African American Women's Preparation for Childbirth From the Perspective of African American Health-Care Providers

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ABSTRACT

Preparation for birthing has focused primarily on Caucasian women. No studies have explored African American women's birth preparation. From the perceptions of 12 African American maternity health-care providers, this study elicited perceptions of the ways in which pregnant African American women prepare for childbirth. Focus group participants answered seven semistructured questions. Four themes emerged: connecting with nurturers, traversing an unresponsive system, the need to be strong, and childbirth classes not a priority. Recommendations for nurses and childbirth educators include: (a) self-awareness of attitudes toward African Americans, (b) empowering of clients for birthing, (c) recognition of the role that pregnant women's mothers play, (d) tailoring of childbirth classes for African American women, and (e) research on how racism influences pregnant African American women's preparation for birthing.

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Pregnancy is a special time in the life of most women (Ladewig, London, & Davidson, 2009; Lowdermilk, & Perry, 2007). Many women face the end of pregnancy and approaching childbirth with trepidation. They are eager for pregnancy to end but worried about the uncertainties of labor and birth (Olds, London, Ladewig, & Davidson, 2004). How women prepare for this experience has thus far been viewed primarily through the eyes of Caucasian women. Little has been documented in the literature about African American women's preparation for childbirth (Lu & Halfon, 2003). Nevertheless, African American women hold a unique place in American society. They are often made to feel marginalized, stigmatized, and stereotyped because of racism practiced against them (Johnson & Staples, 2005; Jones & Shorter-Gooden, 2003; Taylor, 1998). The literature is replete with abysmal, adverse health-care outcomes for pregnant African American women and their newborns (Alexander, Wingate,

Little has been documented in the literature about African American women's preparation for childbirth.

Bader, & Kogan, 2008; Alio et al., 2009; Culhane & Elo, 2005; Gavin, Adams, Hartmann, Benedict, & Chireau, 2004; Gennaro, 2005; Gennaro, Shults, & Garry, 2008; Giscombé & Lobel, 2005; Grady, 2005; Hogan & Ferré, 2001; Hogan, Njoroge, Durant, & Ferré, 2001; Hogue & Bremmer, 2005; Jones, 2005; Lu & Halfon, 2003). The statistical divides between Caucasian and African American represent marked differences in life experiences, which merit renewed interest. The Centers for Disease Control and Prevention (CDC) has championed research into the reasons for this disparity (Williamson et al., 2008). Such research gives voice to pregnant African American women and their "self-defined experiences of pregnancy" (Rowley, 2001, p. 73). Understanding African American women's preparation for childbirth is an attempt to implement, in part, the directives set forth by the CDC. It is also an attempt to fill a gap in the literature about how African American women prepare for childbirth.

The purposes of this article are (a) to review literature pertaining to African American women and childbirth, and (b) to report on a pilot project addressing perceptions by African American healthcare providers of ways in which African American women prepare for birthing, herein referred to as "childbirth." It is hoped that the knowledge acquired can be used to support African American women and their families as they navigate pregnancy and approach the childbirth experience. Especially important is identifying ways to decrease racism's negative impact on childbearing families and their preparation for birthing.

LITERATURE REVIEW

Although no studies specifically focused on addressing African American women's preparation for childbirth, some studies included information about childbirth. Sawyer (1999) explored the transition to motherhood of 17 first-time, mostly middle-class, well-educated African American women. She identified engaged mothering as a process in which the women became actively involved in seeking care, information, and advice throughout the pregnancy. Preparation for pregnancy, labor, and caring of their newborn occurred by taking formal classes, sifting through reading materials, weighing advice given, and observing other parents. All participants related experiences during pregnancy of having been singled out and viewed negatively because of their race. The transition to motherhood following pregnancy was facilitated by support from partners, family, and friends.

Gichia (2000) studied preparation for motherhood in a group of poor, urban, African American women. These women looked for role models such as older female relatives, or if there were none, someone who seemed like a mother to them, such as a neighbor. These role models provided the new mothers with support as well as a critique of their mothering skills. Family support or kinship has also been identified as crucial for pregnant adolescent African Americans (Dallas, 2004). Support includes caring, respect, and provision of information as well as material resources (Coffman & Ray, 1999). Raines and Morgan (2000) compared differences in African American and Caucasian women during childbirth. African American women reported feeling safe and comforted by the presence of their spouse, the baby's father, their mother, their sister, or other female relatives.

