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Black women's experiences with professional accompaniment at prenatal appointments

Cyleste Collins^a, Rong Bai^b, Portia Brown^c, Cassandra L. Bronson^d and Christin Farmer^e

^aCleveland State University, School of Social Work, Cleveland, OH, USA; ^bJack, Joseph, and Morton Mandel School of Applied Social Sciences, Case Western Reserve University, Cleveland, OH, USA; ^cSelf employed, Cleveland, OH, USA; ^dKent State University, Public Health, Kent, MI, USA; ^eBirthing Beautiful Communities, Cleveland, OH, USA

ABSTRACT

U.S. public health statistics report dismal Black infant and maternal mortality rates. Prenatal care alone, while essential, does not reduce such disparities. Objectives: The purpose of the study was to explore Black women's experiences when a perinatal support professional (PSP) accompanies them to prenatal medical appointments. Design: This research used a phenomenological approach, using data from in-depth individual interviews to explore the essence of 25 Black women's experiences. Results: We identified three major themes from the data that together, show that PSPs served as communication bridges for their clients. Clients said their PSPs helped them to understand and feel seen and heard by their medical providers during their prenatal appointments. The third theme was the deep level of trust the clients developed for their PSPs which made the first two themes possible. PSPs' intervention resulted in reduced stress and uncertainty in medical interactions and increased women's trust in their providers' recommendations. Conclusions: Including a trusted, knowledgeable advocate like a PSP may be an important intervention in improving Black women's prenatal care experiences, reducing stress associated with medical interactions, and ultimately reducing pregnancy-related health disparities.

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Introduction

Longitudinal data from the Centers for Disease Control and Prevention (CDC) indicate non-Hispanic Black women in the U.S. have the highest rates of pregnancy-related mortality, with non-Hispanic Black women and infants dying at two to five times the rate of White women and infants (Centers for Disease Control and Prevention 2019b; 2019a). Although public health statistics such as these have been criticized for reifying race rather than viewing it as the social construct it is, it is important to develop an understanding of pregnancy-related mortality among Black women to inform public policy and program development (Nuru-Jeter et al. 2009). In Cleveland, Ohio—where this

CONTACT Cyleste Collins  c.c.collins44@csuohio.edu  Cleveland State University, School of Social Work, Cleveland, OH 44115, USA

research was conducted—rates of infant mortality are at crisis levels, with non-Hispanic Black infants dying before their first birthdays at nearly six times the rate of White infants (First Year Cleveland 2020), a disparity that requires urgent action.

U.S. maternal and infant mortality disparities are theorized to be due in part to the traumatic racist legacies of slavery, Jim Crow laws, and mass incarceration of Black men, that wreak havoc on Black bodies (Dominguez et al. 2008; Wallace et al. 2017). Historical disadvantage, combined with the toxic stress associated with day-to-day microaggressions and overt racism, accumulate in the body, leading to the weathering of Black women's bodies over time, resulting in health disparities (Forde et al. 2019; Geronimus 1992; Slaughter-Acey et al. 2019), including pregnancy-related disparities (Braveman et al. 2017; Carty et al. 2011; Collins et al. 2004; Dominguez et al. 2008).

Black women and prenatal care

Despite mounting evidence of the pernicious impact racism has on the body, research shows that some medical providers tend to blame Black women—not racism—for negative birth outcomes, especially those not seeking prenatal care (Davis 2019). Although early attention to prenatal care early and continuity of care reduce African American infant mortality rates (Johnson et al. 2007; Mazul, Salm Ward, and Ngui 2017), several medical and nonmedical factors act as barriers to Black women's accessing quality prenatal care. Such factors include: health care providers' attitudes and behaviors; perceiving racism in medical provider interactions; distrusting medical providers; lacking transportation to appointments; lacking child care during medical appointments; and low socio-economic status and educational achievement (FitzGerald and Hurst 2017; Nypaver and Shambley-Ebron 2016; Partridge et al. 2012; Slaughter-Acey et al. 2019; Slaughter-Acey, Caldwell, and Misra 2013). Patient-centered communication, however—ensuring patients feel respected, involved, engaged, and knowledgeable about their care—is associated with decreased uncertainty and distress (Epstein and Street 2011).

