BLACK MOTHERS' CHILDBIRTH EXPERIENCES

by

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ABSTRACT

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The childbirth experience is an important life event that can affect the health and wellbeing of mother and child long after labour and delivery has concluded. This study is a qualitative descriptive study of the childbirth experiences of 30 Black mothers who gave birth in the Greater Toronto Area within the past three years. Semi structured interviews were conducted to understand: 1) what Black women's childbirth experiences are and 2) what factors contributed to their experiences. The childbirth experiences of Black mothers giving birth in the GTA are largely shaped by experiences of racism, bias and microaggressions. They experience disrespectful care and feelings of judgment based on their race in addition to their other intersecting identities. Factors that contribute to a positive childbirth experience include continuity of care, family and community support as well as a high-quality relationship with their health care provider. This study employs the use of critical race theory to examine the themes which emerged from data collected.

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Table of Contents

<i>BLACK MOTHERS' CHILDBIRTH EXPERIENCES.....</i>	<i>i</i>
Chapter 1: Introduction	1
Purpose.....	1
Theoretical and Contextual Frameworks	3
Chapter 2: Literature Review	5
Maternity Care in Canada	5
The Importance of the Mothers' Childbirth Experience	7
Application of Critical Race Theory to the Childbirth Experiences of Black Mothers	10
The Childbirth Experiences of Black Women	17
Conclusion	18
Chapter 3: Methodology.....	19
Methodology	19
Inclusion Criteria	20
Recruitment.....	20
Consent	20
Ethics.....	21
Data Collection	21
Data Storage.....	22
Summary	22
Chapter 4: Results.....	24
Participants.....	24
Racism, Bias and Microaggressions Experienced by Participants	26
Factors Contributing to a Positive Birth Experience	35
Chapter 5: Discussion	44
Chapter 6: Implications and Conclusion	52
Implications for Future Research.....	52
Scope and Limitations.....	53
Reflections	54
Recommendations.....	55
Conclusions.....	55
References	57

List of Tables

Table 1: Participant Demographics.....	25
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LIST OF FIGURES

Figure 1: Mind map of Themes.....	23
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Chapter 1: Introduction

It is estimated that in 2018, over 380,000 babies were born in Canada and nearly one third of them were born in Ontario (Statistics Canada, 2019). These data are not listed by race and it unclear how many of these babies were born to Black mothers. According to the 2016 census, Ontario is home to 52.4% of Canada's Black population with the majority (36. 9%) residing in Toronto (Statistics Canada, 2019). Black immigrants in Canada represent over 150 countries, with more than half hailing from the Caribbean, the main country being Jamaica (34%). In 2016, roughly 40% of the Black population were either second or third generation Canadians (Statistics Canada, 2019).

The childbirth experience can influence the health and well-being of the mother and their child long after labour and delivery has concluded (Smarandache et al., 2016). Additionally, the quality of the birth experience can also affect the mother's future health seeking behaviours which in turn can put children and families at risk (Bohren et al., 2014). Unfortunately, there is very limited research examining the childbirth experience for Black women in Canada.

Understanding the childbirth experience of Black women in the Greater Toronto Area (GTA) will not only add to this body of research but will give health care providers the opportunity to better support women during their birth.

Purpose

This study sought to gain insights into the childbirth experience of Black mothers in the Greater Toronto Area (GTA). The research questions this study sought to answer are:

1. What are Black mothers' childbirth experiences in the GTA?

2. From the perspective of Black mothers, what factors contribute to their childbirth experiences?

These research questions are kept broad as there is no literature on the topic for Black women in Canada. The broad and open ended nature of these questions allows for a wide range of responses and insights from participants.

Recording the voices of Black Canadian mothers will support change to policy and celebrate the voices of those who have previously never been heard. In addition to hearing what their experiences are, this research will highlight what Black women believe contributes to their childbirth experiences. This research will also support change in how mothers prepare for their birth as themes related to contributing factors for a positive experience or a negative experience emerge.

