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African American Women's Birth Stories as Told To African American Women Interviewers

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Abstract

Background: A woman's birth story allows each woman to tell her own perspectives about her experience of bringing a child into the world. As healthcare providers, it is always important to value listening to and learning from our clients. Researchers systematically analyzing birth stories can yield insights on ways to improve birthing experiences for women. This is especially important for African American women, who differentially encounter the most numerous health disparities of any racial group, with twice as much infant mortality than other groups.

Purpose: This study examined birth stories of African American women in order to gain insights from them to better meet their needs. In this way, healthcare providers may learn strategies to address health disparities.

Methods: A secondary qualitative analysis of five African American birth stories was conducted.

Findings: Three themes were identified from the women's stories: (a) desire for continuous labor support, (b) preference for certain characteristics of healthcare providers (such as gender and race), and (c) reliance on spirituality for coping.

Conclusions: These findings highlight the importance of listening to and learning from women.

Clinical Relevance: Healthcare providers can likely improve the care of their patients by incorporating these themes into their methods of care. Understanding deeper meanings and taking actions to address the expressed needs of African American women revealed by analyzing their birth stories may ultimately lessen health disparities.

Background and Significance of Problem

Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (CDC, 2012). African American childbearing women experience significant health disparities. Caucasian infants are more than twice as likely to live past their first year of life when compared to African American infants (Lu & Halfon, 2003). A retrospective comparative study done in North Carolina also highlighted the gap in disparities. The incidence of lower birth weight infants was compared between African American and Hispanic families. Although Hispanic families struggle with health vulnerabilities, African American women still had a higher incidence of low birth weight infants and prematurity (Leslie, 2003).

It is not known why African American childbearing women face so many profound health disparities. Researchers speculate that low socioeconomic status or even a lack of prenatal care contribute to this inequality in health (Halfon & Lu, 2003). More recently, researchers have explored the detrimental effects of chronic stress on the body's systems, the cumulative impact on families over multiple generations, and racism as factors that may play a role in health disparities. According to Cox (2009), high amounts of chronic stress, also called allostatic load, contribute to numerous health issues. Incidentally, those persons with higher loads are often the ones with lower socioeconomic status. Cox (2009) also found that African American women, whether "poor" or "nonpoor", had the highest allostatic loads in comparison to African American males, Caucasian females, and Caucasian males.

Marginalization may be associated with the health disparities. This concept is defined as "the process through which individuals or groups are peripheralized on the basis of their identities, associations, experiences, and environments" (Vasas, 2005). In other words,

marginalized populations have to face adversity as a result of "identifiers" that are out of their control. Gender, race, sexual orientation, age group, and social standing are all examples of categories of labels that are used to marginalize populations. Like health disparities, marginalization is a concept that may have negative sequelae for African American childbearing women.

Health disparities and marginalization appear to be linked. When a population is marginalized, it is viewed as less worthy. Instead of women being considered equal, they are categorized and separated by race, economics, education, or other characteristics. There may be negative consequences for any populations that are identified as different and separate from the "accepted" group. The marginalized are viewed as less important. Therefore, their needs in society can often be ignored or acknowledged last. In due course, marginalization can lead to health disparities. An ignored, vulnerable population is not going to get the healthcare attention that it needs. Consequently, marginalized populations can develop poor health outcomes that may have been prevented among more advantaged groups.

According to Vasas (2005), nurses are in a position to help lessen the health disparities that are a result of marginalization. Nurses are advocates who work closely with their patients. Listening closely to African American clients can allow nurses to identify their actual needs. By changing providers' approaches to clients' care, it may be possible to address issues that could lessen health disparities affecting African American women.

Review of Literature

Telling their birth stories provides a way for women to openly express their personal experiences of giving birth. Women are often eager to share their birth stories and commonly take the lead, frequently adding many details. For example, women are able to recall names of

doctors and nurses, the foods they ate, and medicines they were given for pain. Researchers have found that more than two decades after the birth, women are still able to recall when labor began and details about what happened during the birth (Simkin, 1992).

The use of birth stories as data for analysis has picked up momentum. According to Callister (2003), "birth stories provide richly descriptive data for nurse researchers to improve the care of childbearing women and their families". These narratives give researchers an inside look at the way woman experiencing labor perceived their care. It allows healthcare providers to learn what things could use further development and what interventions need to be implemented. Birth stories that are analyzed on deeper levels can actually help nurses better understand their clients' experiences and evaluate improvements in the clinical setting (Callister, 2003).