Studies have found that medical providers tend to show less positive affect and are less likely to use patient-centered communication with African American patients (Lori, Yi, and Martyn 2011). Researchers have identified patterns of negative interactions with medical providers in which pregnant Black women felt they were discriminated against, were treated unfairly and disrespectfully and had difficulty communicating their needs at prenatal visits (Cuevas, O'Brien, and Saha 2016; Dahlem, Villarruel, and Ronis 2015; Lori, Yi, and Martyn 2011; Mazul, Salm Ward, and Ngui 2017; Salm Ward et al. 2013). Davis (2019) describes such experiences as one manifestation of obstetric racism, a dynamic that includes 'neglect, lack of information, dismissiveness, disrespect, and interventions without explanation' (569).

Davis (2019) argues it is essential to recognize the intersections of race and gender in medical interactions. Medical providers' tendency to treat Black bodies without considering or acknowledging social contexts add to Black women's accumulated stress (Davis 2019), threatening their health in pregnancy and beyond. There is a need, then, to better understand Black women's experiences and how we can effectively intervene to reduce such disparities. Best practices must be developed by fully hearing the voices of persons most affected by obstetric racism and health disparities—in this case, Black women. Effective interventions must be community-based, tailored to women's unique

needs, and incorporate tools for managing stress and supporting women during pregnancy. This study discusses one such intervention.

Interventions focused on improving birth outcomes

Clinical interventions that focus on improving women's experiences with prenatal care have shown success engaging low-income high-risk women in prenatal care and reducing infant mortality rates (e.g. Centering Pregnancy, the Nurse-Family Partnership). While powerful, these programs do not explicitly focus on prenatal care for Black women, nor did they evaluate the potential impact of medical provider race on engagement with Black women. Despite the association of patient-provider racial concordance with better communication (Shen et al. 2018) and more positive infant health outcomes (Greenwood et al. 2020), the health care workforce remains predominately White (Artiga et al. 2020). Without concordance, and given that racism likely interferes in the relationship between providers and patients (Davis 2019), interventions that address obstetric racism are likely to be more effective in ensuring Black women receive high-quality prenatal care than interventions focusing on improving Black women's health behaviors (Gennaro et al. 2016).

Community-based programs for pregnant women engage women holistically through education, building social support systems, and building social capital (Coffman and Ray 1999; Hmiel et al. 2019). One integrative review supports this idea, noting that countries whose maternal mortality rates are low include 'the use of holistic woman-centered approaches' and attention to women's well-being (Mirzakhani et al. 2020, 'Conclusion,' para. 2). Community-based doula care is an especially promising approach to addressing disparities through offering emotional support and thereby increasing well-being, self-confidence, positive early attachment behaviors, and supportive networks (Breedlove 2005; Hardeman and Kozhimannil 2016). Research links doula support during labor with positive birth outcomes (Bohren et al. 2019; Kozhimannil et al. 2013). Culturally focused, community-based doulas who provide comprehensive relationship-based support may be a key intervention for Black pregnant women in efforts to reduce infant mortality (Breedlove 2005).

Study context: birthing beautiful communities, Cleveland, Ohio

One intervention centered around an individualized, relationship-based care model is in the program where this research took place, Birthing Beautiful Communities (BBC). A Black-owned nonprofit community-based organization in Northeast Ohio, BBC has served over 600 women since 2014. Focused on reducing Black infant mortality rates, BBC explicitly recognizes the impact of collective historical traumas, systemic racism, and inequities on Black communities. BBC addresses the chronic stress of being Black in a racist society by providing individual and group-based social support to Black pregnant women and their families. Following them through their pregnancies, births, and one year postpartum, BBC pairs women with Black perinatal support professionals (PSPs) (referred to here as doulas) who develop detailed intervention plans to address each client's and family's current needs, and life goals (Hmiel et al. 2019). BBC ensures PSPs consistently serve the same women over time. BBC is led by Black women who see their work as a calling.

BBC's services are individualized to recognize women's diversity, culturally matching PSPs to clients based on their community of residence (Hmiel et al. 2019). PSPs get to know clients and their families, accompany clients to prenatal medical appointments, offer labor and delivery support, support clients postpartum, serve as educators and social networks, and connect them with outside resources. Led mostly by Black experts in the community, the program also offers group-based including classes (e.g. nutrition, cooking, smoking cessation, yoga, breastfeeding) and psychosocial support groups tailored for Black women. Although both PSPs and traditional doulas both help clients prepare for and attend births, PSPs undergo more intensive training and offer more services for a longer period (see Table 1).