Historically, childbirth was a normal event that was supported by local midwives and family members at home but has since been appropriated and medicalized by men in a patriarchal model (Cahill, 2001). This model of care views women as victims of their reproductive system and hormones, and the female body as inferior to that of men. Reproduction is viewed as highly pathological, requiring surveillance and intervention (Cahill, 2001). Instead, childbirth should be a highly individualized experience and women should be allowed to make informed decisions about their care. In the current model of maternity care, women are moved along an assembly line and care is not individualized or personal (Cahill, 2001). Within our current health care system, women interact with many different health care professionals throughout their pregnancy, delivery and post-partum. The majority of women in Canada choose an OBGYN (Obstetrician/Gynecologist) to be their care provider. They may have one pre-natal doctor who they meet with regularly or they may attend appointments at a clinic that has several

medical professionals. Once in labour they encounter several different people, doctors, nurses and other specialists, many of whom they have never met before. During the post-partum period, they are usually moved to a different part of the hospital and tended to by a different set of healthcare professionals. Once discharged, mothers and their baby will meet with a family doctor and/or pediatrician with potentially one follow up with an OBGYN. This fragmented care makes it difficult for women to form relationships with their healthcare professionals. In addition, access to this care may be difficult for some families who live in rural areas or have limited access to transportation or other resources to attend appointments with healthcare professionals. In this model, pregnant women are seen as the sick patient and not as a person who is an expert in their own body (Women and Health Care Reform, 2007).

Theoretical and Contextual Frameworks

The present study is informed by critical race theory (CRT). CRT recognizes that racism exists in every aspect of society, and as such examines power structures that are based on white privilege and white supremacy which marginalize racialized people (Delgado & Stegancic, 2017). CRT is suspicious of liberalism and rejects the ideology of colour blindness and neutrality. Many different complex concepts make up critical race theory, which is described later in this Major Research Paper (MRP).

My personal location is that of a Black mother who has two biological children and one stepchild. My first biological child was born when I was 18 years old where I used the care of an OBGYN. My second when I was 23 and I used the care of a midwife. Moving through the maternity care system in a young Black body in two very different settings has brought attention to some gaps in the health care system for Black women, especially those who are young. These

experiences have sparked an interest in childbirth, culture and racism within the maternity care system and obstetric justice.

I am currently writing and conducting research during a very challenging time for all people, especially for Black people. This study is being completed during the COVID-19 pandemic and worldwide Black Lives Matter protests. As a society we are currently thinking about racism more than ever before and conversations are being had about systemic racism as well as issues within institutions such as hospitals and prisons. Social media are flooded with pictures of Black people who have been murdered at the hands of police which has been challenging for all but it is most impactful on the Black community.

I would also like to acknowledge that not all people who give birth identify as women or mothers. In this study, I focused on individuals who identified as women and mothers so I will be referring to them as such throughout the MRP.

Chapter 2: Literature Review

This literature review will briefly explore the current state of maternity care in Canada as well as how it differs from the system in the United States. In the U.S., there are disaggregated data examining the outcomes of both Black women and their children in addition to qualitative accounts of their personal experiences. The literature review also considers the importance of the childbirth experience for both the mother and child. Then a connection is made between the Critical Race Theory (CRT) and the focus of this MRP – that is the childbirth experiences of Black mothers in Canada

Maternity Care in Canada

The Ontario Health Insurance Plan (OHIP) is government funded health insurance for Canadian citizens, Indigenous peoples, permanent residents as well as others with specific living or work permits who reside in Ontario 153 days out of a 12-month period (Ontario, 2020). In respect to pre and post-natal care, OHIP covers the cost of care for family doctors, OB/GYN, registered midwives (RM), any medical tests and scans needed, any costs associated with hospital stays or surgeries for both mother and baby as well as costs associated with births at home or in a birthing centre (Ontario, 2020). Pregnant women must choose one primary health care provider to care for them during their pregnancy and women who choose an obstetrician will also need to find a family doctor or pediatrician to care for their baby post-partum. In Ontario, the majority of pregnant women choose an OB/GYN to be their primary care provider. In 2016, 78.8 % of babies were born to mothers who used the care of an OB/GYN (Born Ontario, 2016), 15.2 % were under the care of a RM (CAM, 2016), and the remaining 6% under the care of a family physician. All three primary healthcare professionals care for pregnant women from very early in their pregnancy until the birth of their baby. They provide the same

amount of appointments to expectant mothers (i.e., 11-12 times) throughout their pregnancy, and can order the same routine tests utilised during pregnancy such as ultrasound screening and blood work (Ontario Midwives, 2020). Additionally, midwives provide postpartum care for mothers and babies for 6 weeks postpartum as well. Use of the care from these healthcare professionals however is dependent on access, proximity, and availability of each professionals services to the women seeking such services.

