they often gave birth with one nurse for support without family or friends present. During this time, pregnant women were unprepared for birth interventions in the hospital such as pain reducing medication and cesarean sections (C-section), which led to a need for more formal childbirth education.

Three main models of childbirth education serve as the foundation for the early promotion of natural childbirth (Bailey et al., 2008). The Bradley method was created by Dr. Robert Bradley in the late 1940s and based on the instincts of animals birthing their babies in a natural way (Riedmann, 2008). The Bradley Method focuses on health during pregnancy, pain management, relaxation and breathing, and a support person serving as a coach (Bradley Birth, 2020).

The Lamaze method was created by a French obstetrician Dr. Fernand Lamaze in 1951. The philosophy of Lamaze education focuses on natural childbirth without medicinal intervention, women's intuition and confidence during birth, safety in any birth setting, and the empowerment to make informed choices during birth (Riedmann, 2008). Like the Bradley Method, it is to empower women to give birth in a natural way, medication free and with an

active support person.

The Board of Directors of The International Childbirth Education Association (ICEA) created a childbirth curriculum in 1961. Family centered maternity care and birth are the educational focus of ICEA (International Childbirth Education Association, 2020). The goals include compassion, collaboration, and choice in how and where to give birth and placing the priority of informed, natural birth based on the needs of the individual and the family. These three main models of childbirth education, Bradley, Lamaze, and ICEA, serve as the foundation for the early promotion of natural childbirth through maternal education.

Since these earlier programs, others have emerged (Riedmann, 2008). These other programs include Hypnobirthing, Centering Pregnancy, and mindfulness-based methods (Walker et al., 2009). In addition to the curriculums, childbirth organizations were formed to train childbirth educators to teach the natural birth curricula. Two of the largest are Childbirth and Postpartum Professional Association (CAPPA) and Doulas of North America (DONA). Hospitals also began to create childbirth curriculum to prepare for women choosing a natural childbirth and or alternative ways to give birth (Bailey et al., 2008). The various labor and childbirth education curricula provide options for pregnant women and families to prepare for childbirth.

Components of childbirth education. The foundational principles of childbirth education are similar across curricula, but the structure of the courses can be different. The timetable on childbirth education varies based on type of course, setting, and attendees. Most group childbirth education and hypnobirthing courses, including those based on Lamaze and ICEA, last two hours a week for four to six weeks (ICEA, 2020). The Bradley Method is a 12-week class. Hospital-based courses typically last two to four hours for one or two weeks. In

addition to differences in duration, there is diversity in the teaching methods used across curricula (Riedmann, 2008).

There are several ways instructors engage their childbirth education women during class. Lamaze uses experiential engagement and asks participants to practice relaxation, positioning, and breathing technique that they might find helpful in labor (Lamaze International, 2020). The Bradley Method uses labor rehearsals called scenario rehearsal to practice laboring with the support person practicing coaching through labor (American Pregnancy Association, 2020). Hypnobirthing focuses solely on the practice of breathing and relaxation while listening to the audio hypnobirthing tracks. Additionally, classes from DONA, ICEA, and CAPPA make use of models of the pelvis, stuffed babies, charts, and videos to explain the stages of labor and childbirth. The goal of childbirth education is to prepare pregnant women to give birth and have positive birth outcomes no matter the curriculum and method used (Koehn, 2002).

Impact of childbirth education. Childbirth education informs families of natural childbirth options and types of medical intervention to allow pregnant women to make knowledgeable choices about their birth (Bailey et al., 2008). Childbirth education impacts obstetric outcomes pertaining to stress level, level of medical intervention, prevention of premature birth, and baby birth weight. The effect of childbirth education on birth outcomes such as the type of birth, pain management, and the health of the newborn was studied in a large urban U.S. hospital (Hetherington, 1990). Eighty-three couples enrolled in the research; 52 couples completing childbirth education class over six weeks and 31 couples who did not attend or complete the class. Three outcomes were measured during birth: administration of anesthesia, induction of labor versus spontaneous labor, and premature versus full term birth. Data was collected and analyzed through observations during childbirth education and a review of the

participants' medical records before and after birth. The researchers found several distinguishable differences between the groups. First, pregnant women were more confident and prepared after taking the class. Second, there was less medical intervention such as episiotomies and cesarean sections for the women who had the childbirth education information. Third, there was a higher rate of full-term babies, which are babies born after 37 weeks gestation, than participants that did not attend childbirth education. The researchers reported a possible correlation between childbirth education and positive birth outcomes. Equipping pregnant women for childbirth can impact confidence in labor, reduce medical intervention, and improve the health of the baby (Hetherington, 1990). In addition to the impact on physical health and stress during birth, there are probable emotional benefits on the pregnant woman during childbirth.

Childbirth education positively impacts the mother's confidence about labor and birth (Drummond & Rickwood, 1997). Researchers sought to test the validity of the Childbirth Self-Efficacy Inventory (CBSEI) to measure the effectiveness of childbirth education on participants' confidence in labor. The inventory, developed by Lowe (1993), has four categories: coping behavior during active labor, self-efficacy during active labor, outcome expectancies during birth, and self-efficacy expectancies during birth. Researchers Drummond and Rickwood (1997) distributed the survey to 100 Australian women who attended a childbirth education in their third trimester of pregnancy. Of the participants, 26% had attended a recent childbirth class, and 56% had previously attended a childbirth class. Results indicated there is a correlation between childbirth education, self-efficacy and outcome expectancies for labor and birth. There was also a high correlation between gaining knowledge during childbirth education and confidence in coping skills during labor. Researchers discussed the positive impact of childbirth education on

self-efficacy, coping, improved confidence during birth, and teach ways to handle the stress of labor and birth.

The type of childbirth education may have a strong impact on the pregnant woman's confidence about birth and ability to implement coping strategies during labor (Koehn, 2002). A pilot study conducted by Byrne, Hauck, Fisher, Bayes, and Schutze (2014) measured the impact of Mindfulness-Based Childbirth Education (MBCE) on fear, stress, anxiety, and self-efficacy of pregnant women during birth. Twelve women and their support partners attended an eight-week MBCE course. After attending the classes, participants completed a series of questionnaires between three weeks and three months postpartum. The series consisted of the Mindful Attention Awareness Scale (Brown & Ryan, 2004), the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987), the CBSEI (Lowe, 1993) and the Wijma Delivery Expectancy Questionnaire (Wijma, Wijma, & Zar, 1998). The results of the assessments showed a negative correlation between childbirth education and reduced fear and stress. Conversely, the data displayed a strong positive correlation between childbirth education and high self-efficacy during labor. The authors state that there can be a positive impact of MBCE to increase confidence in pregnant women during labor and birth. Childbirth education can be an important part of informing families with needed knowledge to prepare for labor and birth and can result in improved physical and emotional outcomes in birth (Byrne et al., 2014; Hetherington, 1990). Research has shown that preparing for birth through curriculum-based education can be effective in multiple ways.

Several studies reported the influence of childbirth education on stress levels in birth (Hetherington,1990; Drummond & Rickwood, 1997; Byrne et al., 2014). Hetherington (1990) found that education for childbirth can produce positive birth outcomes, less medical

intervention and increased likelihood of full-term babies. Even though this study looked at obstetric outcomes, Drummond and Rickwood (1997) furthered the research on stress levels in birth and evaluated self-efficacy of pregnant women as a result of attending childbirth education. The researchers found that childbirth education can increase confidence in birth and how to cope with stress that may occur in birth. Similarly, Byrne et al. (2014) researched the correlation between childbirth education and stress management. In addition to self-efficacy, these researchers evaluated anxiety, fear, and whether or not the pregnant women implemented coping strategies during birth. This body of research confirmed a strong relationship between education preparing for birth and reduced stress and fear during birth. All three studies enhance the knowledge of the impact that childbirth education can have physically and emotionally for pregnant women.

Advocacy Education

Self-advocacy is defined as the ability to express and defend what you want, need, and feel (SelfAdvocate Net, 2020). It includes knowing your rights and responsibilities to make informed decisions on your own behalf. In a hospital setting, patients self-advocate to have an active role in the actions taken based on their health needs (Sharf, 1988). The need for self-advocacy for pregnant patients comes from people who felt taken advantage of during their birth (National Advocates for Pregnant Women, 2020). Approximately one-third of all women experience trauma while giving birth (Reed, Sharman, & Inglis, 2017). Survey research conducted by Listening to Mothers stated that mothers who experienced traumatic births and surgical intervention felt pressured from medical professionals to agree to procedures without asking questions (Declercq, Sakala, Corry, & Applebaum, 2007). Tools and education have been developed over the years to equip women to self-advocate with their providers during pregnancy

and labor (National Advocates for Pregnant Women, 2020).

History of advocacy education. Education for patient on treatments, advocacy, and collaborative care began to emerge in the 1960s (Hoving, Visser, Muller, & Borne, 2010). Education began as a health promotion in the 1960s and 1970s. Information brochures were developed based on health care providers thought was important. However, these brochures lacked information about primary care facility system operations such as billing, rights, and medical board complaint departments. As education progressed in the 1980s, patient advocacy organizations began to emerge. Organizations such as the American Cancer Society, March of Dimes, and The National Welfare Rights Organization advocate specifically for people with lower socioeconomic status and focused medical issues (Gonzalez, 2018). During the 1990s and up to the 21st century, advocacy evolved into the central issue of policy change (Hoving et al., 2010). Patient advocacy also shifted from informing patients to informing health care professionals about patient rights and holistic treatment. In the last twenty years, educators trained health professionals to consider patient's environmental factors (i.e., family, work stressors, preexisting conditions) in their health treatment. The issues of shared decision making between patients and providers in treatment options became prominent in advocacy groups, research, and advocacy education. The history of patient advocacy paved the way for specialized education programs for health issues such as pregnancy (National Advocates for Pregnant Women, 2020).

Components of advocacy education. Few structured patient advocacy education programs exist. When searching for programs, primary results pertaining to geriatric patients and children with special needs emerged. The programs for pregnant patients had not been updated in the last ten years. In general there are two organizations that have created accessible information

about self-advocacy for women to use when communicating with providers during labor and birth (National Association to Advance Black Birth, 2020; Birth Rights Bar Association, 2020). The topics from these resources include patient rights, laws surrounding birth, and how to take action if a patient's rights are violated. The following sections will focus on the advocacy materials from these two organizations in conjunction with the National Advocates for Pregnant Women (NAPW).

One advocacy resource available for pregnant patients is *Birth Rights*, written and published by the Birth Rights Bar Association (BRBA) and the National Advocates for Pregnant Women (2020). The Birth Rights Bar Association (2020) is comprised of a board of attorneys that publish information and packets about obstetric violence, rights during birth, and how to take legal action after obstetric violence has occurred (Birth Rights Bar Association, 2020). The National Advocates for Pregnant Women seeks to address the rights of pregnant women who have been criminalized for having an abortion, lack access to health care, or have been separated from their family because of medical misinformation (National Advocates for Pregnant Women, 2020). These rights are addressed by providing legal assistance and publishing information about patient rights and issues that violate rights during pregnancy and birth. The *Birth Rights* information manual is structured in four sections: birth rights, during a violation, after a violation, moving towards birth justice, and resources. These sections detail how to assert rights as a patient during labor and birth.

Another advocacy resource is from the National Association to Advance Black Birth (NAABB, 2020). The NAABB is a new organization that publishes resources and produced a documentary for the purpose of supporting Black mothers as they give birth. The NAABB produced the *Black Birth Bill of Rights* as a resource for Black women to know their rights with

their providers, the hospital, and the health care system. The informational resource is accessible to the public as a download from their website.

Organizations like NAABB and the BRBA as well as the NAPW, are working toward changing self-advocacy education and providing resources to pregnant women. The current lack of established advocacy education may hinder pregnant women from knowing their rights and options during their birth. The impact of advocacy education on pregnant women leads to a positive correlation with informed, confident birth (McFarlane, Parker, Soeken, Silva, & Reel, 1998; Baffour, Jones, & Contreras, 2006).

Impact of advocacy education. Advocacy education is delivered for specific topics pertaining to pregnancy such as domestic abuse. A study conducted by McFarlane et al. (1998) provided resources for 132 pregnant women who experienced physical or sexual abuse within a year prior to or during their pregnancy. The participants received education from *Abuse During Pregnancy: A Protocol for Prevention and Intervention* (McFarlane & Parker, 1994) program three times throughout their pregnancy. Each session lasted 20 minutes and addressed the cycle of violence, safety planning, and community resources. Data was collected through short interviews after the sessions. Participants also received three community referral sessions at which the investigator discussed safety behaviors for the participant. Researchers measured the effectiveness of the advocacy education through the adoption of safety behaviors reported by the participants at each community referral session. Over the six visits including the advocacy education and community referral sessions, the adoption of safety behaviors significantly increased from the first visit to the last. On average 47.6% percent of participants had adopted at least one safety behavior after the first education session. After the completion of six visits, 78.1% of participants had adopted at least one safety behavior. The authors report a significant

impact of advocacy education for pregnant women who have experienced abuse. This type of continuous advocacy knowledge throughout pregnancy can be important for pregnant women to increase their advocacy over time before they give birth (McFarlane et al., 1998).

Targeted advocacy education for Black pregnant women can be important to focus on the topics that relate most to the Black community (Baffour et al., 2006). Researchers Baffour, Jones, and Contreras (2006) conducted focus groups about the creation and implementation of a Family Health Advocacy (FHA) program for rural Black pregnant women. Family health advocates, Black women from the community, served as a bridge for families to receive multiple services for this model of advocacy. Components of the program included peer-led health education, direct referral for services, informal counseling, and social support. Data collected from focus groups participants and health advocates indicated decreased stress and increased confidence due to the peer-led aspect of the program. The researchers discussed the importance of a culturally represented advocacy program for Black women, which potentially leads to higher self-efficacy in pregnancy and parenting. The FHA program model in addition to the abuse intervention education program indicate that education on the topic of self-advocacy may positively impact a woman's pregnancy and postpartum period (McFarlane et al., 1998; Baffour et al., 2006).