Study aims

This study explores clients' experiences with PSPs accompanying them to prenatal appointments. The specific research question asked is: Among Black women enrolled in a community-based perinatal support organization, what was the meaning of their experiences with PSP prenatal medical appointment accompaniment? To our knowledge, this is the first study examining Black women's qualitative experiences with community-based perinatal support professionals at prenatal appointments.

Methods

Design

This study used a phenomenological approach to develop an understanding of Black women's experiences with PSPs accompanying them to prenatal medical appointments. Phenomenology involves identifying the meanings people give to their shared lived experiences (Creswell 2013; Moustakas 1994). Phenomenology assumes reality is both subjective (experienced consciously by the individual) and objective (shared with

Table 1. Doula and PSP Similarities and Differences.

	Perinatal Support Professional (PSP)	Traditional Doula
Differences	<ul style="list-style-type: none"> • Trained and certified • Specialized training in social determinants of health • Lives in the community served • Cultural humility & empathy • Assists client in creating a self-sufficiency & goal plan • Provides: <ul style="list-style-type: none"> ○ Childbirth education ○ Support during pregnancy, labor, and postpartum ○ Sex and reproductive health education ○ Parenting/co-parenting education ○ Stress management support, tools, and skills ○ Prenatal appointment accompaniment • Free Service (paid by donors, other sources) 	<ul style="list-style-type: none"> • Might or might not be trained/certified • Number of prenatal home visits limited • Paid by client
Similarities	<ul style="list-style-type: none"> • Continuous labor support during birth • Support for family • Creates birth plan with client • Encourages breastfeeding • Supports client after birth (not all doulas) 	

others). Thus, we assumed our participants could consciously express their experiences and the meaning of the experience of having a PSP accompany them to appointments. We interviewed participants in-depth one time.

Data collection

Participants

To be eligible for the interview, clients had to have been enrolled in BBC and maintained consistent contact with their PSPs during their pregnancies, attended a series of support groups, and be at least 18 years old. PSPs directly contacted clients who fit the eligibility criteria and asked if they were interested in participating in the study. A research assistant contacted interested participants, explained the study's purpose, interview, and confidentiality procedures, and scheduled the interviews. We contacted 36 clients and interviewed 25.¹ Interviews continued until the interviewers determined the interviews were yielding little new information; that is, the collected data were becoming saturated.

We interviewed 25 Black women between October 2017 and January 2018. All but one identified as African American, one identified as African. On average, participants were 28 years old ($SD = 5.8$); slightly less than one-quarter (24%) of participants were between 18 and 23, 44% were 24–29, and 28% were 30 or older (the oldest was 41). Most (72%) participants were unmarried, either single (44%) or living with a partner (28%). Most (84%) had one or two children (including the child born during the program). Just under two-thirds (64%) reported their highest education level was a high school diploma, 20% had an associate's degree, and 12% had a bachelor's degree or higher. We interviewed participants between six weeks and five months after their babies were born.

Prenatal appointment accompaniment was just one of many services offered through BBC, and not all clients used the service. Sixty percent of our participants reported their PSPs accompanied them to their appointments, and there were no demographic differences between those who accepted and those who declined accompaniment. Of those who declined to be accompanied ($n = 10$), nine offered reasons (having someone else accompany them [$n = 4$]; believing the PSP was too busy to accompany them [$n = 2$]; appointments were too short, unimportant, or not wanting to inconvenience the PSP [$n = 3$]).

Materials and interview guide

Taken from an interview covering the time from prenatal enrollment in the program through the postpartum period, the interview questions explored here examined clients' experiences during pregnancy and at their prenatal appointments. The research team, the organization's CEO and staff, and funders collaboratively generated the interview questions. All questions were open-ended to encourage participants' emic responses. The following questions asked participants about their experiences with prenatal appointment accompaniment: (1) 'What expectations did you have about the doula [PSP] being available to accompany you on your prenatal visits?' (2) 'How well did the both of you [you and your PSP] work out your [birth] plan? What, if anything, would you have done differently or included in your planning?' (3) 'If the doula [PSP] accompanied you to some prenatal visits, how was it different from when you went alone (either with this doctor or any other)?' Responses referring to prenatal appointments were also included from the following prompt: 'Pregnancy can be a stressful

time. Please share any examples of how the doula [PSP] relieved any emotional strains you were dealing with.'

