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Experiences of Black Women During Pregnancy: The Meaning of Perinatal Support

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This study describes findings of a phenomenological study of Black women's experiences with a community-based perinatal support organization based in Cleveland, Ohio. Twenty-five women participated in interviews after their babies were born about how the organization in general, and perinatal support professionals (PSPs) in particular supported them during their pregnancies and the meaning of that support. The overall meaning of perinatal support was described as easing participants' transitions into motherhood through reducing uncertainty, social isolation, and stress. The three main themes described the meaning of perinatal support and included (a) easing the transition to motherhood through emotional support, expressed via love and help managing relationships; (b) easing the transition to motherhood through instrumental support, expressed via helping with basic needs and obtaining material goods for the baby; and (c) easing the transition to motherhood through informational support, expressed via help navigating systems and information, and gaining knowledge and skills around mothering and self-care. Implications for practice, policy, and research are discussed.

Public Policy Relevance Statement
Black infant and maternal mortality rates, which research finds are related to the stress of racism, are at crisis levels. All women should have free access to community-based perinatal support, a cost-effective intervention that could work to reduce health disparities in part by reducing women's stress.

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Infant mortality is defined as the death of a baby before the age of one and is used as an indicator of overall health in a country (Centers for Disease Control and Prevention, 2019). The United States continues to struggle to reduce infant mortality and low birth weight rates (birth weights of fewer than 5 pounds) to those of similarly economically developed countries. The current infant mortality rate in the United States is 5.9 deaths per 1,000 live infant births, a rank of 33rd of 36 countries (United Health Foundation, 2020), and Ohio's (where this research was based) is worse, at 7.2 deaths per 1,000 live births (Centers for Disease Control and Prevention, 2018). Of particular concern is the Black infant mortality rate of 11.4 deaths per 1,000, more than double that

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of both non-Hispanic White babies and Hispanic babies (Centers for Disease Control and Prevention, 2019). The leading causes of infant mortality include birth defects, preterm and low birth weight, maternal pregnancy complications, sudden infant death syndrome, and injuries (suffocation) (Centers for Disease Control and Prevention, 2019). Research finds non-Hispanic Black women are twice as likely to give birth to a low birth weight baby than are non-Hispanic White women (Martin et al., 2019).

While maternal mortality is on the decline around the world, it is on the rise in the United States placing it in the company of countries such as Lesotho, Swaziland, and Afghanistan (Alkema et al., 2016). Similar to infant mortality, the racial disparities for this health outcome are startling. Maternal mortality is more than three times higher for Black mothers in the United States at 42.4 deaths per 100,000 live births than it is for White mothers at 13.0 (Centers for Disease Control and Prevention, 2020).

Infant mortality in Cuyahoga County, Ohio (home to Cleveland, where this research was conducted) is nearly two times (10.5 deaths per 1,000 live births) that of the U.S. (First Year Cleveland, 2020). The differences in the rates for African–American babies (16.1) compared to non-Hispanic White babies (2.4) are especially alarming. The gap may be surprising, given Cleveland is home to world-class medical resources including the Cleveland Clinic, University Hospitals, and a large, well-respected county hospital system, MetroHealth. However, practitioners and researchers are increasingly recognizing the critical role of a range of environmental influences referred to as the social determinants of health, of which proximity to an extensive network of medical providers and high-quality medical facilities is only one consideration (Office of Disease Prevention and Health Promotion, 2014b).

Social determinants of health include economic stability, social and community context, neighborhood and environment, healthcare, and education. Racism and discrimination are considered key issues in the social and community context category and increasingly understood as stressors experienced over the lifetime, related to a range of negative health outcomes, including low birth weight, the leading cause of infant mortality (National Institute for Children's Health Quality, 2020; Office of Disease Prevention and Health Promotion, 2014a). Racial discrimination occurs in individual experiences and institutionalized ways through policies including residential segregation. Cleveland has been recognized as one of the most segregated cities in the United States (24/7 Wall St., 2016) with its well-documented history of redlining, which has resulted in segregation, and high rates of home foreclosure among Black residents (The Kirwan Institute for the Study of Race and Ethnicity, 2015). Opportunities have been further limited by segregation within the school system, and Ohio's unconstitutional funding of schools via property taxes, thus further entrenching poor neighborhoods in poverty (ACLU Ohio, 2015). In 2017–2018, half of Cleveland's schools were rated "failing" according to state guidelines (DeRoos, 2018).