Cultural Competency in Education

This dissertation work is focused on childbirth and advocacy of adult Black pregnant women. Culturally competent educational strategies may benefit participants to connect through Black culture, see themselves represented in education, and challenge the status quo of the mistreatment of Black pregnant women in birth. Cultural competency is an important aspect during planning to deliver education to minority groups. Ladson-Billings and Tate (1995)

defined culturally relevant pedagogy for young learners as collaborative educational empowerment that includes the student experience of academic success, cultural competence, and critical consciousness. Banks and Banks (2007) discussed equity pedagogy for adult learners as strategies and culturally competent teaching for learners to gain and carry on socially conscious knowledge and skills. Both studies note that equitable teaching helps diverse learners gain academic success through connection of their culture, traditions, and background. Even before these educational practices were suggested, Critical Race Theory, an outgrowth of the 1960s Civil Rights Movement, laid the foundation for challenging race and racism in education (Delgado & Stefancic, 2017).

Critical race theory. Critical Race Theory (CRT) challenges race, racism, and power within teaching and education (Delgado & Stefancic, 2017). The theory began from lawyers and activists who wanted to carry the work of the Civil Rights movement on a large scale to battling daily issues of racism in small group environments such as classrooms and companies. Inspiration for the theory is derived from historic leaders such as Frederick Douglass, Sojourner Truth, Cesar Chavez, and Martin Luther King Jr. The main driver of CRT was Derrick Bell, a Harvard law professor, who furthered the theory's tenets primarily in the 1970s (Delgado & Stefancic, 2017). CRT has five main themes: (1) the intersectionality of race and racism, (2) the challenge of the ideology of dominant culture, (3) commitment to social justice, (4) experiential knowledge, and (5) interdisciplinary perspective (Solorzano, 1997). These tenets are used to understand racial inequity in education and schooling to challenge previous methods of teaching and improve minority student group teaching (Ladson-Billings & Tate, 1995).

CRT seeks to challenge the issues of the legal system and claims of the dominant culture such as color blindness and equal opportunity (Solarzano, 1997). It also addresses the privilege

and power of the dominant White culture and encourages discussion on racial oppression. Experiential knowledge is employed from challenging claims of White culture. The theory asserts that the experiences of men and women of minority groups are valid and crucial for understanding and analysis of race and racism (Solarzano, 1997).

An example of the application of CRT is seen through interviews of Black women and their experiences with sexual education. In 2014, The Center for Reproductive Rights and Sister Song Women of Color Reproductive Justice Collective (Sister Song) interviewed 25 Black women about their sexual and reproductive health (Center for Reproductive Rights, 2014). This was not an official study, but a collaborative effort to engage Black women in conversation to learn the reasons for disparities in maternal outcomes by race. The issue was not only views of sex education within the community but a lack of access to reproductive health care. The interviewed women did not know of their rights to birth control or how to advocate for their medical rights at local hospitals. Additionally, childbirth and postpartum care was a difficult experience for some of the women interviewed. Interviewees felt discriminated against due to age and race, factors that may contribute to the risk of maternal mortality. Because the interviews elevated the voices of Black women, a discussion of actionable change occurred. The Center for Reproductive Rights and Sister Song stated the need for better access to health care, the reduction of racial discrimination from health care providers, affordability of health care services, and increased education for Black women on sexual education and reproductive rights. CRT in practice is important for minority populations and can be a powerful tool in the context of advocacy education.

An interdisciplinary approach can be developed from the implementation of experiential knowledge (Ladson-Billings, 2005). In an educational setting, instruction involves an integration

of the voices of minority groups, acknowledgement of racial inequities, and the challenge of systemic injustice. Building on the focus of CRT, those receiving instruction, whether students or patients, need to be seen as the experts in their experiential knowledge to challenge the dominant culture in different institutions and systems (i.e., education, medicine, housing). Advocacy education can be used to challenge systemic inequities, a main component of CRT, and encourage participants to use their knowledge to speak up for themselves. The central focus of this intervention is the elevation of Black pregnant voices in addition to childbirth and expectations to understand and analyze issues of race during childbirth (Dominic & Stefancic, 2017). The following details the structure of the intervention from a birth, advocacy, and CRT lens.

Structure of the Intervention

The intervention in this dissertation was comprised of childbirth and advocacy education. The childbirth education combined aspects of the foundational childbirth education curriculums including Bradley (Bradley Birth, 2020), Lamaze (Riedmann, 2008), ICEA (ICEA, 2020) and DONA. The advocacy education component was informed by the Birth Rights Bar Association (2020) and *Black Bill of Rights* from the NAABB (2020). Since the study participants are Black pregnant women, the development of an intervention included cultural competency components such as CRT for Black pregnant women and is described in the following paragraphs.

Childbirth education. The childbirth education curriculum was developed by Althea Hurd, certified childbirth educator who is Black and has also given birth. The childbirth education class was two hours long and covered components of the longer, detailed childbirth education curriculums. The course began with warning signs before 37 weeks, which would indicate pre-term labor. The second section of the course explained signs and symptoms labor

and pain, aligning with the Bradley method (2020). The third section of the course discussed the phases and stages of labor and breathing, which was derived from the Lamaze method (Riedmann, 2008). The last part of the childbirth course focused on interventions and potential progression of interventions in labor and birth for the purpose of encouraging natural childbirth, which was derived from ICEA (ICEA, 2020). To incorporate cultural competency, Mrs. Hurd addressed the issue of racism in birth and medical issues that occurred during and after birth in patients known to have died in childbirth. She also showed a video about the importance of a support system in birth, which featured other Black family, doulas, or providers. These two components (interventions and support system) of the course applied the CRT model (Solorzano, 1997) by addressing race and racism and experiential knowledge. The structure created for the childbirth curriculum was interdisciplinary and culturally relevant to provide the foundation for the advocacy education course.

Advocacy education. The advocacy education part of the intervention was created by the practitioner researcher. The course began by defining self-advocacy and its importance in addressing the issue of racism in birth and the statistics of maternal mortality for Black women (Solorzano, 1997). After addressing the issue of race, I discussed the Black Birth Bill of Rights from the NAABB (2020). These rights incorporated tenets from the CRT to challenge the dominant culture and commit to social justice. After rights were listed and discussed, the course outlined how to affirm rights, address violations, and engage support for advocacy using the *Birth Rights* (Birth Rights Bar Association, 2020). The affirmation of rights and the process of documentation was based on legal storytelling, a narrative analysis, from CRT (Delgado & Stefancic, 2017). Concluding the advocacy education portion of the class, descriptions of affirmations in birth and suggested meditative statements were provided as a reminder of choice

during birth. The advocacy education built on the concepts in the childbirth education to encourage participants to challenge the status quo of dominant culture (Solorzano, 1997), whiteness and racial discrimination in medical care (Chin et al., 2007) and to self-advocate for better birth outcomes.

Conclusion

Research has suggested that childbirth and advocacy education during the prenatal period decreases the rate of maternal mortality (Taylor et al., 2019). Childbirth education today began from natural, family-centered, and relaxation centered curriculums such as Lamaze (Riedmann, 2008), Bradley method (Bradley Birth, 2020), and ICEA (ICEA, 2020). Childbirth education as studied in research may have an impact on increased confidence in birth and lower rates of preterm birth (Hetherington, 1990; Byrne et al., 2014). Advocacy education evolved throughout the 20th century from information for patients to collaborative care, policy change, and education programming for both patients and providers (Hoving et al., 2010). Advocacy education improves patient confidence in health care decisions and encourages patients to take action to improve birth outcomes in an informed way (McFarlane et al., 1998; Baffour et al., 2006).

Culturally competent education is important for Black students (Banks & Banks, 2007). CRT encourages educators to challenge the status quo of dominant culture and address racial inequities to empower Black voices in the commitment to social justice (Solarzano, 1997). In the structure of the intervention of this study, components of childbirth and advocacy education from established curriculums and the tenets of CRT were implemented. Althea Hurd and the practitioner researcher created new curriculum for Black pregnant participants of this study. The following chapter details the procedures and methods of the intervention.

Chapter 3

Methodology

Black women experience many obstacles when combatting the risk of maternal mortality. In the United States, Black women are almost four times more likely to die while giving birth than any other race (Center for Disease Control, 2017). Maternal death is defined as the death of a mother within 42-day period of giving birth of giving birth (Maternal Health Task Force, 2018). The factors associated with maternal mortality among Black women are racial discrimination, lack of access to quality health care, affordability of health care, and lack of reproductive education (Ronsmans et al., 2006).

Black women endure interpersonal racism throughout their lifetime in combination with systems that are racially oppressive, creating undue stress during pregnancy and birth (Nuru-Jeter et al., 2009). Research has shown that there is a racial disparity in medical care from treatment providers. In addition to the quality of health care providers, maternal health care becomes a costly expense to patients that limits the frequency of well care visits and choice of providers in low income areas (Morello-Frosch & Shenassa, 2006). Lack of education is sparse in highly populated minority areas, which reduces confidence in mothers to advocate for themselves in childbirth (Center for Reproductive Rights, 2014).

Research Questions

Due to the factors Black women experience associated with higher mortality rates than other races, there is a need for intervention and change. The purpose of the intervention was to deliver a course including childbirth and advocacy education to equip pregnant women with knowledge about their birth and their rights to advocate for themselves while giving birth in a hospital. This study highlighted the voices of pregnant women in South Dallas after they

attended a childbirth and advocacy education course. It was anticipated that participants would gain information and an improved ability to self-advocate. The research questions addressed in this study were as follows.

1. How do Black pregnant women in Dallas experience the childbirth and advocacy education course?
2. How do Black pregnant women in Dallas perceive their ability to self-advocate, if at all, during delivery after they attend a childbirth education class?
3. To what do Black women who self-advocated attribute how and why they advocated?
4. To what extent did the childbirth and advocacy education program contribute to their ability to advocate for themselves during childbirth?

Research Design

The design for this research was a single case study with embedded units (Baxter & Jack, 2008). Childbirth and advocacy education were evaluated in this study. To support the rationale for this study, the description by Yin (2003) (as cited in Baxter and Jack, 2008) article on qualitative case study design explained the importance of within and between units based on a medical case study.

> If you were interested in looking at the same issue, but now were intrigued by the different decisions made by women attending different clinics within one hospital, then a holistic case study with embedded units would enable the researcher to explore the case while considering the influence of the various clinics and associated attributes on the women's decision making. The ability to look at sub-units that are situated within a larger case is powerful when you consider that data can be analyzed *within* the subunits separately (within case analysis), *between* the

> different subunits (between case analysis), or *across* all of the subunits (cross-case analysis). The ability to engage in such rich analysis only serves to better illuminate the case. The pitfall that novice researchers fall into is that they analyze at the individual subunit level and fail to return to the global issue that they initially set out to address (Baxter & Jack, 2008, p. 550).

Thematic analysis was conducted after the data collection from the childbirth and advocacy course. The study examined the components of the intervention that participants viewed as valuable and the participants' level of confidence to advocate during birth for pregnant women who attended the course.

The objective of the study was to make a personal and social impact (Onwuegbuzie & Leech, 2006). Thus, to respond to the research questions, qualitative methods were most appropriate. The strength of qualitative research lay in evaluating participants' experiences as it related to the topic of research. Qualitative research provided an opportunity for establishing meaning from the data collected (Huberman, Miles, & Saldana, 2014). The interview questions asked what participants felt, if anything, was valuable in the course and to what extent they felt the education was helpful during their labor.

Context

In Texas, the maternal mortality rate has doubled from 17.0 to 35.8 deaths per 100,000 live births since 2000 (Dallas County Health and Human Services, 2016). Additionally, there are racial disparities in many systems in Dallas. Fair Park is a neighborhood in the heart of South Dallas, home to the nationally famous State Fair of Texas. However, Fair Park residents struggle economically, academically, and with access to quality health care (City of Dallas, 2018). Based on the data provided by the City of Dallas, approximately 35,000 people living in Fair Park,

11,000 households with a median 2.89 people per household. The median age of residents is 35. Out of the entire population in Fair Park, only 37% are employed. There is unequal racial representation within this area with 74.9% Black residents, 20.4% Hispanic, and less than 5.0% of the population White. The number of residents in Fair Park is small compared to other areas in Dallas (City of Dallas, 2018). The majority of residents have less than a high school diploma and per capita income is $10,466, which is below the federal poverty income of $12,499 per person (U.S. DHHS, 2019).

In addition to widespread poverty, the resources in Fair Park are scarce. Fair Park is a food desert, with only one major grocery store in the area (City of Dallas, 2018). Health outcomes are poor, with high rates of diabetes, cardiovascular disease, and obesity. Primary care medical facilities are located outside of the area in the suburbs and surrounding Dallas areas, and there are few low-cost and free clinics that are easily accessible with current transportation options. Inequities in transportation are a major factor in health outcomes (Syed et al., 2013). In 2011, 63% of visits to the emergency room could have been prevented with proper primary health care (City of Dallas, 2018). The majority of the population in the South Dallas neighborhood is uninsured or has Medicaid with limited choice of hospital and providers (Parkland Hospital, 2019). Exacerbating the general health care concerns, slow process times to receive insurance verification for coverage during obstetric visits, limited public transportation, and distance to the nearest labor and delivery room are a cause for concern for women in labor. Due to the factors that simultaneously impact birth outcomes and residents of Fair Park, this neighborhood was the chosen setting for the study.