This study purposely utilized African American women researchers when interviewing the African American participants. It was assumed by the researcher that race-concordance might be significant when African American women were telling their birth stories. However, not all studies have supported the ideas that same-race patient-provider relationships have a definitive benefit to outcomes. A comprehensive review by Meghani, Brooks, Gipson-Jones, Waite, Whitfield-Harris, and Deatrick (2009) examined 27 studies which focused on patient-provider race-concordance in regard to advancing healthcare of minorities. The authors hypothesized that same-race patient-provider relationships would result in increased trust, satisfaction, communication, and respect, thus resulting in improved health outcomes in minorities. However, this hypothesis was not supported, since only 33% of the compared studies were linked to positive health outcomes for minorities. This issue of what can positively impact health outcomes for minorities needs further study.

Methods

A secondary qualitative analysis of five birth stories of African American women was conducted for this study. The birth stories were transcripts of interviews obtained from a study conducted in 2001. During the original study, one of three African American nurse researchers conducted individual interviews with African American women who had given birth. The participants were asked to tell their birth stories in any way they chose. The nurse researcher only used prompts when a response by the participant needed to be clarified or further explained. Demographic information was collected from the participants; however all identifiers had been removed from the transcripts.

In the current study, five transcripts were randomly selected for secondary analysis to explore them again for new meanings. Initially, the researcher coded the interviews to identify keywords and common phrases. Following coding, analysis progressed to identifying vignettes, outliers, and underlying concepts in each birth story. Audit trails and coding notes were reviewed with experienced nurse researchers and resulted in the identification of three themes.

Findings

Three themes were identified as a result of the secondary analysis of the five women's stories. They are: (a) desire for continuous labor support, (b) preference for certain characteristics of healthcare providers, and (c) reliance on spirituality for coping. Table 1 contains the demographics of the five participants whose birth stories were randomly selected for this secondary analysis.

Theme 1: Desire for continuous labor support

One theme expressed by women consisted of positive comments about the presence of another person during their births. Women reported a negative reaction when they were alone in the hospital room while giving birth. As one woman stated, "Who's going to be here when the

baby comes? I was so mad when she [the nurse] left" (Interview 6, p.5). All of the women expressed dismay when either their partners or healthcare providers left them by themselves while they were in labor. On the other hand, the participants were very appreciative when there was a person present in the room with them. One woman recalled, "I am not saying that they [nurses] have to stay for everyone, but they should be assigned to patients and then should stay them" (Interview 6, p. 7). One participant reported that the certified nurse-midwife (CNM) being in the room the entire time helped her cope with feeling worried. The presence in the room did not have to be one of an individual with a health care background, as one woman recalled her gratitude that her grade-school age daughter was present in the room. She stated, "My daughter was such a good help to me. She would just sit there and rub my stomach" (Interview 9, p. 4)

Theme 2: Preference for certain characteristics of healthcare providers

Women in this study had 3 clear preferences in regard to the characteristics of their healthcare providers. Women were able to identify differences in care by CNMs and registered nurses (RNs) compared to medical doctors (MDs) and heavily favored the nursing professionals. When asked about the MD's role in comparison with the CNM's, one participant stated, "He [MD] wasn't there in the beginning, but when I started crowning I guess that's when he came. That's the difference between him and [name of CNM]. [CNM] was there when I went in" (Interview 4, p.11). Another participant had a similar response explaining, "So you are going through most of it with the nurse. Then there is the chance that the doctor won't even make it on time because she's not there" (Interview 7, p. 23). One woman even identified the CNM as being a mother figure to her during the labor process. The preference for a female healthcare provider over a male was apparent as well. One woman explained," The difference to me was because he is a male and she is a female. You know, men don't actually feel okay when they have to go here

and deliver another baby….By being a woman I believe she had more sympathy" (Interview 4, p. 12). The final preferred characteristic for healthcare providers was being of the African American race. When one woman compared having an African American healthcare provider instead of a Caucasian, she specifically stated, "I think black women and white women have different issues, and she'd know my issues. She knows me and I think that contrary to what people believe, I think black and white women have different issues with their body and she is just more in tune with me, we can relate to some of the things that are going on" (Interview 6, p. 10). Another woman expressed that she felt an innate bond and sense of trust with her African American health care providers.

Theme 3: Reliance on spirituality for coping

Although not all of the participants expressed a reliance on spirituality for coping, the two participants who exhibited this concept did so in a strong way. These women believed that God controlled all situations that she encountered. One participant explained," I prayed about it and I was assured that my baby was going to be fine" (Interview 7, pg. 13). Another participant in particular mentioned God repeatedly throughout her birth story. She stated, "And I think there's reasons why I'm going through some of what I'm going through…it's like God give me a second chance."(Interview 10, p. 12). This same participant gave God the credit for her daughter living past the age of one as she stated, "…they told me she wasn't going to make it to one year old and you know it really did get me because she was born small and…God fixed it…" (Interview 10, p. 6). She acknowledged the graciousness of God for allowing her to be a mother again by saying, "I'm blessed with my baby and I'm glad that God allowed me to have one more child" (Interview 10, p. 9). This participant also expressed that on a daily basis, she asks God to forgive her and protect her family from any harm.