Background

Research has identified stress as an important factor affecting preterm birth and infant mortality in Black women (Collins et al., 2004; Dominguez, 2011; Dominguez et al., 2008; Nuru-Jeter et al., 2009), for whom infant mortality rates increase with education level (Din-Dzietham & Hertz-Picciotto, 1998). A recent nationally representative study found that chronic worry about racism and discrimination is related to preterm birth and that African–American women in higher socioeconomic categories have higher levels of chronic worry (Braveman et al., 2017). This research supports a body of work by James Collins, which found that women with more lifetime exposure to racial discrimination were at higher risk of having very low birth weight infants (Collins et al., 2004). This is in part due to the mental and physical toll associated with living in a race-conscious society. Systemic and institutional racism is at the core of why Black mothers are at an increased risk due to persistent wear and tear on their bodies caused by discrimination. Geronimus (1992; Geronimus et al., 2006) coined this concept "weathering" which explains the accelerated physiologic effects related to repeated stress associated with social disadvantage and racism.

Research on infant mortality looking at the mother's birthplace has found that U.S.-born mothers (Mexican-American, White, and African–American) have a higher risk of infant mortality than foreign-born mothers (Collins et al., 2013), and African born black women have similar birth weight patterns to U.S.-born White women than U.S.-born Black women (David & Collins, 1997). Significantly, having a higher level of education is associated with lower infant mortality for White women, but not for Black women (Din-Dzietham & Hertz-Picciotto, 1998). Toxic stress connected to chronic experiences with racism has been identified as one reason for this disparity embodied to such an extent that its affects health and health-care behaviors (Slaughter-Acey et al., 2019; Williams et al., 2019), and ultimately, population-level birth outcomes (Dominguez, 2011; Dominguez et al., 2008; Dunkel Schetter & Tanner, 2012; Nuru-Jeter et al., 2009; Wallace et al., 2017; Willis et al., 2014). Examination of the impacts of general stress, perceived racism, and pregnancy stress has found that perceived racism predicts lower birth weight in African–American births (Dominguez et al., 2008). Complementing this work, low-income African–American women with more social support, higher self-esteem, and positive self-attitudes were more likely to carry their babies to term (Edwards et al., 1994).

Interventions Addressing Infant Mortality

Research has suggested that social support may moderate the relationships between stress and racism and pregnancy outcomes for Black women (Edwards et al., 1994). Doula care is one social support intervention associated with lower levels of negative birth outcomes. A doula is "a trained professional who provides continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible" (DONA International, 2020, para. 3). Social support in pregnancy, including emotional, instrumental, and informational support is associated with positive mental and physical health (Gjerdingen et al., 1991). Research on birth doulas has found that doulas provide support to their clients including physical, socioemotional, and verbal support, play an important role in birth satisfaction, and clients desire to utilize them in subsequent births (Deitrick & Draves, 2008). A review of 26 randomized control trials in 17 countries found that continuous support during labor such as that provided by doulas results in more positive outcomes for mothers and babies, including shorter labor, fewer birth interventions, more positive experiences

among mothers, and higher Apgar scores for babies (Bohren et al., 2017).

Community-based doulas operate differently than traditional doulas. Community-based doulas are matched to clients based on living in the same community as the mothers, racial matching, and having specific training and focus on health equity (DONA International, 2014). Most of the published research on community-based doula with Black women focuses on work with young mothers. One study on community-based doulas serving high-risk pregnant teens found the doulas were a significant source of support and helped to expand teen mothers' social networks, were positive role models, and demonstrated caring for the teens (Breedlove, 2005). Gentry et al. (2010) found that community-based doulas helped low-income Black and Hispanic teens with emotional issues, assisted them in navigating social service systems, and offered tailored services to address their various challenges. Another randomized control trial with young African–American women found that participants in a community doula intervention were more likely to initiate breastfeeding, to breastfeed longer, and delay the introduction of solid foods as compared to women receiving usual prenatal care (Edwards et al., 2013).