A local non-profit organization, Abide Women's Health Services (Abide), is in the center of Fair Park. Because of the substantial economic, health care, and transportation disparities,

Abide exists for the purpose of providing free maternal health care services for expectant families in South Dallas (Abide Women's Health, 2019). The foundational goals of Abide are to (a) reduce maternal and infant mortality, (b) reduce pre-term birth, (c) reduce low-birth weight babies, and (d) increase breastfeeding rates of women in South Dallas. The organization provides free medical consultation, medical laboratory tests, and prenatal care from a licensed midwife and free childbirth education courses provided for the community. The intervention for the present study was delivered in partnership with Abide to provide childbirth and advocacy education to residents of Fair Park and the South Dallas area.

Program Plan

Each component of the intervention contains subcomponents derived from prior childbirth and advocacy curricula using evidence-based practices. The childbirth education was developed by Althea Hurd in 2019 and used with the purpose of educating other Black women to prevent maternal mortality in this Dallas community.

Prepping for Peace is a childbirth education curriculum developed in 2019 by Althea Hurd, certified childbirth educator and doula. This curriculum was designed for Black pregnant women and addressed components of labor and interventions during labor (i.e., C-section, epidural, Pitocin) that would more likely occur in a hospital. The Prepping for Peace childbirth education curriculum was delivered by Althea Hurd herself. The components of this curriculum are listed in the procedure section.

I created and delivered the advocacy education portion of the program. The sources used to create the education session were the American Hospital Association handbook (2018), the Birth Rights Bar Association (2020), and the *Black Birthing Bill of Rights* (National Association to Advance Black Birth, 2020). The components of the advocacy education are listed in the

procedure section.

Method

The following section outlines the method of the research study and intervention. This includes the research sample, components of the intervention, and data sources.

Research sample. The sampling method that aligns with the single case study research design was convenience sampling. It involved choosing individuals or groups of individuals that meet criteria for the purpose of the study and represent a sample of a larger population related to the research topic (Teddlie & Yu, 2007). Pregnant women in Dallas were invited to participate in a childbirth and advocacy education class through social media and word of mouth from birth workers in the community. The study included the recruitment of women who (a) self-identify as Black, (b) were pregnant at the time of the study, and (c) were willing to attend a childbirth and advocacy education course.

All the women who participated in the study were between the ages of 30 and 41. While the target population was pregnant women located in South Dallas, all the participants were located in the Dallas area, with one participant living in southern Dallas. All participants were college educated, partnered, and reported having strong support systems.

Sample size. In qualitative research, saturation of the data was important to capture the depth and breadth of the participants responses relative to the research questions (Mason, 2010). Kitzinger (1995) recommends six to eight participants in a focus group, and Morse (1994) suggests at least six participants for interviews. Because the interviews and focus groups time were short in length, it was hoped that a minimum of ten individuals participate in the study. I sought to have 50% of all participants volunteer to participate in postpartum interviews.

Data Sources

The data sources for the study were focus group interviews, postpartum interviews, and field notes. The interviews and notes collected information about the participants' experiences during the childbirth and advocacy education sessions. Data sources captured the participants perceptions of effective components of the intervention relative to their self-advocacy during childbirth. A research matrix of the data sources and the research questions is shown in Appendix A.

Focus group interviews. The purpose for focus group interviews in the study was to understand and collect information from the participants based on their experience in the childbirth and advocacy sessions. The questions for the focus group are designed to ask about the components of the intervention participants perceived as effective during the childbirth and advocacy education sessions. Questions are detailed in Appendix B. Groups were had between four and eight people to provide an atmosphere for collaborative discussion (Kitzinger, 1995). Examples of the focus group questions are found below.

1. Describe your experience of the childbirth and advocacy education sessions.
2. On a scale of 1-5, with 1 associated with the word unsure and 5 associated with the word confident, how did you feel before the childbirth and advocacy education course? What made you choose that number?

Postpartum interviews. Postpartum interviews took place approximately two weeks after the participant gave birth. The purpose for interviews in the study was to understand what they felt was effective from the childbirth and advocacy sessions and applied during their birth. Questions are detailed in Appendix C. Examples of the questions are provided below.

1. Tell me about your labor and postpartum experience.

2. Thinking back on your labor and postpartum in the hospital, what part of the childbirth education was most useful or effective for you?

Field notes. Field notes were taken during the childbirth and advocacy sessions to document the participants' comments and questions. In addition, I recorded personal reflections after the delivery of the advocacy session and after the conclusion of focus groups. These field notes were used to record observations of the participants' actions and reactions. For example, if participant engagement is low, I wrote down the particular section and participant behavior that indicated low engagement. These notes were used to triangulate data with the focus group and postpartum interviews.

Procedure

In January of 2020, a global pandemic from the Coronavirus (Covid-19) spread across the United States. The virus was able to be spread through interpersonal contact and breathing. This virus had a wide range of symptoms from mild illness to death (Center for Disease Control, 2020). Pregnant women and newborns were included in the list of potentially high-risk populations that were at risk for the virus.

In March of 2020, the number of cases of Coronavirus in the United was high enough and led to a state of emergency across the nation. The governor of Texas declared a statewide shutdown of nonessential businesses and facilities (Limon, 2020). The original date for the study in April 2020 was postponed and was delayed twice during the pandemic. To find an alternate date, an amendment was filed and approved with the Homewood IRB. The childbirth and advocacy education and the focus group were delivered virtually through Zoom. The following sections described participant recruitment, data collection, data analysis, the elements and steps of the advocacy education intervention, and post-session information as it was originally

intended. The details of the changes in procedure are discussed in chapter four.

Participant recruitment. Prior to recruitment that took place at Abide, I engaged the community of birth workers in South Dallas by informing them about the study. A flier was created (Appendix D) for them to distribute to their clients and other pregnant Black women in South Dallas to let them know about the study. My name, as the researcher, will be on the flier for the community birth workers to attest to my collaboration with many birth workers in the Dallas community. It was my hope that engaging the birth community would increase interested attendees to participate at the time of recruitment.

Before the childbirth education course begins, I introduced myself as a student researcher and stated the purpose of my study and why I needed participants from the class to attend a focus group (Appendix E). I distributed the informed consent via the participants' emails through Docusign (Appendix F). I read through the informed consent and stopped after every two sections to ask for any needed clarification. Once the entire informed consent is read, Althea Hurd and I took a short break to allow participants to sign the informed consent without coercion or pressure. I received the signed consent via email and noted who agreed to participate while Mrs. Hurd began the childbirth education course. Participants automatically were given a copy of their signed document from Docusign.

Data collection. I collected data in the role as an insider participant (Labaree, 2002). Data were collected through field notes during the delivery of the childbirth and advocacy education sessions. During the sessions, I encouraged participants to place their questions in the chat box provided on Zoom. I recorded the questions asked in the chat box and wrote observations of participants once questions Mrs. Hurd and I answered.

Mrs. Hurd and I thanked the participants for attending the class and announced that the

educational portion of the class ended. We reminded participants in the course about the purpose of the focus group and invited those who have agreed to attend to join. Focus group and postpartum interviews were recorded and transcribed after each of the events.

Data analysis. I used thematic analysis to organize data according to patterns and themes (Clarke & Braun, 2013). I created codes from direct quotes from the transcripts of the focus groups and the postpartum interviews to make meaning across multiple data sets (Clarke & Braun, 2013). I used a six-step deductive coding approach as described by Clarke and Braun (2013) to analyze the data.

The data from the field notes, focus groups, and postpartum interviews were reviewed multiple times. I began to identify initial codes and potential themes looking for patterns from the literature that could emerge. I explored the data to look for a priori themes and validated the themes, looking for consistency to prevent bias in coding. I re-read the codes and themes that emerged and created a code book. From the code book, I looked for clusters of codes and themes that appeared in the data. I listed, defined, and described main themes to create a code book with an example from the data (see Appendix J). The purpose was to convey the consistent patterns that emerged as a part of that theme. In the final step, after the data were reviewed thoroughly and codes and themes were established and defined, I wrote the data analysis report reflecting the findings.

Intervention and post-session procedures. Participants logged into Zoom with the given link from the recruitment fliers. Before the childbirth and advocacy education course began, Mrs. Hurd and I introduced ourselves and stated our credentials to establish rapport and credibility. Participants attending the childbirth education class were notified that this course was part of a study about the effectiveness of childbirth and advocacy education for pregnant women

in Dallas. Participation in the advocacy session was completely optional and did not have an impact on the services available to them the day of the study or in the future.

I read the informed consent script to the participants before the childbirth session. Participants were informed of the role of the researcher as an observer during the class. I told participants that there was a focus group at the conclusion of the course and participants would be contacted for a postpartum phone interview two weeks after they gave birth. Participants were told that the focus group data would be audio recorded. Participants had the option of choosing a pseudonym to be used in the transcribed documents. I informed participants that attending the childbirth class did not mean there was an obligation to take part in the focus group, and those who agreed to participate in the group after the class did not have to participate in the postpartum phone interview. I sent each participant the informed consent documents via their email through Docusign.

Childbirth education. The childbirth educator, Althea Hurd, delivered the childbirth education curriculum she created and has previously presented at Abide. She stated the objectives before each component was discussed in detail. All activities and information were explained as outlined from the childbirth education curriculum (Appendix G). Multiple interactive techniques were used within each hour of the course and outlined in the description of the childbirth education (Appendix G).

During the childbirth education, I displayed Mrs. Hurd's PowerPoint presentation on my Zoom screen while she used her screen to show her visual aids that were described in Appendix G. Two-minute breaks were given every hour to allow the pregnant participants breaks to take care of their basic needs without missing any content. During the presentation, I took field notes on participant reactions, inaction, and those that stepped away or turned off their screens during

the education session. The participants used the chat box on Zoom to ask questions. After the childbirth education, a longer five-minute break was given for the participants to take the time they needed to prepare for the advocacy education.

The childbirth education included four components that were completed in 2 hours. The first component was the signs of labor. This component addressed physical signs and symptoms of early labor beginning at 37 weeks of pregnancy. The second component was stages of labor that included what to expect and typical physical changes and transitions from the beginning stages of labor through birth. The third section discussed labor interventions that could occur in a hospital setting and what each intervention procedure entails as well as the tools used. The labor intervention component was interactive including physical models for education and a video demonstrating each of the interventions. The fourth component addressed was the birth plan. Participants of the childbirth education course interacted through discussion about their personal wishes for their birth plan and the interventions (i.e. c-section, epidural, etc.) they would like to have during their labor and birth. Mrs. Hurd gave an overview of the four components addressed in the childbirth education to participants. At the end of the childbirth education session, participants were given a short break before the advocacy session of the education course began.

Advocacy education. The advocacy education section of the class lasted approximately 1 hour. I started the session by stating the objectives of the session, which included (a) understanding the importance of advocacy during childbirth, (b) using knowledge of patient rights to self-advocate with providers, (c) using support systems to aid in advocacy, and (d) what to say and do if they experience a violation (Appendix H). I defined advocacy and what it means in regard to the health care system and shared graphics of patient right examples. Next, I displayed the Birth Rights Bar Association's (2020) patient rights and responsibilities brochure

to participants through screen sharing. I discussed and explain the key rights of patients and defined each within a hospital setting. We discussed patient rights, and participants asked questions through the Zoom chat box. After the question and answer part on patient rights and responsibilities, I started an open discussion with participants about who they will include as their support system during labor and what they need from their support system pertaining to advocacy. I shared possible patient scenarios such as emergencies, health care provider attitude and demeanor, support when the patient feels pressured to make a quick decision, and how patients ask for support and uphold their rights. I shared phrases and statements from the Birth Rights Bar Association (2020) manual that participants could use to advocate for themselves or say if they experience a violation. I gave the participants affirmations in the form of electronic, printable cards that included a list of statements to use with providers that affirm they know their right to make decisions in their care and rights of refusal. They were encouraged to bring the affirmations with them to the hospital.

Post-session. The focus group began after the completion of the education and advocacy course. Participants were asked if they would like to choose a pseudonym to use during the focus group and postpartum interviews. I reiterated the purpose of the research for elevating Black women's voices to encourage group discussion and participation. Mrs. Hurd attended the focus group to be a trusted voice.

Before the focus group questions were asked, I discussed the protocol for the focus group according to Stewart and Shamdasani (2014). Participants were asked to raise their hand if they would like to speak, including responding to another participant's comment. I reminded participants that there are no incorrect ways to respond and their experiences and feelings were valid and personal to them regardless of differing opinions. Following the protocol discussion, I

asked the primary questions (Appendix B) and asked follow-up questions if needed for clarification. Answers were recorded using participants' chosen pseudonyms. When the focus group came to an end, I asked for reaffirmation that participants were willing to be contacted for postpartum interviews. I asked for contact information and the estimated due dates of those willing to take part in the interviews. Participants were made aware that the postpartum interview questions would be similar to the focus group. I reminded the participants of the phone number I would call from and encouraged them to write the number down. The purpose of this request was to increase the likelihood of participants answering the phone at the time of the interview and for them to recognize the phone number that is calling. I thanked them for their time.

Postpartum contact. Each participant who signed the informed consent and reaffirmed after the focus group their willingness to participate was contacted by phone 2 weeks after their estimated due date. I used a consent script (Appendix I) to re-identify myself and ask the participant if they were still willing to participate in a postpartum interview. If the participant agreed, I asked the questions about their confidence to self-advocate during their birthing experience and what impact the course might have had (Appendix C). The duration of the interview was 10 to 20 minutes.

Trustworthiness

The purpose of establishing trustworthiness is the interpreting of data in an accurate way to ensure that the data measures the constructs and aligns with the research questions of the study (Tedlie & Yu, 2007). Trustworthiness was addressed by Guba (1981) in four ways: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability. I implemented suggestions from the research of Krefting (1991) to address each of the components.