Leininger and McFarland (2002) noted that mothers and grandmothers act as consultants for health-care issues during pregnancy. Leininger and McFarland also stated that although pregnant African Americans view prenatal care as essential, some professional caregivers are seen as uncaring.

Jackson, Phillips, Hogue, and Curry-Owens (2001) recruited a large sample of 167 college-educated African American women of whom 78 had experienced successful pregnancies. All women in the study reported on the ways in which experiencing racism as an African American was stressful and a burden. Some of the women experienced physical symptoms such as headaches, depression, and feeling physically incapacitated. Others responded with anger or feelings of obligation to stay strong for themselves, their family, and their community. The authors concluded that the burden of racism is ever present in the lives of African American women and that this may be exacerbated by the stress of pregnancy and childbirth, making them vulnerable to adverse birth outcomes.

In the United States, preparation for childbirth and parenting has typically been imparted through organized childbirth classes; although, more recently, other ways of preparation are gaining popularity (Declercq, Sakala, Corry, & Applebaum, 2006; Savage, 2006). Although classes are varied in content, venue, and format (Maestes, 2003; Morton & Hsu, 2007; Schott, 2003), preparation for birthing is almost universally taught in the third trimester, encompassing the last 3 months of pregnancy. Increasing the proportion of pregnant women who attend

formal childbirth classes was first recommended as a preferred strategy in the 1989 document "Caring for our Future: The Content of Prenatal Care." Produced by the U.S. Public Health Service (1989), this document became the gold standard for prenatal care in the United States. Healthy People 2010 also identified this as an objective (U.S. Department of Health and Human Services, 2000). Additionally, both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2002) have promoted attendance at childbirth classes.

Despite the importance given to childbirth classes (Hart, 2000), there is practically no understanding of utilization rates by race and ethnicity. Lu and Halfon (2003) provide the only report of disparities by race in attendance at childbirth classes. In a large nationally representative sample, when controlling for sociodemographic variables, Caucasian mothers were twice as likely as African American mothers to have attended childbirth classes.

In conclusion, a review of the literature provides limited information about ways in which pregnant African American women prepare for childbirth. Still, some suppositions can be made. First, African American women are actively involved in seeking information about their pregnancies and childbirth. Second, they rely on family, especially female relatives, for information and support. Third, they may be less likely than Caucasians to attend childbirth classes. Finally, racism is an experience in the lives of pregnant African American women that may contribute to disparities in the birthing outcomes compared to Caucasian women. Although no authors have specifically studied experiences of racism in childbirth preparation, many authors have documented the many ways pregnant African American women experience racism in everyday life (Barnes, 2008; Dominguez, Strong, Krieger, Gillman, & Rich-Edwards, 2009). Unequal treatment within the health-care system is also known to exist (Smedley, Stith, & Nelson, 2003). Whether or not this is true with respect to childbirth preparation needs to be addressed in future research.

This study was a first step in attempting to identify the ways in which African American women prepare for the childbirth experience. African American health-care professionals who regularly provide care to pregnant African American women were assumed to have a unique perspective on this topic. Therefore, their views were elicited. Information gleaned from the health-care providers will be used in the future to question pregnant African American women, themselves, about their preparation for childbirth.

METHOD

Participants

Following approval from the primary researcher's institutional review board, the sample for this study was solicited through personal contacts the researcher had acquired through a decade of maternity teaching and practice in area hospitals, clinics, and private practice. These individuals agreed to disseminate to potential participants a flyer that outlined the purpose of the study, the research method, monetary remuneration, and the researcher's contact information. Fourteen African American health-care providers expressed interest in participating. Available meeting times limited participation to 12 African American women. Of these women, seven were registered nurses (RNs), four were licensed vocational nurses (LVNs), and one was a certified assistant. One of the LVNs was Caucasian and was inadvertently invited to participate. However, she made only one short comment during the focus group session. One of the RNs was a nurse–midwife; another had a master's degree. Two of the RNs were originally from Jamaica, and the remainder were born in the United States. Thus, all the participants represented professional women who were health-care providers. All of the women had worked at least 5 years in a maternity setting. Eight women were currently working in a hospital either on a mother–baby unit, nursery, or the neonatal intensive care unit. Four women worked in private obstetricians' offices. Most of the women had worked in various maternity settings. All of the women had themselves given birth, except for the one Caucasian participant.