Procedures

Participants took part in one face-to-face in-depth interview at the BBC office in a private room. The interviewers were African American women who pilot-tested the interview guide as part of the training process. BBC staff provided child care if the client wanted or needed it. The interviews averaged 60 minutes long, ranging from 45 to 90 minutes. We recorded interviews using a portable MP3 recorder and a professional transcriptionist transcribed the recordings. Participants received a \$50 gift card for their time. The Cleveland State University institutional review board approved all study protocols under a full board review (#FY2017-75) and each participant signed an informed consent document.

Data analytic strategies and establishing trustworthiness

The research team met regularly during the coding process, collaboratively discussing, processing, and bracketing (consistent with phenomenological procedures; Moustakas, 1994) their own experiences with medical professionals. Of the five-person research team, three were White and two were African American. Having multiple team members contributing to the research, some of whom had been pregnant and others who had not, helped manage potential biases as they discussed, and then set aside, their own experiences with healthcare providers in general and prenatal care in particular.

We analyzed the transcripts in several phases, following procedures for phenomenological research in identifying the essence of participants' experiences. We started by identifying smaller, specific units of analysis in the transcripts (i.e. quotes) and then expanding the analysis to build our interpretation of how participants perceived the broader meanings of their experiences. Team members read through the transcripts and identified quotes that resonated with them regarding the research questions of interest. The team discussed their interpretations of the quotes' significance and meanings, cross-checked each other's work to ensure consistency (i.e. quotes identified and meanings agreed upon), and held discussions to resolve discrepancies (there were few). We developed the codebook using grounded codes, then agreed on categories describing codes across interviews, adding codes as needed.

Member checks involved randomly selecting a sample of participants, emailing them interview summaries, and asking for feedback. Only one participant responded with a comment. Analyst, method, and source triangulation (Patton 2015) were all used to ensure methodological integrity. Multiple analysts coded, and a PSP focus group conducted early in the study allowed source triangulation (those data are not reported here, see Hmiel et al. 2019). Methodological triangulation was established by analyzing agency administrative data (not reported here).

Results

We identified three major themes from the data. Overall, PSPs introduced a sense of ease for clients. In sharing their experiences of when their PSPs attended their appointments,

participants compared those experiences with times when their PSP did not attend, and for those for whom the pregnancy was not their first, with a previous pregnancy in which no PSP or doula accompanied them to appointments. Participants described how their PSPs bridged communication with their medical providers during prenatal appointments by helping them to understand their medical providers and helping them be seen and heard by those providers. The deep level of trust the clients developed for their PSPs made the communication bridging possible and helped reduce clients' stress during appointments (Table 2).

Table 2. Themes and Representative Quotations: PSP as Communication Bridge.

Theme	Representative Quotes
1) Increasing understanding of medical providers	When doctors sometimes talk to you, they say a lot of things that scare you, and so she would just make me feel comfortable with what they just told me.
2) Feeling seen, heard, and understood by their medical providers	She ... let me know that she could ... go to some doctors' appointments with me and kind of help to facilitate the discussion with the doctor.
3) Feeling known by and trusting the PSP	This is gonna be somebody who understands primarily what I want. ... When you're pregnant, you feel all alone and stuff.

Increasing understanding: PSPs helped clients understand their medical providers

Participants said their PSP helped them to understand their medical providers' messages by translating medical terminology into plain language. PSPs also interpreted, clarified, contextualized, and helped participants process medical information, which increased their understanding of diagnoses, treatment options, and recommendations. PSPs' knowledge of the local hospitals and processes was also helpful. Participants said their PSP either translated medical teams' words, rephrased, and/or followed up to ensure participants understood, with one participant saying, 'Doctors like to use fancy words that people don't really know what they mean, and so I would look at her like "What do that mean?" and she'll be like "Oh that means such and such."' Another participant said her PSP 'spoke the language of the doctors,' and another said her PSP would 'read between the lines with my doctor.' PSPs used their knowledge of both medical providers and participants to aid communication, bridging communication gaps between them. Another participant said her PSP was 'kind of like a mom that knows what's going on ... I was scared to ask my midwife, and so it's like the things that I didn't ask her [the midwife] this time, I would just ask my doula in this pregnancy' noting that her PSP was both knowledgeable and trusted.

PSPs also used their knowledge to help clients clarify and process information.