Credibility. Credibility is defined as the confidence of the researcher to ensure truth in

the results of the study (Krefting, 1991). To establish credibility, the participant researcher used triangulation. Triangulation is a method utilizing multiple data sources to verify what participants say during the study (Onwuegbuzie & Leech, 2006). Qualitative coding was reported in themes established through research literature. I used member checking during the postpartum interviews. I used quotes from the transcription of the focus groups and asked the participants to expand on their statements and discuss any inconsistencies or changes. All three components, the focus groups, postpartum interviews, and field notes, were used as part of triangulation to compare and identify discrepancies and gaps among the data (Onwuegbuzie & Leech, 2006).

Transferability. Transferability is defined as the ability to apply the results of the sample size to the larger population (Krefting, 1991). To ensure transferability, I evaluated the focus groups transcripts, interview data, and field notes, to establish that the behavior was typical of the participants (Krefting, 1991). Comparison to research literature was needed to evaluate the sample to the typical behavior of the population as it related to pregnant women and a childbirth education and advocacy course. I used this method to report findings that can be transferred to populations similar to pregnant women in Dallas. For example, I connected quotes from a theme that emerged from the research literature. One theme about advocacy education was to empower patients to prioritize their desires in birth. I used the BRBA's birth rights about refusing treatment from a provider. Kiah said, "But if I can learn to speak up for myself then I feel like I've done right, and I've made the right step" (p. 70). This is one example of transferability.

Dependability. Dependability is consistency in the research results if the study were replicated again (Guba, 1981). Through the use of peer examination, the principal investigator oversaw and checked my research plan and implementation. This method allowed me to have additional peer review.

Confirmability. Confirmability or neutrality is defined as the researcher's distance from the study and ability to limit bias when collecting data and conducting the study (Krefting, 1991). One of the primary strategies mentioned by Guba (1981) in the process of trustworthiness was a research audit. This involved the review of multiple data collected in the study. The principle investigator in this study audited the field notes and observations noted, recordings of the focus group, post-partum interviews, and thematic categories at the conclusion of the data collection in order to confirm the data that were recorded and analyzed and looked for any changes and mistakes that needed to be addressed.

Researcher Subjectivity

The subject of this research was guided by my professional interest and connection to maternal health and mortality for Black women. A statement of potential bias was necessary for this study (Labaree, 2002). Since the time of the study, I have been a mental health therapist who focuses on providing emotional support for prenatal and postpartum women. I have knowledge and training of the components of childbirth education and labor interventions as well as patient rights in a hospital setting. I began this work from my own experience with postpartum depression and the struggles I faced having access to maternal health care outside of labor and delivery.

Additionally, I am of White and Black racial identity. My mom is a Black woman who experienced two difficult births and extensive racial discrimination in her life. My mother grew up in the racially segregated South near the end of the Jim Crow era. She was a nurse at the hospital where she gave birth and worked closely with the doctor who delivered her child. However, through time, my mother was the exception among many Black women. After I gave birth to my daughter, I began to take a deep interest in the physical and emotional toll of birth on

marginalized populations and learned about the maternal mortality rates in the United States as compared to other parts of the world. As a result, my professional practice shifted to creating accessibility to therapy for marginalized populations. I also volunteered with a non-profit organization in Dallas that worked to reduce implicit bias for marginalized populations. The transparency of my subjectivity to my own research is crucial. However, the professional experience and knowledge of the topic of the study aided in relating to the participants and understanding the themes that emerged from the focus groups and postpartum interviews.

Research literature addressed concerns about White-presenting (i.e. looks White but is of a mixed ethnicity) researchers interviewing and conducting cross-cultural research (Mio & Iwamasa, 1993). Experiences of stereotyping, racism, and condescension that minority women face create barriers for willingness to participate in research (Edwards, 1990). I recognize that, because I look White, there was a potential distrust between participants and myself as a researcher (Earl & Penney, 2001). This was due to the history of White researchers experimenting on Black women without consent (Roberts, 1996). Partnering with Mrs. Hurd as a Black educator as part of the intervention may have aided in participants willingness to stay for the advocacy session and focus group that I conducted.

I knew that it was important for me to establish rapport with participants. Engaging the community of Black birth workers that was able to speak to my character and my position as a birth worker in the community fostered a context in which people wanted to participate in the study. I wanted to establish trust during my advocacy session and explain why this subject and this study were personally important to me. In addition to rapport building, changing the wording of questions, establishing a comfortable relationship before the interview, and partnering with women of color were important components to enhance participation and quality of the

participants' responses to the questions (Few, Stephens, & Rouse-Arnett, 2003).

Limitations and Considerations

This section identifies potential barriers of the study. Limitations are conditions outside of the study that may affect the outcome of the research. The goal of the research was transferability to find application in adjacent or similar contexts.

Postpartum schedule. The most concerning limitation for the practitioner researcher was the availability of participants to be interviewed while they took care of their newborn child. The first few weeks with a newborn can be difficult including adjustment to lack of sleep, physical healing for the mother after birth, family visits, and trips to the pediatrician (Jana & Shu, 2015). These factors could have hindered the participant's time and willingness to answer further questions about research. The practitioner researcher called the participants 2 weeks postpartum and reminded them of the research purpose. I asked if they were willing to still participate. The researcher asked if the participant would prefer to be called at a later time in consideration their newborn's schedule. The questions were limited to a 10 to 20-minute period.

Chapter 4

Findings and Discussion

This study included a pre-delivery focus group interviews and postpartum individual interviews of Black pregnant women in Dallas who attend a childbirth and advocacy course. Three months before the study, COVID-19 began. This virus caused a global pandemic that significantly impacted high risk populations including pregnant women and infants (Center for Disease Control, 2020). The education and advocacy course and the focus group interviews occurred in an online format on Zoom for the safety of participants, Althea Hurd, and me.

Findings

In this study, I explored the experience of a childbirth and advocacy course and its effect on self-advocacy perceptions and how to self-advocate. Through the data from the two focus groups and the three postpartum phone interviews, several themes emerged around the key components of the course. From the focus group interviews, the themes of knowledge and empowerment emerged from the focus group. Knowledge of childbirth can lead to confidence about giving birth, and advocacy education can empower participants to prioritize their desires in birth over blind trust in their providers. In addition, confidence in self-advocacy is developed when patients learn their rights and have a support team. From the postpartum interviews, four themes emerged: (a) I voiced changes to my plan as I needed the plan to change,\; (b) I repeated my needs to all providers to be heard; (c) my support team spoke for me when it was difficult to speak in labor; and (d) I reminded myself I have the right to have the birth I want to have. These themes are detailed by the participant narratives in the following paragraphs.

Coding

The Saldana (2013) process of qualitative analysis to code and create categories led to the

themes. The transcribed data from the two focus group discussions was consolidated for each question so that I could look for consistent patterns and trends across all participants in the dialogue. I read line by line and created a code for each set of dialogue. A priori coding, codes established before the data were collected, are based on the literature. Examples of a priori coding include patient-provider relationship (Saha et al., 2003) and birth plan (Nolan, 1997). I used the a priori and emergent codes in the transcripts and highlighted patterns in different colors. After looking at the clusters of similar codes, I created categories of codes. I evaluated the categories and combined similar categories to label the theme that best described the combination of category. A codebook was developed (see Table 1). The creation of the codebook serves the purpose of organizing quotes according to their codes and seeing what themes are most prominent in the data. Following is data to support the developed themes and address the research questions.

Table 1

Data Analysis of Sample Codes, Examples, and Themes

Code	Quote	Theme
Provider Relationship	"I am trusting that this is their profession and they know what they're doing and they're going to have my best interests in mind."	Desires and Wishes Prioritized over Blind Provider Trust
Provider Listening to Patient	"And she's challenging my request, like, you know, I just changed my mind. I have the prerogative to do that."	Kept repeating needs to be heard
Birth Plan	"Just having a birth plan, you want to have a plan A, B, and C, and I had talked about this thoroughly with the midwife,…"	Changed Birth Plan When needed to change
Birth Plan	"…so this is going to help me create my birth plan where it's more of my choices, my decisions for my body"	Knowledge of Childbirth Increased Confidence in Birth

Participant Experience of the Childbirth and Advocacy Education Course. During the focus group, participants were asked to share their experiences during the course. I asked questions about the participants' experiences and what was effective and least effective (Appendix B). I also asked participants to express how the course impacted their knowledge of childbirth and postpartum. From their responses, two themes surfaced.

***Knowledge of childbirth can lead to confidence to give birth*.** Participants expressed that the course gave them knowledge about stages of labor, pain management, and birth. During the course, Mrs. Hurd discussed the types of interventions in labor such as epidural, magnesium, and Pitocin. She spoke to participants about the types of interventions that can lead to a C-section, which can involve a long post birth recovery period. Kiah, who was pregnant in her second trimester of pregnancy, talked about her experience learning about the types of interventions explained by Mrs. Hurd.

> I've taken other childbirth classes before, and I would say that I don't think I've had anyone break down the interventions in a way that she did before. And so I really appreciate it. Just like, here's what this is and the benefits and risk; and these are the different pain management techniques that they're going to do. I felt like that was probably like the most helpful part for me, was getting a better understanding of like what each one is and the benefits and risk of each (Kiah, focus group, July 18, 2020).

Several participants expressed similar sentiments about the knowledge of the stages and phases of labor as helpful. Ashley said the specific knowledge of the stages of labor helped her differentiate between reality and the panic that is displayed in movies and television. Carla, a second time mother in her third trimester, stated that the visual of length and duration of

contractions helped refreshed her memory about the stages of labor.

> With my first, I just kind of relied on everyone around me to know what they were doing, to tell me that I was in labor, and I needed to go to the hospital; but now, I feel I feel more power in knowing what I should be looking for in terms of like, just the contractions (Carla, focus group, July 17, 2020).

Participants also expressed the desire to use this knowledge to create a plan for their birth. Felicia, a first-time mother in her third trimester of pregnancy, discussed confidence in making decisions for her birth from the course.

> In my plan, I've included some of the topics we talked about; but then, knowing more about like for narcotic pain management, knowing more about that, and when I can have that, gave me more information to make, to really think about my decision to make a more informed decision. So I think everything we've talked about as kind of giving me a deeper understanding and knowledge about some of the things I'm going to face in delivery that I may want to revisit and maybe re-evaluate my plan or either; you know, solidify some of the things that I had in place already (Felicia, focus group, July 18, 2020).

Participants' experience of the childbirth course was helpful with the addition of visuals and charts that described the specifics of labor and interventions during birth. From this knowledge, participants expressed the desire to implement the knowledge into their preparation for birth with their support systems.

Advocacy education can empower patients to prioritize their desires in birth over blind trust in their providers. The second theme that emerged from participants' experiences after the childbirth and advocacy course came from the participants' new understanding of patient rights.

During the advocacy session, I spoke to participants about the right to refuse treatment from a provider, the right to change providers, and the right to change birth plans. I also discussed a patient's right to ask for increased time to make informed decisions based on the perceived risks and benefits of each intervention.

Carla expressed that she did not know she could change her birth plan even after talking with her provider about a specific plan.

> But I just, whenever I'm paying anyone for a service, I'm assuming; and I'm trusting that they are, give, they are giving me the best that they can give me and that they're providing me with, you know, their best. And I don't necessarily question anything that's happening because I am trusting that this is their profession and they know what they're doing and they're going to have my best interests in mind. So hearing the advocacy piece of it was really eye opening because I realized that's not necessarily the case always. And so it's important to have these tools. You know that you have the right to say, wait a minute, this is not right (Carla, focus group, July 17, 2020).

In the advocacy education course, I talked about the right to change providers and question provider choices when patients feel their rights are being violated. Crystal recognized her need to ask more questions.

> I mean, I've always felt comfortable speaking up for myself regarding what I want, you know, but sometimes, you know, maybe I don't ask more questions, right. I'm like, you know, to dig a little deeper, you know, don't be quick to make a decision. Take a minute to think about it. You know, when I just think about my previous pregnancy. When offered with it when I was presented with the option to

> induce at 39 weeks. You know, I just thought about having a baby. I didn't ask, okay, what are the risk associated with it. I think that the advocacy portion has helped me to say okay just take a minute. Don't be quick to make a decision (Crystal, focus group, July 18, 2020).

In the course, I talked about the right to refuse treatment. The BRBA's (2020) list of patient rights includes the right to change providers and the right to refuse surgery or medical treatment. Although doctors are obligated to do no harm and treat patients if they are in need of medical care, the patient does not have to accept the medical treatment (Birth Rights Bar Association, 2020). Participants consistently commented they needed to trust themselves and the process of birth and asking more questions of their providers. Kiah discussed.

> I feel like that part, like the advocacy part, was very empowering to say this is the stuff you need to be looking into. These are the words you need to be saying like these are your legal rights. So that part to me definitely felt like was the most important part. I do like knowing the stages of labor and the interventions. That's very helpful. But if I can learn to speak up for myself and not just to, like, not to assume that the doctors, whatever the doctor say is law, then I feel like I've done right. I've made the right step. I've gained the knowledge that I need to do in order to, like, move forward and trust my body to do what it needs to do (Kiah, Focus Group, July 18, 2020).

De'Aundria, in her second trimester of pregnancy, talked about learning in the workshop that she could refuse treatment from the provider. She detailed that her mother and her five aunts all gave birth through Cesarean section (C-section). She went on to explain that her mother and aunts all expressed the suspicion that the C-section was not necessary in all their births but felt

the providers were often in a rush to prioritize their needs.