Active legislation is currently being pursued in the US Congress to include doula care in Medicaid reimbursement. The National Health Law Program tracks the legislation with a goal that "all pregnant individuals enrolled in Medicaid who want access to a doula, will have one" (National Health Law Program, 2020, para. 1). Currently, however, only three states (Indiana, Oregon, and Minnesota) commit Medicaid funds for doula services (Gebel & Hoden, 2020), leaving families who would benefit from doula care being unable to access the service due to having to pay out of pocket. The support of a doula should not be viewed as a luxury reserved only for wealthier women but a valuable service accessible to anyone regardless of insurance coverage or financial means.

Program Setting: Birthing Beautiful Communities

The purpose of Birthing Beautiful Communities (BBC) is to provide comprehensive, holistic support to pregnant African–American women through both individualized and group-based (class) relationships, specifically focusing on underserved communities within the city of Cleveland. A key support intervention, Sister Circles (SOS), developed for helping African–American women with anxiety (Neal-Barnett et al., 2011) was required for all clients. Although BBC refers to its perinatal support professionals (PSPs) as "doulas," their community-based focus goes well beyond traditional doula care and birth support. Instead, they focus on the mother and her ecological system, providing comprehensive, holistic support through the pregnancy, birth, and critically, during the postpartum period, for at least one year postbirth. Approaching mother and child with an appreciation for their wider social context, PSPs help establish a strong foundation for them, helping the family identify, plan, and achieve life aspirations, including, but not limited to, educational and employment goals (Hmiel et al., 2019).

Purpose of This Study/Aims

The purpose of this study was to explore the meaning of perinatal support for Black pregnant mothers, thereby exploring the mechanisms by which perinatal support might act to improve birth outcomes among this population of women. Our overarching question was, among Black women participating in a culturally tailored perinatal support program, what was the meaning and essence of their lived experiences of support during pregnancy?

Method

Participants

Clients eligible to participate in the study were older than 18, must have attended the SOS classes, and they must have maintained contact with their PSP throughout their pregnancies. A total of 25 BBC clients participated in the interviews between October 2017 and January 2018. Participants ranged in age 18–41, were on average, in their mid-20s, had between one and six children (with most having one or two), about two-thirds reported education levels of high school or below, and about one-sixth of the sample was married. All participants were women of African descent (all but one, African–American). More than three-quarters reported having one or two children including the BBC-born baby, and 16% had more than three children.

Participants' perspectives represented experiences with 12 different PSPs. At intake, participants reported being on average, 14.4 weeks pregnant ($SD = 8.4$), though more than half (52%) reported being in their first trimester (12 or fewer weeks pregnant). Clients most often reported that they were referred to the organization through word-of-mouth. About 40% of participants reported they knew someone who had used the organization's services, and slightly less than one-quarter knew someone who worked there or knew someone whose friend worked there. Only 16% were referred by a professional in the community (e.g., physician, midwife, other service provider). A little over one-third (36%) learned about it from a community event (16%) through social media, or the internet (20%). Nearly two-thirds (64%) of participants reported they did not know what a doula was before becoming involved in the program. Nearly three-quarters of participants (72%) said they contacted BBC because they recognized that they lacked adequate support and/or needed support, more than one-third (36%) said they hoped to get education (topics mentioned included nutrition, childbirth, and breastfeeding), 20% mentioned specific social determinants of health causing them stress, 16% said that they either had negative experiences with prior births, negative interactions with hospital staff, or wanted to avoid interventions, 12% said they needed BBC because their pregnancies were high risk, and one person said she wanted to get out of the house. Most (60%) reported that their PSP accompanied them to prenatal visits, and 88% reported their PSP was present for their birth.