Design and Procedure

A qualitative approach to research with African American women has been advocated. Banks-Wallace (2000) promotes the use of dialogue and storytelling as a means of sharing experience, knowledge, and wisdom among African American women. She adds that this approach also fosters the sense of community of participating women. Banks-Wallace (2000), Taylor (1998), and Shambley-Ebron and Boyle (2004) encourage researchers to be sensitive to and include in research discourse of racism as it affects the lives of African American women.

Focus groups as a research tool have been advocated as a means of exploring people's knowledge and experiences (Morgan & Krueger, 1998). Morgan and

Krueger add that the interaction between researcher and participants is as important as dialogue. They add that focus groups are an appropriate method when little is known about the topic or group being studied. Focus groups have been used extensively in research with female African American populations. Examples of focus group topics investigated among this population have been pregnancy (Peacock et al., 2001); cancer (Jernigan, Trauth, Neal-Ferguson, & Cartier-Ulrich, 2001); diabetes (Samuel-Hodge et al., 2000); and views on research (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999; Freimuth et al., 2001).

A qualitative approach using focus groups was deemed appropriate for the purposes of this study. Because this was a pilot project, plans were made for one focus group. Subsequently, it was determined that there were very few African American health-care providers in the metropolitan area surrounding the southern city where the research was conducted. Thus, in retrospect, it would have been difficult to recruit adequate numbers of participants for more than one focus group.

Morgan and Krueger (1998) recommend six to eight persons for a focus group. Fearing poor attendance, the researcher in this study elected to invite 14 participants. Thus, the final focus group included 12 participants, more than anticipated. The women arrived in the evening, most having worked a 12-hour shift. They met on the campus of a large southern university. Because the meeting time was during dinner, a meal was provided. The meal was also seen as a way to promote a causal atmosphere, allow for informal discussion prior to the focus group session, and as a way to meet the African American moderator.

After the meal, an introduction by the Caucasian researcher, who also identified herself as the note taker, clarified both the roles of those gathered and the procedure that would follow. She reminded participants that the session was being audiotaped but assured participants of anonymity. The moderator, an African American woman with extensive experience as a focus group moderator, then proceeded with the semistructured questions. Questions were developed using input from a panel of content experts. The questions were also previewed by the moderator who made further suggestions regarding appropriateness in wording, content, and scope (see Table 1). The session proceeded as planned, with the moderator asking questions and using probes to clarify meaning. An attempt was made to periodically summarize comments made as a means of ensuring mutual understanding of key points. After 90 minutes, the participants were thanked and the session ended.

TABLE 1
Focus Group Questions

1. Tell us your name and your experience with maternity care.
2. Have you or someone you know experienced pregnancy?
3. What are some of the ways in which African American women prepare for giving birth?
4. Do you think African American women consider taking childbirth classes?
5. What are some of the reasons African American women might choose/not choose to attend a childbirth class?
6. Do African American women have other options (resources)?
7. Is there anything else that you feel is important that we have left out of this discussion?
8. How much of this is an African American/Caucasian thing?

Each participant was paid $100, as promised. Immediately following the end of the session, the moderator and researcher briefly reviewed initial impressions and observations about the focus group dialogue and group dynamics. The audiotape was then transcribed and reviewed by the researcher and moderator.

Analysis

Systematic analysis was employed using the methods outlined by Morgan and Krueger (1998). Both the transcription and the field notes were used in arriving at analysis of the data. Following a rereading of the transcript by both the moderator and the researcher, the researcher proceeded to code the data. Morgan and Krueger indicate that this process involves identifying ideas or phenomena, giving each a label and noting the appropriate label in the margins of the transcript. The researcher reviewed the transcript two more times, allowing the codes to emerge from the data. After all the codes had been identified, the researcher met again with the moderator to validate codes and clarify meanings. The codes were then combined into themes that were found to have been repeated throughout the transcription. The role of the moderator was crucial to analysis of the data. In addition to being a moderator, because she is an African American, she was able to interpret language unfamiliar to the researcher and provide alternative meanings when appropriate. Thus, the moderator, who was also a mother of four children, was seen as a person who could provide validity and reliability to the interpretation of data.