Discussion

All three of the identified themes highlight areas that could be adjusted in the care of African American women, to improve their care and possibly help reduce health disparities. Theme 1 reinforced a reality that providers may over look; women want someone continually present when they are experiencing childbirth. Something as simple as the nurse being there to hold the client's hand made a big difference is the woman's satisfaction and childbirth outcomes (Hodnett, 2011). Participants consistently felt abandoned or upset when no one was in the room with them. This theme emphasized the importance of nurses doing their best to stay by women's sides during labor, as supported by related research. Continuous labor support is a clinical intervention that may seem minor but can have a lasting effect on the experience of the African American woman during childbirth.

Theme 2 demonstrated ways healthcare providers could make clients feel more comfortable by addressing their preferences whenever possible. The participants preferred having female healthcare providers compared to males. One participant mentioned that she believed that women are naturally more sensitive. According to Carolan (2006), women feel they receive more support, both socially and emotionally, from other women. The interviewed women favored having healthcare professionals with nursing backgrounds in comparison to those who were physicians. Overall, it appeared that the women felt that MDs were only present when the baby was just about to be born, whereas the CNMs and RNs remained with laboring women throughout the entire process, supporting and facilitating bonding between them. Further, African American women may feel more connected and comfortable with providers of the same race. The participants expressed that African American healthcare providers related to them more readily, not only medically, but personally as well. Providing the women with same-race

healthcare providers may foster trust and better relationships with them. Ideally, this could encourage women to be more comfortable with coming in to see their healthcare providers when something is wrong and to be more open and trusting with their providers. Therefore, efforts to educate more African American health professionals should be supported. Applying this theme in practice may allow women to be guided early to providers with whom they might feel more comfortable.

Theme 3 shows that spirituality is important at times such as labor and birth. Providers could be more aware of how some women may choose to deal with health hardships and encourage them to express their spiritual beliefs. A study on spirituality in childbearing women by Callister and Khalaf (2010) identified "the use of religious beliefs and rituals as powerful coping mechanisms" as one of its themes. When one of the participants was worried about her daughter living past the age of one, she did not attribute that success to doctors and nurses; she gave God all of the credit. When this participant's children were healthy, she did not see that as a result of them going to see their pediatrician; she believed that God was the reason. Even with the hardships that happened during her labor, the woman saw God as the reason for what happened, including coping with such a tough labor. This is a prime example showing that, as healthcare providers, we need to be more aware of the spiritual aspects of patients and how their unique spirituality may express itself. Healthcare providers need to be accepting of spirituality so that patients will not be afraid to express it. As previously stated, one participant stated that the only reason her daughter had lived as long as she had is due to the will of God, not because of her healthcare providers. These are concise examples of why beliefs need to be incorporated into the care that is provided for patients. If at all possible, this will encourage patients to not only

express their religious beliefs, but to have faith and trust that their healthcare providers will support their spiritual needs as well.

Limitations

This study was limited by the small qualitative subsample used for this secondary analysis. This researcher did not meet the women nor participate in the interview process, but was able to provide fresh insights. These birth stories were told to African American researchers in 2001 and therefore were initially analyzed at the same time by experienced nurses and midwives. This researcher was also new to the qualitative analysis process and to the profession of nursing. Future studies should investigate the analysis of more recent African American women's birth stories. In addition, a study examining the effects of providers' characteristics, awareness of spirituality, and use of nursing presence during labor may be beneficial to the exploration of African American women's birth stories.

Conclusion

African American women's childbirth experiences can be honored through the use of birth story research. By listening closely to African American women and learning what is important to each of them, nurses can lessen marginalization and make each woman's experiences central during birth. This study has highlighted certain African American women's desires for continuous labor support, preference for provider characteristics, and reliance on spirituality for coping. By changing providers' approaches to clients' care, it may be possible to positively and preventively address issues that could ultimately lessen health disparities differentially affecting African American women and their infants.

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Table 1. **Participants' Demographic Information**

All 5 women had normal vaginal births		[total of 7 births reported]
Parity:	3 primiparas	2 multiparas
Marital status:	4 single	1 married
Providers' race:	4 African American	2 Caucasian 1 Filipino
Religion:	5 Protestant	
Other Characteristics	**Range**	**Mean**
Maternal age (years)	23-33	26.6
Maternal education (years)	10-16	13.6