Design

A psychological phenomenological approach (Moustakas, 1994) was taken to explore the research questions. We were interested in taking an in-depth approach to participants' narratives of their lived experiences of working with the organization through their pregnancies, participants' perceptions of the dynamics of their interactions with their PSP, and the meaning of such interactions through their pregnancies, making a phenomenological approach ideal.

Measure

The interview guide was constructed collaboratively between BBC's executive director, the program's funders, and the research team. Interview questions were developed after a PSP focus group in which PSPs' experiences with clients were explored. Interview questions asked participants to walk the interviewer through their BBC experience, from initial referral and intake, meetings, their pregnancy, classes attended, prenatal visits, birth, and postpartum. This study focuses on questions on social support during pregnancy.

Procedure

The interview guide and informed consent protocols were reviewed and approved by the full Cleveland State University Institutional Review Board (#IRB-FY2017-75). All participants signed informed consent documents before the interview. Before beginning the interviews, a student research assistant was trained on qualitative inquiry and analysis. Training included readings on qualitative methods, background on the methodology, and interviewing best practices (e.g., question phrasing, active listening, probes, following up, asking open-ended questions). The second author (an expert in narrative inquiry) observed the research assistant's initial three interviews as part of the training process. The remaining interviews were divided between the research assistant and her.

In recruiting participants, PSPs identified clients that met the eligibility criteria. The interviews were timed such that participants reported on their experiences retrospectively after their babies had been born and postpartum. PSPs contacted potential participants to determine their interest in participating in the study, and with permission, the research assistant contacted them to explain the interview process and confidentiality procedures. Clients who agreed to participate were scheduled for an interview, provided a copy of the informed consent document, and were sent email reminders about the interview date and time.

Interviews were held at the agency office in a private room and consistent with the agency's approach, philosophy, and client base, and were conducted by Black women. For participants without transportation, Uber transportation was provided to the interview site. Clients received a $50 gift card to thank them for their time. Each interview lasted between 45 and 90 min, was recorded on an MP3 recorder and transcribed by a professional transcriptionist. The audio recordings, interview notes, signed confidentiality agreements, and gift cards were stored in a locked box at the agency, accessible only to the research team.

At the interview, the interviewers greeted the participant and began the interview by giving the participants an introduction to their background and their relationship with BBC. The interviewer described the interview process and confidentiality agreement, reminding participants that the information collected would be kept confidential. Interviewers reviewed the consent form with each participant to confirm their agreement to participate and ensure they understood their right to decline to respond to any question and to end the session at their choosing. Clients were encouraged to speak freely about their experiences. Interviewers kept field notes recording observations, impressions, and notes about interviewee nonverbal behavior.

Analysis and Safeguarding Trustworthiness

Interviews were coded and analyzed by two doctoral-level researchers with experience in qualitative research, a master's in public health graduate student, and a master's level research assistant. Authors one and two trained the students. Analysts met twice monthly over 5 months while actively coding to discuss the insights they were identifying in the interviews that addressed the questions of interest. The transcripts were analyzed in a multistep process. First, the interviews were read through and remarkable sections were highlighted. Authors one and two reviewed the students' and each other's coding process for consistency and ensuring the coding process was following a systematic pattern. Inconsistencies were resolved through discussion and additional training, as needed. After all coders had completed the initial transcript read-through, focused coding proceeded. A codebook was created and as transcripts were analyzed, participant quotations (including line numbers in the transcripts) were placed under categories that were developed iteratively, and added to, as more transcripts were examined. During that process, 47 main codes were identified. Interpretive categories emerged from memo writing, sorting, and group discussion. Eventually, after collaborative discussion, codes were merged, and some categories were coded quantitatively and/or categorically rather than strictly qualitatively (weeks' gestation, referral source, delivery hospital, etc.). During subsequent rounds of analyses, the team developed themes from the assembled codes, which were then examined for trends. As a member check, we sent interview summaries to a random sample of 40% of participants to check our interpretations of their interviews. Only one participant asked us to edit our summary on a minor point.

Results

Interviews revealed three general themes related to how PSPs supported and helped clients process and reduce the stress in their lives. Participants overall expressed that the meaning of perinatal support was that it eased the transition from pregnancy to motherhood, reducing uncertainty, social isolation, and stress. The transition was eased through receiving emotional, instrumental, and informational support.