It was very helpful, and if they [medical providers] said something to me that I didn't necessarily want to happen ... she would clarify it with me and make me look at it at a different angle than how they try to make it seem like. ... You know when doctors sometimes talk to you, they say a lot of things that scare you, and so she would just make me feel comfortable with what they just told me.

Another participant said the PSP's experience and knowledge led her to ask specific questions: 'she thought of some questions I didn't think of.' Another participant said her PSP reassured her. After hearing information from her provider, the client said

would check with her PSP to find out if a condition or issue was common and then follow up with her provider. ‘So then when I asked my doctor about it, just something simple, that he further explained.’ In helping women process information through clarifying, contextualizing it and normalizing it, PSPs helped clients reduce their fear, uncertainty, and stress.

Another participant echoed the idea that medical providers’ messages confused and/or upset her. She said when her provider described dangerous conditions such as obesity and preeclampsia, her PSP’s support and ability ‘to understand these things’ decreased her discomfort. PSPs’ knowledge about medical alternatives aided clients in understanding their medical options and asking providers questions about alternative courses of treatment. One participant explained how her PSP facilitated a discussion on her options.

I think when we were discussing the VBAC versus the cesarean, she kind of let me know that she could, if I wanted, go to some doctors’ appointments with me and kind of help to facilitate the discussion with the doctor about that, which was good, because I didn’t know how to have the discussion ‘cause I didn’t even know there was a such thing.

This quote suggests the PSP’s pregnancy knowledge of options and the medical environment opened pathways to alternative care options. Through helping clients better understand their providers, PSPs helped reduced their uncertainty and informed decision-making. Even when they did not attend appointments, participants said their PSPs followed up to help them process information from and feelings about appointments.

Feeling seen and heard: PSPs helped clients feel seen and heard by their medical providers

Besides to helping clients understand their healthcare providers, participants also said their PSPs empowered them and advocated for them by helping their providers see, hear, and understand them. Empowerment and advocacy were manifest in PSPs’ preparing clients for prenatal appointments ahead of time, encouraging clients to ask questions, translating clients’ questions for providers, and speaking up for them when needed.

PSPs’ preparations for prenatal appointments included developing questions in advance. Participants considered this active preparation very important. One participant said she and her PSP would talk about concerns she was having and make a list of issues to discuss at the appointment so ‘nothing would go unresolved.’ Another said the early preparation helped her feel ‘very comfortable and not nervous to go and see my doctor. ... [When] I’m just by myself, it’s confusing.’

During the appointments, participants said their PSPs documented the discussion, encouraging and reminding them to ask questions, and (when needed and appropriate) advocated by directly speaking up for them. One participant said, ‘[my PSP would] be like “Oh, didn’t you wanna ask her about that before she leaves,” and I be like, “Oh yeah. Thanks for reminding me.”’ This participant described her PSP as her ‘extra memory.’ Another client said her PSPs’ documenting the appointment helped reduce her stress. ‘Sometimes I couldn’t remember the stuff that the midwife was saying. It was nice to have [the PSP] there ... she was writing stuff down; I was just sitting there a little bit overwhelmed.’ This quote suggests the PSP helped reduce clients’ stress.

In addition to helping clients consume information, PSPs encouraged them to speak up for themselves, and when necessary, spoke for them. One client said, ‘she was my

advocate, so things I wouldn't feel comfortable saying, she would say.' Another participant said that her PSP, after clarifying her provider's question, would ask, 'Do you mind if I answer it for you?' Another participant shared how her PSP's advocacy and intervention helped reduce her anxiety. 'During the end it was a little rough and a little anxiety came about. So to have my doula to be able to call and actually get answers, because she's familiar with what's going on in the hospitals, that was nice.' Another participant said, 'at the appointments, she made sure my words got through to my doctor.' Another said her PSP questioned medical providers when needed, prompting them to provide more clarity.

I think they [providers] took me more serious when she was there because, honestly, when you go to an appointment by yourself, if you don't got no questions, they don't have no questions. ... Your doula can ask questions for you and have them check things, and things you might not think about. And then they'll ... take the time and sit there and explain to you.

Another noted that her PSP would directly ask providers about alternative treatment options.

I will say that if the midwife or doctor tried to tell me something that she knew didn't necessarily have to happen or go the way that they were saying that it has to go, she [the PSP] would speak up right then and there, and then the midwife or doctor would be like, 'Oh yeah, well we can do it that way, or it can go that way.'