In Canada, the cost of childbirth is not a burden that falls directly on the parents. In Ontario, specifically, the cost of prenatal care, birth and postnatal care are covered under OHIP and there are no upfront fees for the patient (Ontario, 2020). If the mother is hospitalized after the birth of their child, the cost of hospital care is also covered, however, parents may opt to pay an additional fee to stay in a private room instead of a shared room (Mount Sinai Hospital, 2020). In comparison, in the US, the cost of birth falls to the parents and their private insurance company. Some low-income families in the US, may qualify for the national health care coverage and do not need to worry about the costs associated with their birth. However, there is judgement and stigma attached to the use of this service (West & Bartkowski, 2019). The funding structure of the health care system as a whole varies distinctively in Canada and the US, and the effect it has on the culture of birth is significant. Another way that these two maternity care systems differ is accessibility to midwifery care. Certified Professional Midwives are only legally allowed to practice in 35 of 50 American states (Midwife Alliance, 2020). The midwifery health care system varies drastically from state to state. In Canada, midwifery care is legal and regulated in all provinces and territories except for the Yukon who is anticipating regulation to be completed soon (CAM, 2020). Those who are cared for by midwives are less likely to give birth via caesarean section and/or experience interventions such as forceps and vacuum

extraction (CAM, 2020). Midwives also offer more choices in terms of the setting in which women can give birth such as hospital, home, or birth centre (whereas OB/GYNs typically only attend births in a hospital).

Childbirth in western society is highly medicalized. The caesarean section rates are high in Canada (28.8%) and the United States (US) (31.9%) in comparison to the World Health Organization's recommended number (10%) (Canadian Institute for Health Information, 2019; CDC, 2018; WHO, 2017). Furthermore, the caesarean section rates have been increasing over time. For example, in 2000 caesarean section rates were 21.4% compared to 28.8% in 2019 (Statistics Canada, 2019). Induction rates have also increased from 12.9% in 1991 to 21.8% in 2005 (more recent percentages are not available). Data needs to be made available regarding the health and well-being of Black mothers in Canada in order to address the gaps in care effectively and as quickly as possible.

The Importance of the Mothers' Childbirth Experience

It is well established that the mother's physical health during pregnancy is critical for the child's development in utero. However, the mother's mental health is as important. Research has demonstrated that stress and anxiety in pregnancy can be associated with preterm labour, poor infant outcomes, as well as cognitive, behavioural, and interpersonal problems in young children (Glasheen, Richardson & Fabio, 2009).

The majority of research on post-partum mental health in mothers has focused mostly on the effects of post-partum depression (PPD) that affects 10%-15% of women (Rahman, Surkan, Cayetano, Rwagatare & Dickson, 2013). The research on PPD shows that affected mothers may have reduced maternal sensitivity to the infant and poor attachment with the infant (Rahman et al. 2013). There are also links to poor developmental outcomes in the infant and these

associations are even higher when the infant is male (Rahman et al. 2013). Unfortunately, PPD is not the only mental health challenge women may experience post-partum. Birth related post-traumatic stress disorder (PTSD) affects between 3.1% and 15.7% of post-partum women (Grekin & O'Hara, 2014). There is limited research about the direct pathway for how post-partum PTSD affects the mother-child dyad and the infant's development. However, a meta-analysis suggests that mothers may be less responsive to their babies if they associate their child with their traumatic experience which could influence the type of attachment the infant develops with their mother (Ayers, Bond, Bertillies & Wijma, 2016). There are several factors that contribute to childbirth related PTSD, and one of the most prevalent factors is a negative birth experience (Smarandache, Kim, Bohr & Tamin, 2016). For example, Smarandache et al. (2016) found a varying percentages of negative birth experiences that ranged for example, from 6.2% in Quebec to 19.6% in Nunavut, with the national average being 9%. These statistics were not separated by maternal age and it is unclear at what rate Black mothers encounter a negative birth experience. Risk factors for a negative birth experience can include being under the age of 20, not having a partner, first birth, not attending pre-natal classes, having experienced violence in their lifetime, being of low socioeconomic status, and not having social support.