Easing the Transition Into Motherhood: Emotional Support

Participants described the meaning of support as easing the transition to motherhood, and this was expressed through PSPs loving them and participants loving and trusting the PSP, and PSPs' assistance in helping manage relationships.

Loving and Being Loved. Participants frequently discussed their experiences with their PSPs using the word "love." They described a mutual relationship built on having love for their PSP and feeling loved by them and the organization as a whole. Love was expressed through intensive individual PSP-client relationships and group interactions in classes with other clients,

instructors, and the staff. One participant described "the sisterhood aspect" of the agency as deeply meaningful. Another participant said, of having a personal relationship with her PSP,

> It was a good feeling, someone to help you, guide you through your pregnancy, someone with you to talk to you, to hold your hand. I mean that was a good feeling. I loved it. It makes me very happy, 'cause I never had that experience, no one to be there with me with that.... It was like/it felt she was my sister sitting with me all along ... I feel loved.

Another participant said her immediate response to her PSP was strongly positive. "It was a warm feeling. I knew that she was gonna protect me. Meeting her for the first time, I felt loved. She remind me of my grandmother, an angel. She's so sweet." [#17, 22, two children]

Describing the closeness she developed with her PSP, another participant said,

> Just in a whole, she's a godsend ... I f-in' loved her because she helped put me in a state of calm and peace ... she was completely just nonjudgmental, understanding, and made me feel better about the space and helped me keep my head up and not so much in the dumps ... getting just as personal with me as personal as I got with her ... just communicating ... She would even just bring stuff over, like "I'm on the way," and she'd come over with honey or tea. [#15, 21, one child]

The participant's reference to calm and peace suggest the ease and stress reduction the PSP helped bring to her pregnancy.

Managing Relationships. In addition to caring for clients, participants said their PSPs also helped them emotionally with managing personal relationships. Participants frequently mentioned challenges navigating relationships with friends, partners, children, and/or other family members. PSPs encouraged clients to communicate and ask for help as needed (e.g., help around the house). One participant said, "they made it easier for me to tell him that you know I needed this help ... to say what I needed." [#6, 33, two children] One participant said she appreciated her PSP's support and neutrality. "She never talked down about anybody that I was talking about. She just kind of listened and tried not to just be one-sided, and she's always honest with me." [#10, 29, one child]

Another participant talked about having "a little drama" with her partner and family while pregnant, feeling "detached" from her daughter and "just being emotional and just crying, and I'd just keep that to myself." She said the support "basically let me know that everything that I was feeling was normal and 'Don't beat yourself up about it, and if you need somebody to talk to, call your doula.'" [#6, 33, two children] One participant distinguished between the PSP and her familial support system, saying her family could be "distracting and focused on worst-case scenarios" around her pregnancy while her PSP offered more constructive experience-based feedback and advice. The participant said, "it just kind of make you feel a little bit better, like 'Okay, (maybe I'm not) going crazy.'" [#2, 28, one child] One participant said her PSP would pick her up to get her out of a conflictual situation and take her out. "When I told her I'm into it with somebody, she'll be like 'Well I'm coming to get you to take you for a ride.'" [#25, 30, four children] Participants' descriptions of emotional support and PSPs' help in reducing social isolation emphasized the indirect and direct ways that they led to stress reduction.

Easing the Transition to Motherhood: Instrumental Support

The theme of easing the transition to motherhood and reducing stress through instrumental support involved meeting basic material needs and obtaining supplies for the baby. Quotes were coded as falling in the instrumental support category when participants described PSPs helping to get them something in particular, for example, material goods or services. Basic needs included helping clients obtain housing, employment, transportation, food, medical services, and connecting them to social service benefit resources such as WIC. One participant talked about how she and her husband were both unemployed during her pregnancy, which led them into a stressful housing situation with a family member. Her PSP helped resolve the situation, saying she "actually put us in the right direction for certain employment things, even with the thought of possibly being employed here." Transportation services were also frequently highlighted as an important benefit and service that helped reduce uncertainty, increase service access, and alleviate stress.