Another participant said her PSPs' role became especially clear when her medical provider gave her unnecessary medication and did not listen to her when her PSP was not with her. She said, 'they wasn't listening to anything that I was saying there concerning my health or how I felt.' But when her PSP became involved, she said, 'then they really paid attention. ... I don't know why they listened to her more than they listened to me, but ... when she's not there, they don't really listen to the symptoms that I had. They went, "Oh it's normal."' Comparing a previous pregnancy to the one with her PSP, another participant said, 'I wish I would've had somebody to go with me ... if I would've had somebody with more information going with me, I feel like I wouldn't have been treated like I wasn't nobody.' Another participant felt her providers took advantage of when her PSP was not with her, saying, 'they tried to play me.' These quotes suggest PSPs' advocacy at appointments helped clients feel seen and heard by their providers.

Feeling known: clients deeply trusted their PSPs

How were PSPs able to help clients so effectively? Participants noted their PSPs established deep, close, trusting relationships with them by helping to remove barriers related to the social determinants of health so that clients could more easily attend their prenatal appointments. PSPs were available for any reason or need, not just specific services. They helped arrange transportation to appointments and to pick up medications and sometimes provided childcare during especially long appointments (e.g. ultrasounds). One participant described the connection her PSP had with her child, developed during appointments. 'They had their own little relationship. ... That was a godsend because having a 5-year-old, and you're trying to get a vaginal exam is not easy ... It was definitely what I needed.' This quote shows the importance of clients' trust in PSPs developed in part by their help in relieving barriers to care. Another participant described how her PSP earned her trust and reduced feelings of isolation.

‘We want to give you tools to succeed,’ is basically what she was saying. ... That was something that made me feel very comfortable. ... The goal is to kind of mentally, emotionally advance you so that you’re not forever needy, but it’s good that you can still have that support while you’re getting to that point. ... It was the most supportive, short conversation that I had. I didn’t know that lady from a can of paint, but I felt like, ‘This is gonna be somebody who understands primarily what I want, and then it’s telling me, as we grow together and learn more, then this is a place where people can be there for you too.’ When you’re pregnant, you feel all alone and stuff.

This quote emphasizes the participant’s receptivity to the PSP’s offers to be there for her, for any need she had. Comparing times when her PSP attended appointments to times when she attended alone, another participant described how much her trust in her PSP meant. ‘It was a couple of times where I went by myself and my blood pressure would be sky-high, but then soon as I went with my doula, I had a normal blood pressure.’ This comment suggests the trust clients had for their PSPs might have helped measurably reduce stress and was foundational to clients’ positive prenatal appointment experiences.

Discussion

Black pregnant women who attended prenatal appointments with a PSP felt their PSPs acted as communication bridges, helping them to better understand their healthcare providers, and ensuring their providers saw and heard them. Through translating, interpreting, clarifying, and contextualizing providers’ information, asking questions, encouraging clients’ questions, helping clients plan for appointments, recording information at appointments, speaking up for them when necessary, and removing practical barriers to clients’ prenatal care, PSPs empowered their clients. Participants said their PSPs’ actions helped them feel more relaxed and less stressed when they attended appointments accompanied by their PSPs, in contrast to when they attended without them. The PSP’s communication skills, experience, knowledge (of pregnancy, healthcare, Black women’s challenges, and communities), and removal of barriers contributed to clients’ developing trust in their PSPs. Through deeply knowing their clients’ lives, families, and social contexts, PSPs prepared clients to actively engage in their prenatal care.

Contribution to the literature

Our study is uniquely located in its focus on the intersections of race and gender, and as such, contributes to our understanding of Black women’s experiences with medical care in general and prenatal care, in particular, by focusing on the meanings and value professional support had for them. It is important to develop a strong understanding of how a PSP model can help Black women navigate barriers and communication obstacles in prenatal care and systemic racism in medical care. Knowing the specific ways their experiences add to the ‘weathering’ of pregnant Black women’s bodies that have accumulated toxic stress (Geronimus 1992) is essential to identifying interventions that can help reduce burdens that contribute to the disproportionate risk of adverse birth outcomes for this population (Dominguez et al. 2008). Our centering of Black women’s voices about being accompanied to prenatal appointments within the auspices of a unique, individualized community-based perinatal support model highlights a promising approach to improving women’s experiences with prenatal care, and potentially, maternal and infant mortality rates.