> My mother gave birth to me via C section. She talked about my story, and I don't think it was necessary. I just think my mom did tell me the doctor was tired; he wanted to go home. And she was not progressing as fast as he wanted her to be. So she said after like 20 something hours she had a C-section; but now, looking at this late stages of labor, it's like 20 hours is really not a long time for a first time mom. She didn't have any preeclampsia. Nothing. The doctor was just like, okay, you know, you pushed long enough (De'Aundria, focus group, July 18, 2020).

As she was telling the story, the other participants were nodding their heads in agreement. At several points during each of the focus groups, the conversation shifted to maternal mortality. De'Aundria stated, "Coming into this, I was very apprehensive about the situation and learning about birth because I only heard trauma stories. So I know that should not be the norm for Black women even though it has been."

Ashley is a first-time mom, pregnant in her second trimester, talked about her concerns when she found out she was pregnant.

> Two of my main concerns when I found out I was pregnant was the mortality rate of women of color, specifically Black women dying, you know, after giving birth to their children, and the concerns with the current state that we're in, in this pandemic. I did not want to be in a position where I didn't have anyone there for me to be able to advocate for me especially becoming pregnant in the middle of all this going on that I would have to have my first baby alone. And I think that that was reiterated in this presentation that, you know, having a support system is key to giving to having a more successful, stress free birth (Ashley, focus group,

July 17, 2020).

Participants, regardless whether they commented or not, nodded in agreement when others expressed their fears about dying in childbirth or having providers that do not look like them. De'Aundria changed providers after feeling uncomfortable.

> I've already switched OBs early on because I didn't feel comfortable and I don't want to be labeled as somebody that's difficult; but knowing, like, I can be informed; and it really is much better than someone who's just going through the process and just allowing it to happen. I didn't know that I don't have to allow certain things to happen, so this is going to help me create my birth plan where it's more of my choices, my decisions for my body (De'Aundria, focus group, July 18, 2020).

Participants talked about the important need to advocate for themselves instead of trusting providers without asking questions. Crystal statements summed it up at the end of the focus group.

> The more and more you educate yourself, it's empowering; and you just really have to invest that time. I'm excited about what you all are doing to, you know, educate more Black women because we don't know. I've definitely walked away with some tools to help me to get the birth that I want and to know that we can't control everything, but we have a say (Crystal, focus group, July 18, 2020).

Advocacy education reminded participants to talk to providers, to ask questions, and to know their birth is their choice. Even though some participants changed providers or have the birth team they feel confident in, all of the participants commented or agreed to self-advocate when they do not feel their provider is acting in their best interest.

Participant Perceptions About Self-Advocating. The impact of knowing patient rights and the creation of a birth support team emerged as themes pertaining to self-advocacy. The first theme, knowing patient rights, can increases confidence for self-advocacy and increased knowledge about rights and health education can increase collaborative involvement in patient care (Baffour et al., 2006). In addition, the positive correlation of community and better birth outcomes seen in research literature (Collins et al., 1993: McFarlane et al., 1998; Baffour, 2006) supported the second theme about the importance of support systems.

Learning patient rights can increase confidence for self-advocacy. In the beginning of the advocacy education session, I talked about patient rights in pregnancy and birth. I also explained phrases to use if a violation of these rights occurred. Kiah expressed the importance of knowing rights to combat maternal mortality.

> I think I've said this before but definitely walking through the ways to advocate for yourself in the Bill of Rights. I definitely did a Facebook post in the middle of a session and called out to all the moms. I know saying, like, we need to be talking about this, like we need to know our Bill of Rights. I hear a lot about like the Black maternal death rates and the research that's coming out and it's scary. It's scary to think about because then at this point, you're like, oh, what do I do. Like, I don't know what I can do (Kiah, focus group, July 18, 2020).

Kiah went on to talk about the power of legal rights so that patients know how to affirm that providers hear them and are following protocol. She states, "But I feel like that part, like the advocacy part, was very empowering to say: this is the stuff you need to be looking into like this; these are the words you need to be saying like these are your

legal rights."

De'Aundria, drawing from her family experiences and her concern for other pregnant family members, stated that there is a lack of widespread advocacy education. For her, it was important to talk to others as she was experiencing the education session.

> For me, this is a steppingstone for me to go and learn more. And as I learned more, like, I'm texting my cousin, like, hey, you need to be in this class. We got to figure out how to get you this class in Alabama. Because they're not doing this for women who look like us. I mean, you hear about maternal mortality, but you don't hear about the resources, and I feel like it should be mandated by doctors or legislation. This is a crisis. So when you're in a crisis, how do you respond? You respond by education, you respond by putting tools and resources at a problem. We were blessed and privileged enough to sit in this class today, but we all know someone else who could benefit from having an advocate or professional. So this is very much needed (De'Aundria, focus group, July 18, 2020).

As Kiah and De'Aundria were verbalizing their thoughts, the rest of the participants were nodding their heads in agreement. Participants in the course reiterated their appreciation for this course but indicated this course is needed for more Black pregnant women to change birth outcomes. The topic of maternal mortality and patient rights was a central topic in the advocacy education course and focus group discussion.

A support team can help with advocacy. A birth team and community support can be invaluable for birth outcomes (Morton & Clift, 2014). In this study, I discussed the importance of communicating the patient's wishes, desires, and needs to their support team. The team can then relay the patient's wishes when labor becomes difficult and hard

for the pregnant woman to speak for herself. Felicia discussed how she built on her prior knowledge of advocacy to allow her team to face the difficult aspects of birth.

> I'm a nurse as well. However, I don't work with laboring moms. I don't work with kids. This is my first baby. So I do have some learning curve with giving birth and being pregnant. I do understand the advocacy part of it because, as a nurse, we are supposed to be advocates for our patients. I don't have a problem speaking up for myself. But then, at the time when I'm laboring, I don't know what kind of a mind frame I'm going to be in. My husband has a good understanding of what I want, what I don't want. He has been very good about, okay, let's take a beat, talk about it, give us some time to think about it, what are our options. So he's been given how to initiate those types of may be difficult conversations we may face (Felicia, focus group, July 18, 2020).

The part of the training regarding support and birth teams encouraged Crystal to start planning how her team can support her.

> When we talked about having your team and making sure that you have your team in place, and I do have a team in place, you know. But for them to understand their roles in what I need from each of them, that is something that I have not clearly defined. What is it that I'm wanting from my mom and how do I want her to support me in the postpartum period. What is it that I need my husband to do. So I think that will definitely decrease some of the stress (Crystal, focus group, July 18, 2020)

Many of the participants had heard about this course from their doula. Out of the six participants, five had the same doula, Yvette Akins, who was hired to attend and support them in

birth. Yvette has encouraged and helped two of the participants, De'Aundria and Crystal to change providers because they continued to not feel comfortable with the level of care they received. De'Aundria planned to communicate her advocacy needs to her doula before birth.

> I'm about 15 weeks, so I haven't started to make a birth plan. But hearing some of the things like hearing my rights, hearing how I can advocate for myself, it's going to help me to have the conversation with my husband and have the conversation with my doula too so that they understand these are the things that I wish to do. And these are the things that I wish not to do; so when you see people, you know, reminding me like, hey, you have an option for epidural. You know, like keep bringing certain things up for them to be able to step in and be my advocates (De'Aundria, focus group, July 18, 2020).

During the advocacy education course, I talked with participants about defining what they consider to be a violation from a provider or a medical attendant at their birth. Examples of violation included but weren't limited to a provider not asking consent to do a cervical check, shaming language as a patient declines a medical intervention, and minimizing health concerns that patients bring to the provider's attention. I also talked with the group about words and phrases to consider using or having their birth team advocates to use if a violation occurs. These phrases can include, "I need more time;" "What are the risks and benefits?" "I need you to hear what I'm saying;"and "I am saying no, but are you hearing me say no?" In the focus group, Kiah echoed a similar comment as De'Aundria and discussed what she needed from her birth team.

> I would say I'm going back and talking to my support team about what their roles are in like walking them through, like the bill, like the patient Bill of Rights. I think especially my husband. I just think there's a lot of people that are just so

> kind of ingrained in this whatever the doctor says goes and then that's it. I think, to go back and just have that conversation with them about like these. Oh, this is what I'm going to say; and this is what I expect you to say and support me with that as well. I feel like that's my next step, is to read through the documents and have a sit-down meeting. This is like another part of my birth plan I guess that I didn't think about. It's like just getting everybody on the same page about what I want my needs and my rights and what that looks like to advocate in that setting (De'Aundria, focus group, July 18, 2020).

Participant Reflections on Self-Advocacy. I conducted individual interviews with three participants postpartum who had attended the education session and participated in a focus group. Each woman detailed their birth and talked about their labor experience as they remembered. I asked several questions about how and why they advocated during their birth. Two themes emerged from the interviews. The first theme was the need to be heard by the provider and the nurses to make sure their needs were met. The second theme related to the importance of a support team speaking for them when they could not speak during labor.

It is valuable to continually self-advocate to ensure being heard. For each participant, making sure each provider knew what they wanted and supported them was an important component during labor and birth. For Crystal, talking to her provider about her plans and backup plans before and during her birth was vital to her comfort.

> One of the midwives, she's great. She asked me how that makes me feel, you know? 'How does that make you feel starting Pitocin? Does that scare you?' And I'm like, no, it doesn't scare me. You know, the thing that I don't want to be on Pitocin for a long period of time. Let's chop it for 12 hours and see if I progress.

> But if I'm not progressing, then let's stop it. And let's go ahead and do a C-section. You know, that's what I told her. That's what I wanted because I don't want, I just don't want the outcome that I had before. And so we were good with that. And then, as we started the Pitocin. You know, if I, there was, there was time where, okay, like we needed to increase it. I'm like, okay, well, I should wait a little bit. It's 30 minutes, and I'm contracting well, on the current dose, you know, this is the nurse that's working with me then. Then, let's not increase (Crystal, interview, September 21, 2020).

Carla had a similar experience expressing what she wanted. Her providers were supportive of what she asked at each stage of labor. She talked about advocating for the first time.

> I felt really confident. Well, I felt a little nervous at first. I was like, I don't know. Like my first whatever little request, I can't even remember what it was to be honest. And they jumped on board right away. It gave me a lot more confidence. So I was a little bit nervous; but then I gained a lot more confidence (Carla, interview, August 12, 2020).

Felicia's experience, however, was not as ideal. Both before and during birth, she remembers having to continuously state what she wanted. Her doctor strongly urged her to be induced, but Felicia wanted to wait.

> It (the course) validated the things that I was asking my provider like, you know, what are the risks? What are the benefits? Like, really, what is the actual risk of me going past 40 weeks because that was the thing. My OB (obstetrician), because I really wanted to give my body and my baby a chance to come on his own and for my body to let me know that my body was ready. Because, you

> know, I felt confident in my health in my body that I'll be healthy enough to continue to go a little past (Felicia, interview, September 21, 2020).

She later follows up about her hindsight with her provider saying, "So I was really trying to just give her (my obstetrician) a chance. And I feel, I feel, I feel disappointed. I feel disappointed. So I really I kind of wish that I would have really researched and looked into having a midwife" (Felicia, interview, September 21, 2020).

Another instance occurred during birth when Felicia had to advocate with the nurse assigned to her. She changed her mind about an epidural and experienced push back from the nurse, explaining that her wishes had changed.

> And we did kind of have an issue with that, with one of the nurses, because when I asked for the epidural, she kind of gave me pushback about you know, can I ask you why you don't want an unmedicated birth? You know, I [the nurse] was assigned to you because, you know, you said you didn't want no medication. And at this point, I [Felicia] still haven't had my epidural. So my pain is like over a 10 out of 10. And she's challenging my request, like, you know, I just changed my mind. I have the prerogative to do that (Felicia, interview, September 21, 2020).

A support team can help communicate patient wishes during labor. Each participant talked about having a supportive spouse during birth. Carla's husband asked questions to keep abreast of what was going on at each stage. She said, "He was really, really great. He was actually asking a lot of questions to them, you know. They respected his wishes, and they respected his request just as much as they respect him, so he was great" (Carla, interview, DATE). She went on to talk about her postpartum experience in the hospital. She expressed that the nurses were not as attentive as the nurses during labor and she was not given food for a long

time after she gave birth. Her husband advocated for her needs.

> The postpartum area was definitely different than labor and delivery. Nurses were not as attentive. I didn't have, like, any food until, five o'clock that afternoon and I hadn't eaten since two o'clock that morning. It was okay for a little bit I guess. My husband was telling them, anyone who walked in the room at that time, 'Hey my wife needs to eat'. He was able to use his voice to help my voice (Carla, interview, August, 12, 2020).

Felicia's husband supported her when the nurse questioned her decision to get an epidural. While she experienced resistance from the doctor, her husband stepped in.

> My husband basically told her (the doctor), that's what we want to do. We changed our mind, that's what we want to do. Like, we don't really owe you an explanation. Hmm. Right. So he basically stood up and was that's what we want. So I thought that was a little inconsiderate and inappropriate. Um, but yeah, I think that the advocacy part of it, knowing my husband, you know, being comfortable speaking up in the safe place with my team (Felicia, interview, September 21, 2020).

He supported her in all her choices and needs. They kept constant communication during her birth. She talked about his role throughout her birth.

> He basically spoke for me and for us and our baby. He backed me up if I made a decision or said something. And if I was kind of, you know, either unsure, or maybe I just wasn't in the right frame of mind to answer a question or, you know, give a decision. We had already probably talked about it, and so he was able to speak up for me during that time (Felicia, interview, September 21, 2020).

Crystal did not feel that anyone had to speak for her, but she relied on her team before her birth to go through the plan and be encouraged to speak for herself. Her doula played a part in reassuring her ability to say what she wanted and needed.