Participants also expressed how obtaining goods such as baby boxes, car seats, strollers, blankets, clothing, diapers, wipes, and supplies needed for breastfeeding assisted with the transition from pregnancy to motherhood. One participant said that "more things were offered" than she needed or knew about.

> Even getting the resources for things I didn't have, like car seats and CPR classes and all of that, I didn't even know that stuff existed.... She made sure I had somewhere for [baby] to sleep, and the nursing stuff, 'cause I wanted to nurse .... so I kind of made a checklist through our conversation of things I needed, things I wanted to make sure I had prior to coming home from the hospital. [#2, 28, one child]

For first-time mothers especially, getting help in obtaining the various supplies needed was seen as invaluable in easing the transition between pregnancy and motherhood.

Easing the Transition to Motherhood: Informational Support

The transition to motherhood, participants said, was also eased by their receiving informational support, particularly with navigating systems and attaining knowledge and skills around pregnancy, childbirth, and parenting. One participant said that for every question she had, "they were very knowledgeable ... they basically had an answer, and if they didn't have an answer, they pointed me in the right direction." Having a trusted resource to turn to for information meant participants felt more confident and less uncertain about their pregnancies and life situations.

Navigating Systems. PSPs' informational support included offering clients techniques and skills for identifying, communicating with, and navigating systems and community resources. These included information on WIC, Jobs and Family Services, Supplemental Nutrition Assistance Program (SNAP) benefits, labor laws, Family Medical Leave Act (FMLA), CPR classes, hospital resources (e.g., midwives, awareness of vaginal birth after Cesarean [VBAC]-friendly hospitals, free clinics), and other resources. Clients said their PSPs' connections, understanding of "red tape," and systems navigation. One participant said, " I just never know how to traverse those things by myself." The PSPs' information, based on their knowledge

and experience, was highly valued. PSPs would not only give information to clients but encouraged and empowered them to act on that information. One client said, the PSP "basically opened up that door for me to take the information that they gave me and take it into my own hands and do further research on it, and so you know that was awesome."

One participant whose daughter had been removed from her custody described how her PSP's social network connections helped her navigate the social welfare system. She explained:

> [PSP] had friends that were lawyers, and she would take different things that were going on with my case and ask them questions of how to deal with certain issues legally, like "What do I say to the social workers? How do I deal with social workers saying this?" [#5, 33, two children]

The participant said her PSP "went with me to ... every single court hearing, she was there ... She fought tooth and nail right along with me to bring <daughter> home." The participant explained that her PSP's support in navigating the court process, telling her what to expect and how to interact with the system was invaluable, and the reason she had custody of her daughter.

Gaining Knowledge and Attaining Skills. Gaining knowledge and skills also eased the transition to motherhood. Participants said they obtained knowledge from the group-based classes and that their PSPs reinforced their learning. Breastfeeding and nutrition classes were highlighted as particularly helpful in giving mothers a roadmap to follow, reducing uncertainty around having a healthy pregnancy.

> I really loved the nutrition one so much because I feel like a lot of pregnant women need to know that more, especially us Black women in the Black community need to know about healthy eating while you're pregnant, and after. [#10, 29, one child]

While the transition into motherhood was particularly important for first-time mothers, participants with more than one child also said PSPs the information they received and reinforced their skills by providing additional tools, reminders, support, and encouragement. Participants said PSPs also taught them specific self-care skills, including giving advice and information on coping skills. Several participants explained they learned stress was better expressed rather than internalized ("better out than in"). One client said, "they told me a lot of ways to deal (with stress), handle, managing it, not to let it bother me and writing about it ... or different ways to address the situation." Participants also described how learning about journaling, meditation, walking, breathing, and employing distraction as coping techniques helped ease their stress.