RESULTS

Four themes emerged from the data analysis: connecting with nurturers, traversing an unresponsive system, the need to be strong, and childbirth classes not a priority.

Connecting With Nurturers

Preparation for childbirth among African American women means connecting with others who can nurture and mother. Primary sources to connect with are individuals with prior childbirth experience. These persons are most often female relatives. In particular, mothers and grandmothers are viewed as experts in the birthing process. For example, one participant voiced what a pregnant woman might say, "My mamma had a baby, she knew what to do." One woman said, "And the information I got from my mom when I was pregnant, you know, how to breastfeed, you know, changing diapers, taking care of the circumcision. Things like that I got from my mom." Another woman stated, "I think it's cultural, because a lot of them [pregnant women] listen to what Mama tells them." Still another said, "Mama's going to be there. Grandma is going to be there." Asked by the moderator who pregnant African American women turn to for advice, the immediate response was "Your mom" or "grandmamma." Sisters were also viewed as caring persons. Boyfriends and spouses were less frequently mentioned, although one participant said, "And my husband, he was very supportive."

Participants also acknowledged that some women, especially teens, might not have someone to care for them. When this happened, the focus group participants talked about how they attempted to corral support for those women. Alternatively, the caregivers provided the caring themselves. For example, one caregiver expressed what others had echoed:

> *And the teenagers, I spend more time with the teenagers because they are not getting that. And I think that they are falling through the cracks whether it be in school, at home, and I find out: Are you with a church group? If you are not, you need to get with a church group. If you are not with this type of group or whatever, I try to find some other avenue for them so they can have some type of support.*

Another participant said, "Being a mommy myself, I like to reach out to young ladies. However, I think the greatest impediment is that these young ladies come from environments where they've got to have this foundation [health education] for support." An RN working in an obstetrician's office explained her approach to pregnant teens: "And I say, 'Now you're here with me. I'm your mama.'" She later revealed that others in the office referred to her as "Mamma Veronica" (name changed for the purpose of anonymity).

People without family close by to nurture them might turn to the church. For example, one person said:

> *There's a couple at church that don't have any family here. They were having twins. They didn't do classes. They just passed all the money [that they would have spent on classes] to the church [which rallied around them]. That's what they did, gave all the money to the church.*

Traversing an Unresponsive System

Many of the women had personal stories to tell of frustrations with systems that devalued them or were unresponsive to them or their pregnant clients' needs. In particular, stories centered on the medical system. One woman related the experience of her first pregnancy:

> *And I went to see my doctor and just that Thursday before I got ready to have a baby, which I thought was one baby. And I have to tell you then because their dad was a twin. And I said, "Well, am I having twins?" He's like, "No, you're not. I've had three patients who were pregnant with having twins and you're not one of them." I said, "Okay." I was young, and I'm like, "He knows what he's talking about." So when I delivered, I delivered one baby and the doctor came around and said, "There's another baby." I didn't know I was having twins until I delivered this baby. They were 59 minutes apart. And it was a teaching hospital, so I had every white coat possible in the hospital in that delivery room.*

Dismissive or presumptive attitudes of professionals in the medical or welfare system were also of concern. Some health professionals were viewed as being unaware of their condescending and stereotypical attitudes toward African Americans. One comment was:

> *I think a lot of it is kind of based on what they told you on your education level. If they feel like you're not intelligent, if you're not going to ask questions, they're not going to tell you a whole lot.*

Many of the women had personal stories to tell of frustrations with systems that devalued them or were unresponsive to them.