PTSD can occur in mothers who experienced a traumatic birth and or severe complications during pregnancy. Grekin and O'Hara (2014) estimate that PTSD affects 3.1% of all post-partum women. This statistic is dramatically increased to 15.7%, for women with pregnancies who are considered high risk (Grekin & O'Hara, 2014). The Canadian Mental Health Association (2016) lists reexperiencing and flash backs, emotional numbing, hyperarousal, avoidance, and negative mood as symptoms of PTSD. For birth related PTSD this may include reexperiencing the traumatic birth which results in emotional numbing to escape

these feelings (Grekin & O'Hara, 2014). If the mother associates her child with this traumatic experience she may avoid contact with her child (Garthus-Niegel et al, 2017).

Older case studies have indicated that some mothers with PTSD fail to meaningfully attach to their child, breastfeed and may avoid them entirely which can have lasting health implications on children (Ballard et al 1995; Moleman et al., 1992; as cited in Garthus-Niegel et al, 2017). One study found that maternal postpartum PTSD was associated with poorer cognitive development in children at 17 months old (Parfitt, Pike & Ayers, 2013). The same study also concluded that how parents view their child and their temperament was associated with the children's development outcomes. Garthus-Niegel et al, (2017) also found a connection to maternal PTSD and infant temperament. In this 2 year follow up study, children with mothers who rated their 8-week-old baby as having a difficult temperament, were more likely to have social emotional difficulties at 2 years of age. The results of this study could not clarify if the difficult temperament of the child caused mothers' mental health problems to be more severe or if the mothers mental health challenges caused the child's temperament to become more difficult. The impact of mother's mental health challenges can be different for boys and girls. For example, Garthus-Niegel et al. (2017) reported that boys exposed to maternal PTSD are more likely to have poorer developmental outcomes than girls whose mothers have PTSD symptoms Garthus-Niegel et al, (2017). PTSD is considered to have a comorbidity with depression and in some cases anxiety as well (Ayers et al., 2010). Even when controlling for maternal depression and anxiety separately, maternal PTSD independently there are still significant impacts on child development Garthus-Niegel et al, (2017).

Application of Critical Race Theory to the Childbirth Experiences of Black Mothers

In their section, I apply Delgado and Stefancic (2017)'s work on Critical Race Theory, and explore the relevance of the proposed seven basic tenets of critical race theory.

Social Constructionism

CRT scholars believe that race is a socially constructed phenomenon and that there is no biological basis for our current system of racial categories (Delgado & Stefancic, 2017).

However, race continues to be treated and used in health care as a biological construct. For example, the pain levels of Black people are underestimated by healthcare professionals more often than that of the pain levels of white people (Dore, Hoffman, Lillard & Trawalter, 2014, Staton et al, 2007; Hoffman, Trawalter, Axt & Oliver, 2016). This belief goes as far as (and beyond) the history of medical experimentation on Black people. Dr. J Marion Sims is one of the more famous doctors who performed unmedicated surgery on enslaved Black women who had vesicovaginal fistula which is a childbirth complication (Wall 2006). Sims experimented on enslaved African women in Montgomery, Alabama from 1845 until 1849 in order to perfect the fistula repair surgery. Regarded as the "father of gynecology," his surgeries are now seen as the cruel non-consensual experiments that they were. Sims claimed that unlike Black women, white women were unable to stand the pain of the surgery (Wall 2006), and provided anaesthesia to White women undergoing the same surgery. However, such experiences are far from being over. For example, a qualitative study conducted in San Antonio, Texas in 2019, provides a personal account of insufficient pain management for a Black mother who gave birth in a hospital setting:

I asked them: "Can I have something for pain while I wait for the epidural?" They gave me 500 mg of Tylenol. I'm a nurse, and I'm just like, "Why even give this to me?" So, there is that. I was vomiting from the pain and they wouldn't even give me a tissue to wipe my face or a throw-up bag. They let me labor with no pain medication, no

supervision for several hours. I kept asking, you know, for a doctor, for assistance. With my second, I tried to stand up because they wouldn't give me any pain medicine. So, I was like I do know if I stand up I feel better. You know? And they were like, "No, lay down." They wouldn't let me do anything. Like not even normal pain management, like non-pharmaceutical (Ashley, Hospital)" (West & Bartkowski, 2019, p. 12).

This is a horrible example of how Black women are treated during their birthing experience.

Racism as Normal

Another tenet of CRT (proposed by Delgado & Stefancic, 2017) is racism as a normal or ordinary and natural part of everyday life. This means that racism is present in all aspects of everyday life. Looking at the above story, it is appalling that the Black mother had negative experiences surrounding pain management with not one but both of her births. In the same study, another mother who was also a labour and delivery nurse with 14 years of experience recalled that often times "even though a woman of colour is ready to go, if someone else comes in they'll give it [an epidural] to her instead" (West & Bartkowski, 2019, p. 10). She even recalled that racialized women often received their food after white mothers have received their food even though the black mothers they delivered first (West & Bartkowski, 2019).

Another mother involved in the same study told that she repeatedly called for assistance with the call button, but no one came to her aid. When a nurse who remembered her from her previous birth came in to check on her, she discovered the mother had a prolapsed cord and she was rushed off for an emergency caesarean section. Doctors told the mother that if not for the nurse who checked on her, her baby likely would have died. The mother reported that she was treated this way only because she was Black and their incorrect assumption that she was on

Medicaid (the federal and state funded medical insurance for low income citizens) even though the woman had an annual household income of over \$100,000 (West & Bartkowski, 2019). When difficult births occur, medical professionals may wave it off and say “well at least you’re alive and your baby is alive.” This is normalizing racist behaviour. Unfortunately, these stories are not unique but occur regularly. I have read accounts of obstetric violence directed at Black birthers on social media.

Differential Racialization

Differential racialization is the notion that different groups of people are racialized in different ways and that the same group of people can be racialized in different ways in different time periods or contexts (Delgado & Stefancic, 2017). For example, Serena Williams, an incredibly successful Black woman, delivered her daughter, via emergency caesarean in 2018. After the surgery, Serena began experiencing an intense cough and as someone who had experienced blood clots before and knew exactly what it was, and requested a CT scan without contrast and a blood thinner immediately. The nurse assumed that Serena was confused because of her pain medication, and the doctor performed an ultrasound on her legs which revealed nothing. Eventually, a CT scan was done which showed that she had several small blood clots in her lungs. Even though Serena is a world-famous athlete, she was waved off by healthcare professionals (Chiu, 2018). They did not believe her to be an expert in her own body. Attanasio and Hardeman (2019) warn that Black women attempting to advocate for themselves are stereotypically perceived as the “angry Black woman.” This example shows how a racialized person can be perceived differently in different spaces.

Interest Convergence

Interest convergence suggests that white people with decision making power in our society will only make changes to policy that improve the lives of racialized people when they can also (in this case, further) benefit from such changes (Delgado & Stefancic, 2017)

There are many decisions involved in childbirth. Pregnant women must choose the location they wish to give birth, with which type of medical care provider and which medical interventions, procedures and medications they will or will not consent to. Parents may choose to opt out of or delay procedures for themselves or their child such as inductions, epidurals, continuous fetal monitoring caesarean sections, antibiotic eye ointment, immediate cord clamping, vitamin K injections and formula supplementation (Marcewicz et al., 2017). Unfortunately, for some parents, trying to assert their agency by denying or delaying procedures acquires them some nasty labels. Mothers (regardless of race) may be labeled “problem patients” and are more likely to report perceived discrimination during their hospitalization (Attanasio & Hardeman, 2019). Unsurprisingly, this label is more often applied to racialized women than it is to white women. One study found that these behaviours in white mothers were more often viewed positively and as manifestations of health literacy and patient engagement (Koh, 2015). While another found Black women exhibiting the same behaviour were perceived as aggressive and difficult (Sacks, 2017). Hospital policies that support all women in the choices they make during their labour and delivery will not change unless there is a shift or interest convergence in those with decision making power.