Discussion

This study found that PSPs played a key role in easing pregnant Black women's transitions to motherhood–for both first-time and mothers welcoming an additional baby–through reducing uncertainty, social isolation, and stress, providing women with resources, and increasing knowledge and skills. Participants felt their PSPs provided them with socioemotional, instrumental, and informational support, modeling key aspects of social support first identified by House (1981). Participants said their PSPs helped them emotionally by demonstrating love, assisting them in working through difficult relationship issues, instrumentally helping them obtain tangible goods to meet their families' basic and baby-related needs, and informationally by getting information that helped them navigate service systems and learn life skills. Detailing the meaning of such supports, women emphasized the importance of being able to meet their own and their families' needs, their need to engage in self-care, and having someone care for them who had their best interests at heart. Our findings echo those of other qualitative findings that indicate the positive relationship between social support and pregnancy outcomes for African–American pregnant women (Barnes, 2008; Edwards et al., 1994). Our findings support those of other research on community-based doulas that emphasized the diversity of roles needed to support clients, particularly serving as a central point of connection for them in disconnected social service systems (Gentry et al., 2010). The PSPs take on roles of family or friend, social service provider, advocate, and "life coach and counselor" (p. 32) similar to those of Gentry et al. (2010) and Breedlove (2005) whose studies identified the impact of community-based doula work for African–American and Latina adolescents. Similarly, Hairston's (2019) review of 15 studies of African–American women found that support, empowerment, knowledge, and resources were all important.

Our findings that participants reported feeling loved and cared about by their PSPs, and the organization as a whole dovetail with such work. Clients' feelings that their PSPs were engaged "knew" them and cared for them and their families were important factors in their experiences being so positive. These findings are similar to Deitrick and Draves's (2008) on the importance of socioemotional support. The finding also echoes that of other research on Black women's experiences that it is essential to attend to the context in which services are provided, not just what services are provided. For example, one study of African–American women's experiences with health-care providers teaching them about health behaviors associated with reduced infant mortality and low birth weight found that providers' qualities of friendliness, demonstration of caring, and respectful interactions were important predictors of the women's applying what they learned (Coleman, 2009).

The emotional support mothers described gaining from their PSPs was similar to themes identified in a qualitative study of a culturally specific program for African–American pregnant women of the importance of "soul nourishment," and "companionship" (Nypaver & Shambley-Ebron, 2016) and in another study, relationship-based caring (Breedlove, 2005) Taking our findings together with that of Woods-Giscombe and colleagues, on Superwoman Schema, and Strong Black Woman Script (Woods-Giscombé, 2010; Woods-Giscombé & Black, 2010; Woods-Giscombé & Gaylord, 2014) suggests that PSPs might interrupt some of the negative influences of the schema and script, including strains on relationships, health behaviors related to stress, the need for independence and demonstrating strength at all costs, while emphasizing positive aspects such as valuing one's culture, and taking care of oneself.

Our findings also indicated that in addition to feeling cared about, mothers felt understood and empowered as a result of their PSPs' support (Campbell-Voytal et al., 2011). The Strong Black Woman Stereotype identifies a tendency to encourage Black women to be "strong" and take care of others rather than themselves, and this is implicated in negative health and mental health in Black women (Abrams et al., 2014; Watson & Hunter, 2016). It may be this organization's approach that helps Black women to fight this stereotype, reach out to others who look like them for help and

get the emotional support they need during pregnancy, which can be an incredibly stressful, emotional, and uncertain time. In one study, one participant said, "care during pregnancy should not be based solely on physical, medical care, but rather on intangible supportive care that nourishes the soul to achieve mental health" (Nypaver & Shambley-Ebron, 2016, p. 562). Our findings support this assertion.

Resource access was identified as an invaluable asset; thus among clients who faced challenges around social determinants of health, getting access to resources related to housing, transportation, education, employment, system navigation, and other material goods were essential (Gentry et al., 2010). This finding is similar to Breedlove's (2005) finding of the importance of the doula's network for pregnant adolescents. Concerning instrumental support, our work also supports the "help me, teach me" theme Nypaver and Shambley-Ebron (2016) identified in their work. The emotional, instrumental, and informational forms of support may serve to reduce clients' social isolation and ultimately, psychological distress, thus a protective measure that results in better birth outcomes (Edwards et al., 1994) and potentially other health outcomes (Reblin & Uchino, 2008).