One of the participants recounted her reaction to a colleague's assessment of a young father's learning needs. "I started to do primary nursing on a baby because all I kept hearing [from the nurse] was, 'I talked to this dad over and over and over again and I don't think he understands what I'm saying.'" The participant continued, "And I thought, you know, I thought, from my perception he did understand. I sat down with him and he did understand. Yes he did. But he felt so overwhelmed . . . by his baby going to surgery." An RN whose friend works with a mainly African American population recounted:

> *And she says there seems to be an apathy among the health-care workers who converse with this population of teenage young ladies. It was well, "You don't have the understanding . . . .You're not going to understand what we're talking about anyway or what's going on . . . ." And sometimes they [health-care workers] have a condescending attitude. We were discussing it and she was like, really very distraught about it . . .*

One of the participants talked about the "Catch-22" of the system. She related how her friend attempted to seek financial assistance from the welfare office. "She's like, 'I'm making minimum wage, I'm in school full time, I'm single, and I've got two small children.' And they are like, 'Well, Charlotte, you don't qualify.' She said, and the guy told her, 'Have another child.'"

The Need to Be Strong

The focus group participants conveyed pride in themselves as strong African American women. One comment summed up this feeling:

> *It's just because of our ethnic background. Because I don't care what other races say. I just feel Black women in most instances are strong women. And we were just built and made and taught to be that way. And a lot of the young girls are embarrassing us today . . . They don't have that strong willpower.*

Another participant said, "They just don't carry themselves with pride." Perceived lack of personal strength on the part of teens was conveyed in the statement, "You know when it is that easy, they want another baby and another baby . . . . They have to go through what we went through, we didn't get epidurals . . . . I had a nine-pound baby. It was nasty. I had courage."

Participants viewed being strong as being empowered. Several of them reacted to pregnant women's comments about having babies because their men wanted it that way. One of the women noted, "If this is what the man wants, this is what they [women] do. . . She doesn't know about birth control. She doesn't know how to say no. I like to empower women. I mean, I think it has to do with their self-esteem." One nurse added, "And knowledge is power. A lot of young ladies just don't know. But then on the other hand, they don't want you to tell them anything."

Childbirth Classes Not a Priority

Participants voiced mixed feelings that pregnant women might exhibit toward childbirth classes. Based on their own experience and interaction with clients, birthing is often seen as a natural phenomenon and not something that needs much preparation, as one participant explained:

> *They didn't see a need to take childbirth care. They could get what they needed from their mothers and their mothers. And they had read literature that would be informative. When they read, it seemed more like a natural process.*

One nurse recounted trying to explain childbirth to a defiant teen, who said to the nurse, "I know how to have a baby, I'm just going to push."

Other reasons women might not attend childbirth classes were voiced. One participant said, "What I found the issue was that childbirth classes were offered, but they weren't free." Additionally, "Paying for the childbirth classes, there's nothing tangible. They have to have benefits to it. 'I'm going to have my baby anyway.'" Sometimes, even when classes are free, impediments are, "Lack of motivation, transportation, you know." Another comment was, ". . . They still didn't see it as I have to go type [to classes]. . . because somebody else is going to help me with this baby . . ." One nurse explained what happened, "Given the information in their packet, a lot of the ones that take advantage of it [classes] are not a minority. And that's because of the cost, because of location." Speaking of her own intentions to attend a childbirth class, one participant said, "My intentions were not to go. I was like, 'I've done labor and delivery for three years. I've done mother baby for five years. He's [husband] a CPR instructor. We're not going.'"

The research participants debated the value of childbirth classes. One nurse expressed doubt that

the classes could create a true picture of labor. "I don't know, maybe it's just me or my ethnic background that what can a class teach me that I have to be experiencing. I have to go through it." Alternately, one participant said, "But I encouraged all my kids to go to prenatal classes. But they know I am a nurse, I'm a mom." Her children came to her for information about birthing. Her daughter, in particular, did not have time for childbirth classes. "She went a couple of times, the first baby. But you're talking about a young lady who goes to school, works, or will spend time in church." One woman shared that a friend's daughter had attended childbirth classes because there were some things her mother "wouldn't be able to tell her. She wanted something. She thought she could get something to gain out of it [classes], which she did. She really did."