Anti-Essentialism

There is no one shared experience for all Black people. Anti-essentialism argues that there is no essential experience or trait that defines a racial group and there is no one “black experience” (Delgado & Stefancic, 2017). It may appear that by suggesting that many racialized

women have negative or more disadvantaged childbirth experiences it also means that this is the reality for all racialized people. That is not the case. In a nationally representative sample of the US conducted in 2017, 32% of Black Americans reported experiencing racial discrimination in a healthcare context (Discrimination in America: Final Summary, 2018). While this is 32% too many reports, the good news is that for 68% of respondents they did not feel discriminated against. Although the purpose of this paper is to reveal what is wrong with maternity care and how it repeatedly fails racialized parents there are positive stories out there.

The same study that produced the previously mentioned negative narratives also produced some positive ones. Giselle felt safe delivering her child in hospital after experiencing complications with her previous birth. Brooke had a home birth and developed a close relationship with her midwife who she felt was like an older sister to her. Tara felt empowered by her midwife who referred to her as superwoman (West & Bartkowski, 2019).

In this study there were accounts from mothers who had negative experiences with midwives and doctors and there were others who had positive experiences with each medical professional as well. When talking about traumatic birth experiences it is difficult to quantify because it is subjective to each person in their own context. Studies have shown that it is not the act of a caesarean section that causes trauma, but under which circumstances they occur (Smarandache et al., 2016). Planned caesareans are not usually traumatic because the patient was a part of the plan and gave consent. Emergency caesareans are more often traumatic because there is a loss of control from the parent (Grekin & O'Hara, 2014). From these accounts we see that while racialized women are more at risk of experiencing traumatic births and higher rates of maternal mortality this isn't a collective experience for all Black parents.

Intersectionality

Intersectionality is the way in which other forms of oppression such as capitalism, heterosexism, patriarchy and others, shape forms of oppression and exploitation and individual identity (Crenshaw, 1988).

The oppression of Black women during childbirth intersects with several other structures such as age, sex, social economic status, capitalism, and patriarchy (Dillaway & Brubaker, 2006). Young parents (15-19) are more likely to have a negative childbirth experience (Public Health Agency of Canada, 2009). Birthing people who do not identify as female may face stigma which can contribute to a negative experience (Hoffkling, Obedin-Maliver & Sevelius, 2017). As we saw previously with Lindsey's story, she was treated poorly because her care providers assumed, she was of a low socioeconomic status and using government assistance to pay for her birth (West & Bartkowski, 2019).

Childbirth in a hospital setting is a pay per service system, therefore childbirth is a business. Hospitals and doctors are paid for each service they provide and there is no financial incentive attached to outcomes for each birth (Canadian Institute for Health Information, 2006). A system set up to reward interventions like inductions and caesarean sections and essentially punish uneventful and unmedicated births, are huge contributing factors to the oppression of women. The capitalistic system that exists within hospitals and obstetric care puts many parents and babies lives at risk unnecessarily. Hospitals are designed to run like a factory and when labouring parents are not moving through the assembly line fast enough, interventions are performed in order to speed up the process (Lindheim, 1981). The development of hospitals and labour wards coincides with the criminalizing of midwifery care in the US after World War II (Lindheim, 1981). In Canada, midwifery care was never illegal, however it wasn't considered a regulated profession until 1991 in Ontario and is still not regulated in all provinces and territories

(Canadian Association of Midwives, 2020). Midwifery care differs from maternity care with an OBGYN in that midwives are compensated per patient and not per procedure (Canadian Institute for Health Information, 2006). This is a protective factor for women because midwives are not financially motivated to perform unnecessary procedures. Additionally, midwives are mostly women making the asymmetrical power relationship between medical professionals and patients less out of balance than it would be with a white male OBGYN (West & Bartkowski, 2019). This fact of course does not guarantee that mother will have a positive birth experience or that she will not be subject to racism.