> I had talked to Yve about the Pitocin and like the increased demand. And, and she was like, 'Yeah, that's reasonable.' And, you know, we can talk to the nurses about that. I mean, that's, you know; so she didn't think that that was unreasonable for me to be, you know, asking about that (Crystal, interview, September 23, 2020).

All three participants relied on their support team in at least one instance before or during birth. Although Carla and Felicia's husbands stepped in to speak for them during times when they were in pain or early postpartum and providers to acted swiftly to give care.

Participant Experience in Advocating. When analyzing how the advocacy education course impacted participants' ability to self-advocate, another major theme emerged. All the participants who were interviewed indicated that among the knowledge delivered was the repeated message to change the plan when they needed to change the plan. The singular theme came from the interviews as the affirmations to listen to their body and to speak up. The following narrative supports this theme.

***Confidence in voicing changes to a birth plan can lead to personalized choice in birth*.** In the interviews, each participant talked about an aspect of their birth experience that was different than their original plan. Crystal's her original birth plan with no medical or medicinal intervention changed plan did change from her original birth plan with no medical or medicinal intervention. She explained that she was prepared with her alternative plans, which allowed her

to be adaptable when she needed Pitocin to speed up her labor.

> Just having a birth plan, you want to have a plan A, B, and C, and I had talked about this thoroughly with the midwife. We already had a plan, like, okay, the goal is for a vaginal birth after cesarean (VBAC). But then by the 21st of the month, if I haven't gone into labor, and let's try foley bulb induction. If my cervix is favorable, let's do Pitocin. So it was like we had already had a plan, and I want to be on it for 12 hours. Then if that didn't work, we proceed with the C-Section because I did not want the outcome that I had before (Crystal, interview, September 23, 2020).

Carla's plan also changed. Although she had an induction scheduled, she decided to wait for her epidural. She described what she found helpful saying, "Just knowing that I had a right to say, or that I had the power to say, I need a minute to think about that or I've changed my mind." In her experience her providers listened and followed the changes to the plan. She stated, "It was really nice that when I did say that the nurses were like, 'Okay, well, let's do it.' And they were ready to be great, you know, whatever I needed them to be."

Felicia's birth plan occurred differently as planned. She realized she wanted more pain management than she originally anticipated, but she ultimately was happy getting an epidural to take care of her needs.

> I went ahead outside of my birth plan and got an epidural, which I'm glad I did, because I don't think I could have labored like that for the duration of the labor and birth, so I went ahead and got an epidural. And from then on, and it was awesome, I was more peaceful. I was able to relax (Felicia, interview, September 21, 2020).

Each participant reported satisfaction with their birth. Although each plan was adapted, the participants voiced how important it was for them to listen to their body and do what was right for them. Crystal said, "I was able to birth the way I wanted, you know, like, having a voice in whatever the outcome was. And so I think that the advocacy portion really prepared me for that."

The data from the focus groups and the interviews highlighted the experiences of the participants during the course and after birth. The themes from the data formed key points for discussion. First, patient advocacy can increase confidence to give birth. Second, knowing patient rights is important for the patient-provider relationship before and during the birth process. And finally, a support team is vital to advocacy when the patient cannot verbalize their needs given the physical demands of labor.

Discussion

Self-advocacy before, during, and after birth can be a critical tool for Black pregnant women (Center for Reproductive Rights, 2014). Several key points resulted from the data in this study. Participants who attended the advocacy education affirmed their rights of refusal and were more confident to advocate for themselves. Additionally, participants' relationships with their providers greatly influenced their birth experience and comfort to ask for what they needed. In this study, participants also discussed the importance of a support team in the advocacy process.

Knowing Patient Rights

Each of the six participants from the focus groups spoke of one aspect of their rights they learned from the education session. Carla realized she doesn't have to trust that everything that happens is in her best interest. She discussed that she learned that, when something feels wrong, she has the right to ask questions. Other participants engaged in conversation about learning they

can refuse care or leave the hospital if they feel their rights are being violated. The participants relate their confidence from learning how to refuse care or ask questions from the Black Birthing Bill of Rights (Birth Rights Bar Association, 2020).

The value of using rights became clear in the postpartum interviews when Crystal talked about reminding herself that she could leave if she wanted. Kiah and Carla both talked about trusting providers to make the best medical decisions and changing their opinions after the course. Both participants indicated that they did not want doctors to dictate their birth, but they can be heard for what they want and need. Felicia used her rights to ensure she was being heard when she expressed that she did not want to be induced. These examples echo what research says about targeted advocacy for Black pregnant women (Baffour et al., 2006). The implementation of advocacy programs involving rights followed with focus groups for discussion can lead to Black women feeling decreased stress and increased confidence about birth and postpartum (Baffour et al., 2006).

During the interviews, each participant reported that they advocated or asked questions to their provider during birth. Each woman indicated some level of confidence to advocate for their needs. What was indicated in the postpartum interviews showed that provider response played a large role in the continuance of self-advocacy. This aligned with the research from the Brashers et al. (2000) study; participants advocated more when providers engaged in collaborative decision-making for patient medical treatments. Carla asked more questions and expressed her needs after the doctor and nurses responded favorably the first time. Crystal's midwife asked how she was feeling emotionally about the change in her birth plan, which led her to communicate with her provider about the changes in the birth plan and the backup plans in place. When Felicia was questioned about her decision to change her birth plan and asked for the

epidural, her support team stepped in to affirm her desire for pain management. Facione and Facione (2007) discuss the emotional and physical impact of stress that providers can have on Black pregnant women. This stress comes from a strained patient-provider relationship. Although there may be an increased confidence in self-advocacy after learning and affirming patient rights, support and communication from the provider can influence how pregnant women continue to advocate during their birth.

Patient-Provider Relationship

During the focus groups, participants discussed the process of selecting their providers for several different reasons. These reasons include changing birth outcomes from a previous birth, comfortability during prenatal appointments, or choosing a Black provider for racial representation. Crystal changed providers after feeling uncomfortable with the original provider. De'Aundria talked about wanting a different birth from her family history and concerns about medically unnecessary C-sections. De'Aundria's family story is similar to many stories of Black pregnant women who are not confident in their health care provider choosing the best care for the patient (Hall et al., 2015). The research on prenatal care for Black women found that the quality of care is often lower than prenatal care for White women (Saha et al., 2003). The choice of a provider can significantly impact birth outcomes (Facione & Facione, 2007). During her postpartum interview, Carla stated that she felt comfortable asking questions to her provider and verbalizing her concerns. Although she had a positive experience, Felicia's careful choice to have a Black provider still did not lead to an ideal experience before and during birth. Felicia repeatedly asked to not be induced even if she did not have a baby by her due date, and she repeatedly had to ask for pain management. Felicia described her provider relationship as disappointing.

The issue of cultural knowledge and sensitivity is prevalent in the patient-provider relationship (Betancourt et al., 2002). Although participants did not indicate an instance of bias during their birth, participants expressed the need to know what they wanted to say if they felt violated in birth or not heard from a White provider. De'Aundria talked about the possibility of being labeled as difficult by a White provider or nurse if she asked too many questions. She switched providers after feeling uncomfortable with her previous White provider. Black women have historically been dismissed when bringing up health concerns to their providers (Chin et al., 2007). This can play a role in stress during pregnancy and birth, which not only contributes to birth outcomes but the bigger issue of maternal mortality (Rich-Edwards et al., 2001).

Participants expressed the advocacy education as positive prevention for combatting maternal mortality and violations experienced in birth. De'Aundria and Crystal talked about their appreciation for learning more about their patient rights, so they know how to identify a violation, especially when labor requires focus on their body and bringing their baby into the world. There is a chance implicit bias may be missed in some instances when a patient's attention is diverted; but rights such as consent, collaborative decision-making, and respect can be identified and reported when they do not occur (BRBA, 2020). Because of the need to identify and self-advocate when provider bias is experienced, the support team of a Black pregnant woman can serve as an influential role in ensuring equitable care in birth.

Support Team

A support team can significantly decrease stress during birth and depression during the postpartum period (Collins et al., 1993). Felicia communicated to her husband her needs and how she wanted to be supported in advocacy in pregnancy. She discussed that they had consistent communication about decision making at each stage of labor and how to speak up if

they did not feel heard. In the postpartum interview she explained that her husband spoke up for her when she was not being respected by the nurse. She continued to say that they kept talking throughout birth about what she needed so he could be her voice when needed. For Carla, her husband helped her advocate postpartum when she felt ignored and did not receive a meal after the delivery. Because he spoke up for her, she was able to get her basic needs met. A support team helping in the advocacy process has been found to give strength to a pregnant patient (Morton & Clift, 2014).

The use of doulas was another component of support that was mentioned in the focus groups and interviews. A doula's role in birth is an integral part to the labor and birthing process (Gruber et al. 2013). Doulas can provide emotional, physical, and educational support during pregnancy and birth that allows a pregnant woman to make informed decisions about her care. Crystal had minimal medical intervention and received comfort measures from her doula to manage the pain surges during labor. De'Aundria planned to have her doula be her voice if there was a need for someone to step in. The use of a doula on the support team may provide stress relief in the process of advocacy as a knowledgeable third party for the pregnant woman (Gruber et al. 2013).

Limitations

In any research there can be limitations and that was true in this study. One of the most challenging limitations was brought on by the Coronavirus pandemic and the health risk to conduct an in-person study. The Johns Hopkins HIRB restricted in-person research. Therefore, the childbirth and advocacy education were held online. This did not impact the recruitment process of the study, but the restrictions did impact the recruitment of participants from the target study area. The original intent was for participants in the study to be from South Dallas.

However, all participants from various parts of the Dallas area and learned about the study from social media posts and contacts that they directly knew. There is a need to find better participant recruitment for South Dallas residents to attend the advocacy education in future delivery of the course.

Another limitation of the study was the online format. The original plan for the study did not require participants to bring any materials or have any technological equipment. Mrs. Hurd and I planned to display all visuals and videos on our equipment. We also planned to distribute informed consent and handouts. There were six total participants, and only one participant resides in South Dallas. With the changes to the study, participants needed to have a computer, internet access, and access to email to attend the study and receive the informed consent. This may have affected the number and demographics of participants due to access of a computer and internet. This can create a barrier for lower socioeconomic status families, which aligns with the statistics and disparities of the population who resides in South Dallas (City of Dallas, 2018).

Environment is important for the optimal learning environment (Banks & Banks, 2007). Because the education courses were online, all participants stated they were sitting in their home environment. There were distractions at home during a four-hour course such as children, partners, and pets. For example, a participant attended the first part of the childbirth education but had to leave after an hour because her husband left for work and she had to watch her children. The in-person education and advocacy course would have provided childcare and been accessible to attendees from South Dallas.

Implications for Future Research

There are several indicators for future research that pertain to the issue of patient advocacy in birth. The influence doulas have on patient's ability and frequency to self-advocate

in labor and birth should be studied further. During the focus groups, the topic of having a doula as part of the support team was discussed by the participants. The focus of the post-partum interview was to collect data on the participants' birthing experience. The questions were designed to answer the research questions and not specifically the role of the doula. Participants who used a doula talked about how their doula helped them plan their birth, change providers if necessary, and support them to have the birth they wanted to have. I would like to further explore the role of the doula as it pertains to aiding in Black patients self-advocating and their confidence to self-advocate.

The difference of care and support provided by obstetricians versus midwives is another consideration for future research. Felicia's disappointment with her provider, who is Black, is a result that differs from the research (Association of American Colleges Report, 2010). Research demonstrate that the psychological and physical stress of Black pregnant women is higher when there is perceived implicit bias by providers or providers are of a different race than the patient (Betancourt et al., 2002). In this case, a Black obstetrician questioned the decisions and requests of her patient, resulting in a disappointing provider experience. Crystal's experience with her midwives, however, was supportive and positive even though her providers were White. Because of these results from the data, more research may be needed about provider support. I would like to explore the differences in level of support and comfort in the provider-patient relationship for Black women who choose obstetricians and those who choose midwives.

Another topic of future research is implicit bias, which was not prominently addressed in the study. However, the issue of racism and implicit bias was highlighted in the research literature. There is a local organization in Dallas that educates birth professionals such as midwives, doulas, and lactation consultants on the issue of implicit bias and racism in the history

of Black birth in the United States. Because there were not clearly stated experiences of implicit bias or racism during the births of the participants, I would like to explore the impact of implicit bias training on provider practice.

Conclusion

This experience has opened my eyes to the importance of advocacy in birth for Black pregnant women. I learned a lot from listening to the participants' stories and prior experiential knowledge. By creating an education course that was developed in a conceptual framework such as CRT, participants shared what they knew and saw and heard throughout their lives, which enhanced the training. After this study, I want to further the work of advocacy in my community for many underserved populations. I would also like to develop the advocacy education course to teach birth professionals (i.e. midwives, doulas, and nurses) how to help their patients advocate for themselves to reduce stress in birth and increase positive birth outcomes.