Participants related that some clients might not attend classes for fear of feeling "the stigma of being in a class where everybody else is going to have a husband." Finally, an issue that emerged at the end of the focus group discussion was perhaps the most important. Participants were asked if being an African American would affect childbirth class attendance. One response was, "I've heard that before. Why am I going to listen to what the White man says?" Other responses were: "That's right. They [African Americans] are feeling out of place." "And the White people make you feel it." "Right. Exactly. Anytime you go in that system, it happens." "That's so true." "Right. But it's hard when you're the one that had to deal with it." "Because in my sister's class, there was one Black couple."

DISCUSSION

The African American health-care providers who participated in the focus group expressed various opinions about the ways in which pregnant African American women prepare for childbirth. Although there was agreement on some issues, there was divergence on others. The diversity of opinion is to be expected because African Americans are not a monolithic, homogenous group (Banks-Wallace, 2000; Sawyer, 1999; Shambley-Ebron & Boyle, 2004; Taylor, 1998). Emergent themes suggest that family and community support tend to be a preferred vehicle for childbirth preparation; however, classes were considered important for people who "fall through the cracks."

As Banks-Wallace (2000) indicated, knowledge grounded in life experiences for African Americans holds great meaning and value. Many of the research participants saw African American women's preparation for childbirth as a positive activity fully supported by family and community members. Mothers and grandmothers were primary sources for information about birth preparation. Other female relatives were also seen as knowledgeable about pregnancy and birthing. Some pregnant women turned to friends, partners, or spouses for help in birth preparation. Especially important was connecting with women who already had birthing experience. Focus group participants also related that pregnant African American women might turn to people at church for information and support about birthing.

Mothers and grandmothers were primary sources for information about birth preparation.

Although there were many issues thought to affect attendance at childbirth classes, an underlying theme was a questioning of the value, of what was being taught in the classes. Perhaps paraphrasing, one could state, "Why go to a class when you have someone who has been through many births who can teach you what you need to know." Additionally, some of the participants saw the cost of classes as a potential barrier. They stated that, for some pregnant African American women, the benefits of taking a class did not outweigh the cost.

There was, however, great concern expressed by the study participants for women who were pregnant and without support systems who were "falling through the cracks." This topic was passionately and vehemently discussed at length. Because some of their pregnant African American clients often lived at a distance from extended family, the focus group participants felt the need to take on the mothering role, imparting knowledge about birth preparation and newborn care, and empowering their clients to believe in themselves. Thus, the health-care providers in this study tried to positively affect pregnant women they encountered in the health-care systems in which they worked.

African American health-care professionals voiced concerns about differential treatment of pregnant African American women. They were particularly concerned about being treated based on stereotypes of African Americans as poor, uneducated, and stupid. This viewpoint is in line with many researchers inside and outside African American communities who have raised the alarm about long-term deleterious effects

Providers need to consider the ways in which their attitudes and behaviors send unwelcoming messages to African American women seeking prenatal care or childbirth classes.

of racism. Racism affecting type and quality of care was highlighted by the National Institutes of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Smedley, Stith, & Nelson, 2003).

IMPLICATIONS FOR PRACTICE

Health-care providers delivering care to pregnant African American women need to be informed about the variety of ways in which childbirth preparation can occur, as in any other group of pregnant women. Whether or not African American women look to the health-care system, written literature, the Internet, or families for information about childbirth will vary among individuals. Additionally, providers need to consider the ways in which their attitudes and behaviors send unwelcoming messages to African American women seeking prenatal care or childbirth classes, which negatively affect encounters between prenatal health-care providers and pregnant health-care consumers. Health-care providers need to have more self-awareness of their attitudes toward pregnant African American women. Additional research is recommended to determine whether greater attention by childbirth educators to cultural concerns and racial sensitivities would increase the use of childbirth and prenatal classes by pregnant African American women. It would be important to understand not only the availability and accessibility of childbirth preparation classes but also the attitudes toward African American attendees of professionals who teach those classes. Replicating this research with other groups of pregnant African American women would broaden understanding of the issues that African American women face in preparing for childbirth.

Finally, pregnant African American women often receive support from their communities as well as families and friends. For women who have moved away from extended family, the church may function as a source for information and support during pregnancy. As with any pregnant mother, health-care providers will want to explore community and church resources available to pregnant African American women. African American women and their partners may be more likely to seek childbirth classes if options are available that include diverse membership, a culturally grounded curriculum, and an instructor sensitive to issues of racism.

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