PSP's communication bridge efforts ultimately reduced clients' stress. Participants affirmed their PSP's role in helping reduce stress, with one woman specifically noting her blood pressure was lower when her PSP accompanied her, a potential physiological manifestation of clients' reduced stress through PSP support. These data support the benefits of PSP prenatal appointment accompaniment and prior research on the benefits of doulas in pregnancy (Kozhimannil et al. 2016) and labor (Hardeman and Kozhimannil 2016).

The importance of relationships

The necessary precondition to PSPs being an effective presence at prenatal appointments was that they had a strong relationship with their clients; they knew and trusted them. Matching clients with PSPs from similar communities (Hmiel et al. 2019) helped initially establish trust. From there, PSPs' frequent and consistent engagement with clients, assessing and removing barriers to prenatal care demonstrated caring for their clients (Coffman and Ray 1999; Kozhimannil et al. 2016; Nypaver and Shambley-Ebron 2016). PSPs showed their commitment to their clients through their reliability, responsiveness, and access to resources, setting the stage to support clients at prenatal appointments. That clients were more accepting of health information coming from and interpreted by the PSP, a trusted and known member of their community, is significant in understanding how PSPs could bridge communication gaps between clients and their healthcare providers. Our findings suggest these personal connections and a 'mutual intentionality' (Coffman and Ray 1999) might have facilitated their relationship.

Understanding information to improve health and trust of healthcare providers

One key to good communication and to becoming engaged healthcare consumers who make informed decisions is understanding healthcare providers' information. The participants in this study described feeling stress and anxiety when they did not understand their providers and/or suspected their providers did not have their best interests at heart, findings consistent with previous research (Mazul, Salm Ward, and Ngui 2017). PSPs helped facilitate client-provider relationships through increasing clients' understandings, serving as healthcare advocates (Agency for Healthcare Research and Quality (AHRQ) 2016), reducing clients' anxiety, and improving the prenatal appointment experience. PSPs taught their clients skills (e.g. planning for appointments) and modeled health literacy and self-efficacy which may lead to increased self-determination (Porr, Drummond, and Richter 2006). PSPs also encouraged clients to be more active and engaged in their prenatal care, promoting positive communication and interactions between patients and their providers which encourages provider patient-centeredness (Wheatley et al. 2008).

Fighting the effects of racism through patient-centeredness and doula care

In addition to fully understanding the information healthcare providers give us, it is also essential that providers practice patient-centered care. Patient-centeredness in care involves 'the patient feeling known, respected, involved, engaged, and knowledgeable,' (Epstein and Street 2011, 101), and is demonstrated by listening, seeing people as individuals, being respectful, 'showing interest, and being non-judgmental and accepting'

to ensure patients feel ‘welcome and respected and valued’ (Heaman et al. 2015, 7; Wheatley et al. 2008). Patient-centeredness can thus help ‘mitigate a patient’s distress’ (Epstein and Street 2011, 101) and involve concrete actions that run counter obstetric racism (Davis 2019) and implicit bias which interfere with a positive prenatal experience (Davis 2019; FitzGerald and Hurst 2017; Thomas 2018).

Davis conceptualizes doulas’ work as a way to disrupt obstetric racism and resist the medicalization of pregnancy and childbirth (2019). When providers communicate effectively, demonstrate respect, caring, and earn clients’ trust (characteristics of PSPs), patients are more satisfied and adhere to providers’ care recommendations (Cricco-Lizza 2005; Evans and Sheu 2019; Lori, Yi, and Martyn 2011; Wheatley et al. 2008). Although health-care providers would ideally have these qualities, our findings show PSPs can bridge existing gaps between clients and providers whether gaps exist because of racial bias, lack of interest, time constraints, and/or other reasons (FitzGerald and Hurst 2017; Thomas 2018). Given racial disparities in birth outcomes, developing a trusting relationship with an advocate who can improve communication between Black women and their medical providers may be a crucial tool in improving outcomes through reducing anxiety, uncertainty, and stress, and potentially, improving birth outcomes.