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Appendix A

Research Matrix

Research Questions	Constructs	Data Collection	Data Analysis
RQ 1: How do Black pregnant women in Dallas experience the childbirth and advocacy education course?	• Perceptions of program delivery	• Post intervention Interviews • During Intervention Observation	• Thematic Coding
RQ2: How do Black pregnant women in Dallas perceive their ability to self-advocate, if any, during delivery after they attend a childbirth education class?	• Self-advocacy • Perceptions of program delivery	• Post intervention Interviews • During intervention Observation	• Thematic Coding
RQ3: To what do Black women who self-advocated attribute how and why they advocated?	• Reflections on self-advocacy • Perceptions of program delivery related to birth outcomes	• Post intervention Qualitative Interviews	• Thematic Coding
RQ4: To what extent did the childbirth and advocacy education program contribute to their ability to advocate for themselves during childbirth?	• Self-advocacy • Perceptions of program delivery	• Post intervention Qualitative Interviews	• Thematic Coding • Triangulation

Appendix B

Focus Group of Perceptions of Pregnant Women after Childbirth Education

1. Describe your experience of the childbirth and advocacy education sessions.
2. On a scale of 1-5, with 1 associated with the word unsure and 5 associated with the word confident, how did you feel before the childbirth and advocacy education course? What made you choose that number?
3. Based on the three particular sections we discussed today, what was most effective? This could be content, activities, and delivery of information.
4. What parts of the education class were least effective?
5. How has the knowledge presented in the childbirth education portion impacted your knowledge of childbirth and postpartum?
    a. What new information do you feel will be important to incorporate in your birth?
    b. What information do you feel was not covered enough and left lingering questions?
6. On a scale of 1-5, with 1 associated with the word unsure and 5 associated with the word confident, how do you feel after the childbirth and advocacy education sessions? What made you choose that number?
7. about knowing your patient rights during birth and postpartum after experiencing this course.
8. Please describe your feelings about advocating for your rights during birth and postpartum after this course.
    a. What information do you feel will be important to incorporate in your birth?

b. What information do you feel was not covered enough and left lingering questions?

9. Is there anything else you would like to share in regard to your class experience?

Appendix C

Interview Questions of Perceptions of Postpartum Women after Childbirth Education

1. Tell me about your labor and postpartum experience.
2. Thinking back on your labor and postpartum in the hospital, what part of the childbirth education was most useful or effective for you?
3. What parts of the education classes were least useful or effective?
4. How did you use the knowledge presented in the childbirth and advocacy session?
    a. What new information did you feel was important and incorporated into your birth?
    b. What information did you feel was least important for your birth?
5. On a scale of 1-5, with one associated with the word unsure and 5 associated with the word confident, how did you feel about use your patient rights during birth and postpartum?
6. How confident did you feel about advocating for your rights during birth and postpartum? How did your support person during birth help you advocate? Please provide examples.
7. How did the knowledge presented in the advocacy education session impact your confidence to advocate in childbirth and postpartum?
8. How confident did you feel asking your provider questions after the advocacy education session of the class?
9. How do you feel the childbirth and advocacy sessions impacted your birth?
10. Is there anything else you would like to share in regard to your education experience, birth, or advocacy?

ELEVATING YOUR VOICE

YOUR VOICE MATTERS & WE WANT TO HEAR FROM YOU!

Come participate in research that can contribute to the conversation about advocacy and birth in the Dallas community. The purpose of this study is to elevate the voices of Black pregnant women in South Dallas through research.

What to Expect:

- Free Childbirth Education
- Advocacy Education – know your patient rights
- Focus Group
  - Self-advocacy during birth
  - Tools you find valuable from the course

When:

(choose one)

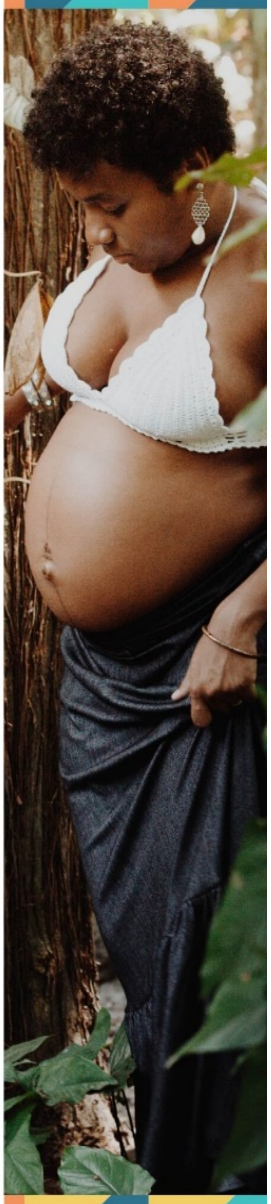
April 18, 2020 9 am – 1 pm

April 19, 2020 1 pm – 5 pm

Where:

Abide Women's Health Services
2612 MLK Jr. Blvd.
Dallas, TX 75215

For any questions about the study, please contact
Tiffany Wicks, Student Researcher
Phone: 214.596.8318 Email: twicks2@jhu.edu



ELEVATING YOUR VOICE

YOUR VOICE MATTERS & WE WANT TO HEAR FROM YOU!

Come participate in research that can contribute to the conversation about self-advocacy and childbirth. The purpose is to invite only Black pregnant women in the Dallas community to hear your unique experience and elevate your voice.

What to Expect:

- FreeChildbirth Education
- Advocacy Education – know your patient rights
- Focus Group
  - Self-advocacy during birth
  - Tools you find valuable from the course

When:

(choose one)

July 17, 2020 9 am – 1 pm

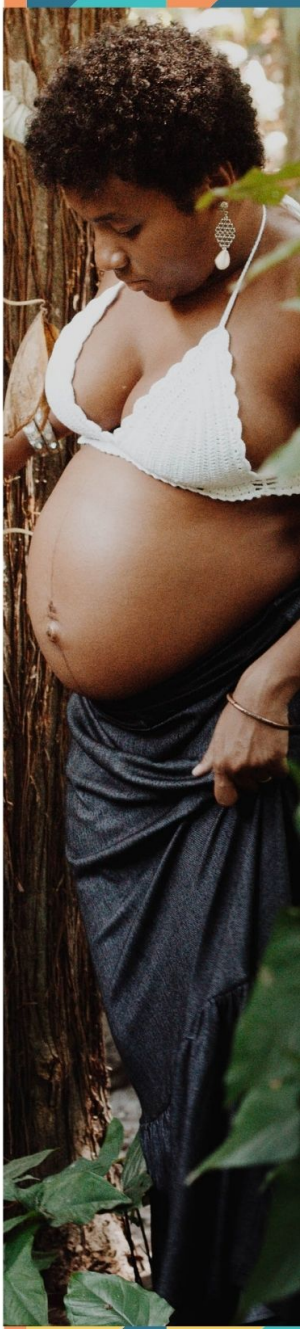
July 18 2020 1 pm – 5 pm

Where:

https://us02web.zoom.us/j/88672912828

*This is an interactive session so please have pen and paper ready!

For any questions about the study, please contact
Tiffany Wicks, Student Researcher
Phone: 214.596.8318 Email: twicks2@jhu.edu



Appendix E

Focus Group Recruitment Script

Hello, my name is Tiffany Wicks. I am a student researcher in the School of Education at Johns Hopkins University in the School of Education. I am conducting research on the effectiveness of a childbirth and advocacy education course and how pregnant women in South Dallas use the education to self-advocate during their childbirth. You are being asked to participate because you are pregnant and attending this childbirth education course.

Participation in this research includes participating in a focus group about what you felt, if anything, was valuable as you attended the childbirth and advocacy sessions of the course. In addition, if you are willing, I would like to contact you by phone after you give birth for an interview about what you found valuable from the childbirth and advocacy sessions, if anything, that helped you self-advocate during your birth.

Your participation in the advocacy education, focus group, and interviews is completely voluntary and you may withdraw at any time. If you choose not to participate, you will still receive the childbirth education. Does anyone have any questions?

Appendix F

Informed Consent

JOHNS HOPKINS UNIVERSITY

HOMEWOOD INSTITUTIONAL REVIEW BOARD (HIRB)
RESEARCH PARTICIPANT INFORMED CONSENT FORM

Study Title: Elevating Voices for Self-Advocacy: Making the Case for Childbirth and Advocacy Education for Black Pregnant Women in South Dallas

Application No.: HIRB00010527

Principal Investigator: Dr. Elizabeth T. Brown, JHU SOE, Visiting Assistant Professor
522 Evergreen Pl Ct. Louisville, KY 40223
Phone: (502) 974-9899 Email: ebrow121@jhu.edu

You are being asked to join a research study. Participation in this study is voluntary. Even if you decide to join now, you can change your mind later. This is a student research project that is part of Tiffany Wick's Ed.D. dissertation at Johns Hopkins University, School of Education

1. Research Summary (Key Information):

The information in this section is intended to be an introduction to the study only. Complete details of the study are listed in the sections below. If you are considering participation in the study, the entire document should be discussed with you before you make your final decision. You can ask questions about the study now and at any time in the future.

- Participants will attend a childbirth and advocacy education course for 3 hours
- Participants will participate in a focus group following the childbirth and advocacy course that will last 30-45 minutes. Focus group interviews will be video-recorded.
- Participants will have the option to participate in postpartum interviews that will last 20 minutes over the phone. Postpartum interviews will be audio recorded.

2. Why is this research being done?

- The purpose of this research study is to determine the effectiveness of an intervention to inform pregnant women in South Dallas of their childbirth options and ways to self-advocate during their birth.

3. What will happen if you join this study?

If you agree to be in this study, we will ask you to do the following things:

- Complete one childbirth and advocacy education course that will last 3 hours.

- Participate in focus group interviews that lasts 30-45 minutes.
- Participate in individual interviews after you give birth that last 20 minutes

Photographs/Audio recordings:

As part of this research, we are requesting your permission to video-record focus group interviews and audio record postpartum phone interviews. Any video or audio-recordings will not be used for advertising or non-study related purposes.

You should know that:

- You may request that the video recording be stopped at any time.
- If you agree to allow the audio recording and then change your mind, you may ask us to destroy that imaging/recording. If the imaging/recording has had all identifiers removed, we may not be able to do this.
- We will only use these audio recordings for the purposes of this research.

Please indicate your decision below by checking the appropriate statement:

_____I **agree** to allow the study to use video and audio recordings of me for the purpose of this study.

_____I **do not agree** to allow the study team to use video and audio recordings of me (or the participant I represent) for the purpose of this study.

_____ _____

Participant Signature Date

(or Legally Authorized Representative Signature, if applicable)

How long will you be in the study?

You will be in this study for approximately 2.5 months.

4. What are the risks or discomforts of the study?

The risks associated with participation in this study are no greater than those encountered in daily life [or during the performance of routine physical or psychological examinations or tests].

5. Are there benefits to being in the study?

This study may benefit society if the results lead to a better understanding the effectiveness of a childbirth and advocacy education on how pregnant women in South Dallas self-advocate during their birth.

6. Will it cost you anything to be in this study?

No

7. Will you be paid if you join this study?

No

8. Can you leave the study early?

- You can agree to be in the study now and change your mind later, without any penalty or loss of benefits.
- If you wish to stop, please tell us right away.
- If you want to withdraw from the study, please email Tiffany Wicks, student researcher at twicks2@jhu.edu to inform her of your withdrawal.

9. How will the confidentiality of your data be protected?

Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Johns Hopkins University Homewood Institutional Review Board. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

To protect confidential information, all study records will be created and maintained by the student investigator and stored in a locked file cabinet. In addition, participant names on data sheets (document artifacts) will be replaced with code numbers to maintain participant confidentiality. All electronic data will be stored and secured in a password-protected computer file. Only the student investigator and PI will have access to the computer files, which will be backed-up regularly to ensure their protection.

10. What other things should you know about this research study?

What is the Institutional Review Board (IRB) and how does it protect you?

This study has been reviewed by an Institutional Review Board (IRB), a group of people that reviews human research studies. The IRB can help you if you have questions about your rights as a research participant or if you have other questions, concerns or complaints about this research study. You may contact the IRB at 410-516-6580 or hirb@jhu.edu.

What should you do if you have questions about the study?

Call the principal investigator, Elizabeth T. Brown at (502) 974-9899. If you wish, you may contact the principal investigator by letter. The address is on page one of this consent form. If you cannot reach the principal investigator or wish to talk to someone else, call the IRB office at 410-516-5680.

You can ask questions about this research study now or at any time during the study, by talking to the researcher(s) working with you or by calling Tiffany Wicks at (214) 596-8318.

If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Homewood Institutional Review Board at Johns Hopkins University at (410) 516-6580.

14. What does your signature on this consent form mean?

Your signature on this form means that: You understand the information given to you in this form, you accept the provisions in the form, and you agree to join the study. You will not give up any legal rights by signing this consent form.

WE WILL GIVE YOU A COPY OF THIS SIGNED AND DATED CONSENT FORM

_____

Signature of Participant (Print Name)

_____

Date/Time

_____

Signature of Person Obtaining Consent (Print Name)

_____

Date/Time

NOTE: A COPY OF THE SIGNED, DATED CONSENT FORM MUST BE KEPT BY THE PRINCIPAL INVESTIGATOR; A COPY MUST BE GIVEN TO THE PARTICIPANT.