Limitations

Our limitations include those of similarly structured, small qualitative studies based on one organization in one geographical area. We also highlight a potentially important limitation in that the study relied on PSPs for participant recruitment. Because we were interested in learning about clients' program experiences, we asked PSPs to identify clients who had a strong knowledge of the program through their experience. It is possible that PSPs recruited women who were more inclined to report being pleased with the services they received. However, though there was an overwhelming number of participants who expressed positive relationships, there was some evidence in our sample of mothers who did not have positive PSP experiences.

Implications

Practice Implications

Paraprofessional perinatal support is an emerging field and recognizes the holistic nature of pregnancy within the greater context of women's lives. While prenatal care is an important component of a healthy pregnancy, it is far from sufficient. We should be supporting vulnerable women even before their pregnancies, helping them navigate complex health care and service systems to access interventions that may help reduce the toxic stress of being Black in a racist society. While we know that individual-level interventions are not solutions for macrolevel problems like racism, providing women with service providers available to meet their instrumental and material needs as well as their socioemotional needs during pregnancy, through their births and postpartum is one way to begin to effect societal changes. If treating people with empathy, kindness, and respect can affect clients so deeply as we have observed in this study, perhaps if all providers and systems addressed clients in this way, we would begin to see real change in the shameful maternal and infant mortality rates in the U.S.

Policy Implications

Doula care is a preventive, cost-effective service that could reduce economic expenditures on mental health care and physical health expenditures related to stress and pregnancy-related health disparities (Kozhimannil et al., 2013). It is well documented that doula care reduces the incidence of expensive procedures including C-sections and other interventions (Bohren et al., 2017). Women deserve access to support in their journey through childbirth (Green & Hotelling, 2014) therefore, doulas should be accessible to any woman who desires the service. All women should have free access to perinatal support, not just wealthy White women who can pay out of pocket for the service. Knowing the risks and the higher rates of infant mortality and the role of stress in such rates, the widespread use of doulas could have a strong impact on a population level if utilized in women's pregnancies. Policymakers, insurers, and hospitals would be wise to awaken to the potential for cost savings as well as improving the standing of the U.S. in terms of health disparities (Kozhimannil et al., 2013).

Community-based approaches that use data to inform their approach and tackle this problem in a broad-based way, including training professionals and employing intensive case management such as that described by Chao et al. (2010) may have the most likelihood of succeeding. The potential for community-based approaches and to improve not only the experiences of individual pregnant women but also ultimately, through reducing stress, to improve birth outcomes looms large (National Institute for Children's Health Quality, 2020). We join the advocates from the National Health Law Program (2020) in asserting that "all pregnant and postpartum people deserve access to full-spectrum doula care" (image caption) and that such access has the potential to improve outcomes for our highest risk families.

Research Implications

Further research is needed to fully understand how early in a woman's pregnancy is ideal for having support and whether there is a minimum postpartum period that should be monitored. It would also be helpful to have well-validated standardized measures of changes in perceived stress and perceived support from the beginning of the program involvement to later. Understanding the specific ways in which perinatal support specialists' assistance helps shift women's experiences, and what, if any, time periods are "sensitive periods" for having a positive effect on birth outcomes is critical. It would also be valuable to disentangle the literature surrounding emotional support identifying how long the positive effects of perinatal support specialists' social support can be maintained and to what extent professionally based support can be sustained over time.

Conclusion

Our findings suggest that emotional, instrumental, and informational support offered by PSPs is deeply meaningful for pregnant Black women. Feeling loved and loving in return, learning to manage interpersonal relationships, obtaining material goods for basic needs, and to prepare for their baby's arrival, and informational support in the form of learning to navigate systems and gain knowledge and skills were all seen as helpful and important.

The findings add to the literature pointing toward the importance of individualized social support for pregnant women in general, Black women in particular, to the value of community-based doula services, and may suggest one way to reduce pregnant women's stress and improve social determinants of health for this population.

Keywords: Black mothers, pregnancy, social support, health disparities, perinatal support

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