Our findings are generalizable outside the immediate study locale and internationally. Mistreatment of women in the prenatal context is not unique the U.S.; other countries have documented the need for women to be treated with dignity and respect (Sen et al. 2018). Literature on the benefit and value of doulas is also international in nature (Bohren et al. 2019). The addition of a doula or perinatal support professional should benefit any population suffering from health disparities, that has a history and/or experience of mistreatment in a medical context and who may be in need of advocacy.

Limitations

One study limitation is that BBC clients self-select, and they may be more aware of their needs and/or more motivated and engaged in their care than other pregnant women. Clients also had phone and/or email services, kept in touch with the agency, had the time and energy to engage fully with the service model, as well as those interested enough to participate in a research study. Thus, these data might represent particularly motivated clients who could attend prenatal appointments and actively engage with the program. Our findings also represent clients’ retrospective views after their babies were born, so it is possible they omitted information about prenatal appointments due to forgetting. Our findings should transfer well to patients/clients in similar contexts, as our sample’s demographics were similar to those of other local programs. However, the perinatal support model we have described is both specific and intensive; PSPs were available nearly 24 hours a day, spent substantial time with their clients, and knew their clients and their families well.

Implications

Practice implications

The findings have implications for improving access to prenatal healthcare and suggest interventions for reducing pregnancy-related mortality. Practitioners should work toward improving healthcare practices and decreasing disparities through patient-

centeredness and improved communication. It is ethically critical for providers to use clear, understandable, useful language patients understand, avoiding medical jargon (Killian and Coletti 2017), especially when clients have no healthcare advocate such as a doula or PSP to assist them. Engaging with a PSP model of care brings an understanding of race and gender to prenatal care encounters that could help combat obstetric racism. As Black women, PSPs serve other Black women with a deep understanding, identification, and empathy for issues facing Black women in particular. This explicit recognition of the importance of race and gender in healthcare provision allows for a tailored understanding and ability to serve women holistically. Such strategies facilitate trusting relationships, demonstrate caring, and empower women (Carel 2011; Cricco-Lizza 2005; Evans and Sheu 2019; Wheatley et al. 2008).

Policy implications

Policymakers need to recognize how prenatal medical appointment accompaniment could be an essential service given its potential for improving women's care experiences, and ultimately, stress related to racism. Programs that allow pregnant women access to advocates whom they know and trust may improve healthcare experiences during the prenatal period, a time that can be uncertain and stressful because of the many hormonal and bodily changes pregnancy brings. Because Black women are particularly at risk for maternal and infant mortality in part due to exposure to racism, however, specific interventions must be prioritized for this population. With their ability to support, advocate, and translate and interpret healthcare information, PSPs are a critical but underappreciated tool in the battle against maternal and infant mortality. Insurers, including Medicaid, should fully support doula/PSP prenatal appointment accompaniment and other services as a cost-saving strategy for addressing and even preventing health disparities (Hardeman and Kozhimannil 2016; Kozhimannil et al. 2013).

Research implications

Hearing Black pregnant women's voices, learning about their experiences, and understanding the meaning of these experiences are essential for contextualizing pregnancy-related mortality rates and for developing knowledge of Black women's experiences and how they can be improved. Future research utilizing a matched control group without a PSP would be useful to more fully understanding the impact of PSPs' services. Longitudinal research following up on clients could also provide insight into the effects of PSP services on other health disparities in the long term. Future studies could explore interactions between PSPs and medical professionals to identify the extent to which and in what ways medical professionals see PSPs as helpful, boosting the argument that PSPs were helpful to both clients and medical providers. Additionally, including standardized measures of perceived racism and stress could help us to better understand women's experiences and outcomes.

Conclusion

Culturally matching Black pregnant women with perinatal support professionals to accompany them to prenatal appointments has the potential to help reduce pregnancy-related health disparities through dampening the stress-related impacts of

racism. Establishing a trusting relationship in which PSPs removed barriers to prenatal care, PSPs bridged communication gaps, supporting clients before, during, and after prenatal appointments. In providing the continuity of a trusted advocate, and encouraging medical providers to be patient-centered, PSPs may reduce clients' stress and uncertainty around prenatal care, increasing the likelihood they receive high-quality care and improving their health literacy. All Black women deserve the chance to achieve a healthy pregnancy, and PSP appointment accompaniment could be an essential, potentially cost-saving way to achieve that goal.

Note

1. Reasons for non-participation included: client moved out of state (n = 1), no-show to scheduled interview (n = 4), messages left but calls not returned or phone did not accept calls (n = 6).

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