Appendix G

Childbirth Education Curriculum

Created and Delivered by Althea Hurd

1. Intros
    a. Name, estimated due date, interesting fact about you, what excites you about this child, what fears do you have
2. What's in your packet
3. Anatomy
4. Common concerns and discomforts
5. Warning signs BEFORE 37 WEEKS – handout
6. Signs of labor – flip chart
7. Stages and Phases of labor – emotions poster
8. Birth signs video
9. Induction seduction
10. Interventions
11. C-section – flip chart
12. C-section – video
13. Birth plan
14. Comfort measures
15. Evaluations

What's in the packet:

LEFT SIDE	**RIGHT SIDE**
Clarifying pain	Warning signs
Personal relax chart	Phases and stages
Choices for birth	P.E.A.C.E.
Lower SIDS risk	Power Pack
Labor support	Birth plan
B.R.A.I.N.	survey

Warning Signs ******* HANDOUT!!*******

*write at the top of your paper – before 37 weeks

*fever is the #1 sign of infection

*swelling can equal preeclampsia; look for swelling in hands, feet, and face; can't ball up a fist; protein in the urine; high blood pressure

Signs of labor – ***poster* handout*****

*demo of hospital bed birth on back

*wine glass and orange example -*this demonstrates what the affects of being upright vs. lying down (supine)*

Signs and stages of labor	
Content	**Context**
Signs of labor Mom may begin to get restless and get anxious for the birth.	Important to remain patient. Estimated due date – could go to 42 weeks.
Nesting	This is when mom has a **surge of energy**. She may start prepping the baby's room, cleaning, etc. This energy is good, but should be **preserved**. Don't overexert yourself bc you're preparing for a marathon. Do things that will serve to progress labor – **sex produces oxytocin, good time to connect (oxytocin)**
Lightening	When the baby drops. The baby should be turning into position, into the pelvic cavity.
Station	During a vaginal exam, your doctor will feel for your baby's head. If the head is **high and**

	not yet engaged in the birth canal, it may float away from their fingers. At this stage, the fetal station **is -5**. When your baby's head is **level with the ischial spines, the fetal station is zero**. Once your baby's head fills the vaginal opening, **just before birth, the fetal station is +5**.
Bloody show	When baby is engaged with the **cervix**, the pressure pushing on the vagina can cause bloody show. This change in discharge may be pinkish in color. This is not a cause for concern. Enough blood to fill a pad is cause for concern.
Flu-like symptoms	Runny nose, nausea, cramps, diarrhea. Can be hours or even days before labor. This is your body's way of cleaning out to make way for the baby. Just like when we are ill, this is when we should be **hydrating**. The uterine muscle needs to be hydrated. **Rest**
Backache	Braxton-Hicks contractions are warm-up contractions. They may cause back ache. They might not stop you in your tracks. They are not changing your cervix. Your uterine muscle is warming up.
Rupture of membrane	**Water breaking** … this happens in approximately **10-14%** of moms. If water breaks, need to be lying down **C**olor – yellow (urine), green (meconium) **O**dor – nothing or stinking (stinky could mean infection **A**mount – trickle (high break) or gush (low break) **T**ime – how long ago did water break? w/in 6-8 hours, need to be contracting w/in 12-16 hours, now at risk of infection, check temperature 24 hours – need a plan of action
******<u>HANDOUT</u>!!****	

Phases and Stages of Labor – emotions handout	
Stage 1	**Dilating**
Stage 2	**Pushing**
Stage 3	**Placenta**
Phase 1 – early phase **Contractions may not have a consistent pattern at this time. This phase can take up to 24 hours.**	Possible **discomfort,** might not stop you in your tracks or keep you from going about your day. This is a good time to **eat regularly**; fuel up. Make healthy choices – good **protein**, light food. Some moms throw up during labor, so eat something that will be not be too harsh coming back up. Watch movies, read, enjoy your other children, etc. **Relax, chill**, do things you enjoy that won't exert too much energy. You'll need the energy for later. If you go to the hospital during the early phase of labor, you will be checked for progress. If you are not in active labor (which is 6 centimeters with regular contractions), you may be sent back home. A contraction timer app may be useful.
Phase 2 – active phase Contractions can last approximately **60 seconds with a 2 minute break** between. Your cervix is between **3-7 centimeters** Experiencing the most cervical change	Contractions are **impossible to ignore**. They may stop you in your tracks. They may take your breath away. **5-1-1 pattern** 5 minutes apart, 1 minute in duration, 1 hour Your support person can help you time them. **Chiropractic care** has been proven to shorten labor; need a **webster** trained chiropractor
Phase 3 – transition Contractions can last approximately **60-90 seconds with a 1 minute break** between (sometimes feels like stacked on top of each other). Your cervix is changing from **8-10 centimeters**.	Might not be able to formulate coherent thoughts. Might start to feel doubt. Need your support person Support person can remind you about your birth plan **CREATE A BIRTH PLAN** Cervix will come to **COMPLETE** here – 10 centimeters and 100 % effaced

Stage 2 – Pushing **Guided pushing**	Pushing should occur when mom's cervix is complete **(what is complete?)** Pushing positions – open pelvis **w/o epidural** mom will feel contractions and pressure when it is time **w/epidural** mom may not feel contractions coming on but she will feel the pressure - Helpful here b/c support person, etc, can read the monitor to tell mom when it's a good time to push
Stage 3 – Placenta	**Once your baby is skin to skin,** it is time to deliver the placenta About 15 minutes after the birth of the baby The **involution** process is when the uterus begins to go back to size Nurses may perform fundal massage (top of the uterus) Ask your doctor if s/he practices natural involution or assisted - Assisted may include Pitocin; this will prevent uterine hemorrhage Make a plan for what you want done with your placenta – there are options (encapsulation, cord blood, etc)

Induction… no. Seduction - **poster**

- Sex and Intimacy

Releases the happy hormone – oxytocin causes contractions

Semen introduces prostaglandin onto the cervix which can help to ripen (thin) cervix

- Walking

Can encourage baby to get in positions

Baby's head in position can put pressure on the cervix

- Red Raspberry Leaf

Regular/prolonged use in tea or tincture form can contribute to preparing the uterus

You can talk to your midwife about a suggested regimen to begin (when?)

- Evening Primrose Oil

May help to ripen the cervix

Capsule can be taken orally or inserted in the vagina (talk to your midwife)

- Regular Chiropractic care
- Nipple Stimulation

Most effective with a breast pump

The action releases oxytocin

- Castor oil

Of these, this is the only one that has evidence based studies done, but it is gross stuff

INTERVENTIONS ACTIVITY – ***this activity includes notecards with pictures and names of 1st and 2nd stage interventions. This activity demonstrates that one intervention can lead to another and then another, thus causing a cascade of interventions. Instructor will explain risks, benefits, and method of administration of each intervention.***

STAGE 1 INTERVENTIONS	**RISKS**	**BENEFITS**	**ADMINISTRATION**
Toco monitor, fetal heart monitor		Hear how baby is tolerating contractions (baby speaks thru heartbeat) Good indicator if contractions are strong or not strong	Placed around the belly
Vaginal exam	**Introduction of bacteria**	**Cervical dilation indicator**	**Check for cervical dilation**
IV fluid/hep lock	Place the hep lock/iv needle on hand so mom has better mobility after baby is born	Hep lock allows to ambulate	Reduce the risk of dehydration. You may be able to ask for a HEP lock.
Elevated blood pressure (magnesium sulfate)	Nausea, drowsy, limited recollection of birth experience 72 hours, no food, after baby is born (symptons still in effect after baby is born)	Calms system down so that mom does not have a stroke	Run a drip *if lifestyle is stressful, consider Epsom salt baths to leave traces of mag in system; help calm system down
GBS, penicillin	Could be getting unnecessarily if mom does not have an active outbreak; will not be retested If mom tested positive between 32-35 weeks.		Dosage in IV line
Narcotic analgesic	Street grade narcotic; drugs go to mom AND baby Will not give to mom during transition bc it's the quickest stage of labor, drug will still be in baby's system after birth	2 hours of relief, can only receive drugs every 4 hours	Thru IV or in thigh, goes straight to the blood stream

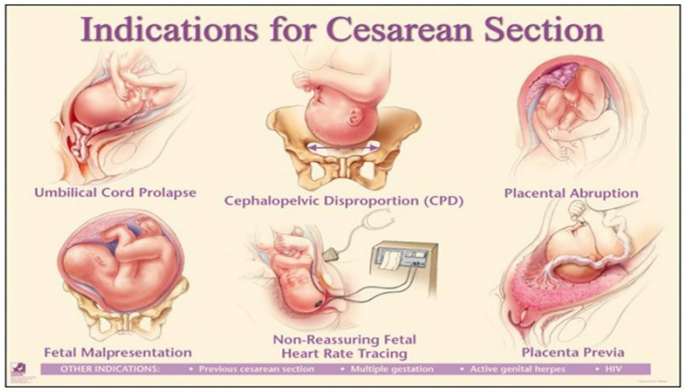
Epidural analgesic	Can slow labor	No pain, just pressure	Usually suggested to get an epidural between 5-6 cm, body is definitely in labor Between 2nd and 3rd lumbar of the spine. Only by dr. anesthetist or certified registered nurse anesthetist. The back is draped, cleaned, and numbed. Needle is inserted in epi space, catheter is threaded thru, needle is removed. Catheter (medication) is removed after birth, feeling returns within the hour. Mom lies down for about 20 minutes for drug to take affect
Catheter	Possible urinary complications	Empties bladder when mom cannot do so	Catheter inserted in urethra to empty bladder
Pitocin	Speeds up labor "unnaturally" very intense contractions; affects oxytocin levels bc the contractions are induced Can cause the need for epidural bc of labor pains	When labor needs to start bc mom or baby is at risk, Pitocin gets the job done	Thru IV
Internal monitor **Fetal scalp electrode**		Much more accurate fetal heart rate and indication of contraction strength	Inserted in vagina, side of uterus Screwed into baby's head
Amnio hook	If baby is high and floating, risk of cord prolapse (cord comes before baby)		Small crochet-looking hook to puncture amniotic sac
Oxygen		At any time during labor,	mask

		mom may be given oxygen to improve baby's heart rate	
STAGE 2 INTERVENTIONS			
Episiotomy	No evidence based proof that this speeds labor		Mediolateral or midline
Vacuum extractor	Additional stress on baby during birth	Helps guide baby's head out of vagina canal	
Forceps	Possible bruising from device	Helps guide baby's head out of vagina canal	

****poster****

Indications for c-section can include the following:

1. Cord prolapse – this is when the cord exits the cervix before the baby; this causes too much pressure on the cord
2. Cephalopelvic disproportion (cpd) – baby head size too large for mom's pelvis
3. Placental abruption – placenta begins to detach from the uterine wall before birth
4. Fetal malpresentation – this is when baby side-lying in the pelvis or breech
5. Non-reassuring fetal heart rate tracing – heart rate drops or spikes and does not return to "normal"
6. Placenta previa – placenta covers the cervical opening



Comfort measures – ***demonstrations***

- Cat/cow

- Hip squeezes
- Tennis ball/massage roller massage
- Lunges
- Assisted squats
- Roving body check

Appendix H

Outline for Advocacy Education

I. What is Self-advocacy?
    a. Objectives
    b. Definition and Self-advocacy in birth
    c. Why self-advocacy is important (i.e. implicit bias, your birth is your choice, etc.)

II. Patient Rights
    a. Hospital Rights for every patient (pass out hospital rights manual)
    b. How to use patient rights during childbirth to self-advocate (statement cards)

III. Support Systems in Birth
    a. The role of your chosen supports in the birth room
    b. How your support systems help echo your voice
    c. Limitations and boundaries your support systems need to know to help advocate

IV. Maintaining Confidence
    a. Words and phrases to say in specific scenarios (statement cards for participants to fill out)
        i. Rude nurses
        ii. Doctors not listening to your wishes in birth
        iii. Shaming language from hospital workers
    b. In case of emergency
        i. Designating a support person to track down nurses who will listen
        ii. Using language from hospital rights to remind staff you have rights to proper care

Appendix I

Interview Script

Hello, my name is Tiffany Wicks. Thank you for agreeing to speak with me today. I am a student researcher in the School of Education at Johns Hopkins University in the School of Education. I am conducting research on the effectiveness of a childbirth and advocacy education course and how pregnant women in South Dallas use the education to self-advocate during their childbirth. You are being asked to participate because you attended a childbirth and advocacy education course and agreed to be contacted postpartum for an interview.

The purpose of this interview is to get your feedback about how you self-advocated during your childbirth. Specifically, I want to understand what was valuable or effective from the childbirth and advocacy education course that helped you self-advocate.

I would like to remind you that to protect your privacy, all transcripts will be coded with pseudonyms, and I would like to ask that you not discuss what is discussed in this interview with anyone else.

The interview will last about 20 minutes and will be audiotaped to make sure that your responses are recorded accurately.

Do you have any questions for me before we begin?

Appendix J

Table of Sample Codes, Examples, and Themes

Code	Examples	Theme
Provider Relationship	"I am trusting that this is their profession and they know what they're doing and they're going to have my best interests in mind."	Desires and Wishes Prioritized over Blind Provider Trust
Provider Listening to Patient	"And she's challenging my request, like, you know, I just changed my mind. I have the prerogative to do that."	Kept repeating needs to be heard
Speaking up	"Like my first whatever little request, I can't even remember what it was to be honest. And they jumped, on board right away. It gave me a lot more confidence."	Kept repeating needs to be heard
Asking Questions	"What are the risks? What are the benefits? Like, really, what is the actual risk of me going past 40 weeks, because that was the thing."	Increased Confidence in Self-Advocacy, Repeating to be Heard
Birth Plan	"Just having a birth plan, you want to have a plan A, B, and C, and I had talked about this thoroughly with the midwife,…"	Changed Birth Plan When needed to change
Birth Plan	"…so this is going to help me create my birth plan where it's more of my choices, my decisions for my body"	Knowledge of Childbirth Increased Confidence in Birth
Maternal Mortality	"I hear a lot about like the Black maternal death rates and the research that's coming out and it's scary. It's scary to think about because then at this point, you're like, oh, what do I do. Like, I don't know what I can do."	Knowledge of Childbirth Increased Confidence in Birth
Pain Management	"Just like, here's what this is and the benefits and risk and these are the different pain management techniques that they're going to do"	Knowledge of Childbirth Increased Confidence in Birth
Interventions	"I would say that I don't think I've had anyone break down the interventions in a way that she did before."	Knowledge of Childbirth Increased Confidence in Birth
Doula	"It's going to help me to have the conversation with my husband and have the conversation with my doula too so that they understand these are the things that I wish to do."	Team helped with Advocacy
Support	"When we talked about having your team and making sure that you have your team in place and I do have a team in place, you know, but for them to understand their roles…"	Team helps with Advocacy
Support	"He was actually asking a lot of questions to them, you know, they respected his wishes and they respected his request just as much as they respect him so he was great"	Team spoke for me when I could not