Male appropriation and medicalization of childbirth has created the misconception that female and birthing bodies are defective and in need of fixing (Cahill, 2001). Consent is a prevalent conversation we are having as a larger society but unfortunately this conversation has not always extended into the childbirth context. There are many reports of women receiving episiotomies, inductions, and caesarean sections without their consent. Doctors are anesthetizing women in order to perform forcible caesarean sections without their consent (Paskova, 2014).

Capitalism and patriarchy are likely the reason interest convergence of policy makers is weak. The trauma inflicted on women and children by a medically unnecessary caesarean section simply does not outweigh the money that doctors, and hospitals make for performing the procedure.

Storytelling

The final core tenet of CRT is storytelling. CRT scholars believe that those who are oppressed and those who are exploited hold valuable knowledge and their stories should be shared to counter dominant narratives (Delgado & Stefancic, 2017).

Qualitative research and informal platforms which share the childbirth stories of Black women in Canada are virtually non-existent. These stories are important and should be valued by society as whole. They should also be used to bring light to any injustice and areas of improvement within the health care system as a whole.

The Childbirth Experiences of Black Women

Limited research has been conducted on the childbirth experience and contributing factors for Black women. Much of the research that has been conducted is reflective of adverse health outcomes for both mother and child and does not focus on the psychological aspects of the experience. As previously mentioned the Black maternal mortality rate in the USA is up to 3 times higher than the white maternal mortality rate. In Canada, there is no national inquiry process to review maternal mortality and rates are not disaggregated by race (Cook, 2017). It is unclear if the racial disparities in Canada are as stark as they are in the US however, one study predicts that it likely is. The report analysing the racial disparities of preterm birth rates in Canada (8.9% to Black mothers and 5.9% to white mothers), indicated that the preterm birth rates of babies born to Black and white mothers are similar to those in the US in relation to population size (12.7% to Black mothers and 8.0% to white mothers) (McKinnon et al., 2015). While factors like social economic status, income, marital status and age play a role in the health outcomes for parent and child, even when you control for these factors, racialized dyads are still at a significant disadvantage.

A secondary analysis of the Maternity Experiences Survey (MES) found that women who are Indigenous or who have a bachelor or graduate level of education are more likely to choose a midwife to be their care provider during their pregnancy but offers no information about other women of colour (Abdullah, Gallant, Saghu, Macpherson & Tamim, 2017). The same study also

found that age, material status, perceived health, pre-pregnancy BMI, number of previous pregnancies, immigrant status and working during pregnancy were not significant factors associated with choosing midwifery care. In Ontario, women are most likely to choose the care of an OBGYN regardless of age or risk level of pregnancy (Guliani, 2015). Unfortunately, none of this data was disaggregated by race beyond “indigenous” and “non-indigenous”.

A clear understanding of the needs of Black women who given birth in Canada is needed in order to create appropriate supports in order to minimize psychological and mental health challenges in addition to physical health outcomes.

Conclusion

From this literature review it was established that the childbirth experience is an important experience for families as it is the beginning of their relationship together. The childbirth experience is not an experience that is only for one day but is prepared for and influences children and parents for a long time after. Ensuring that all women have the most positive experience possible is important for families, parents and children.

In conclusion, this study will create a space for Black women living in the GTA to share their experiences with the maternity care system. It will give some insight into what the experiences of Black parents looks like when they give birth and may shine some light on areas of improvement. Race disaggregated data are important for supporting marginalized individuals and this study will contribute to the limited body of research.

Chapter 3: Methodology

This chapter provides an overview of the methodology used in this MRP. This chapter presents a brief background to the use of qualitative methodology and in particular, the qualitative descriptive approach. This methodology involves interviewing participants about their experience of the phenomenon. A tenet of CRT is storytelling. By conducting interviews using phenomenological research methods, the stories of Black women can be recorded and shared.

Methodology

The methodological approach used for this study was the qualitative descriptive approach. This approach is similar to that of a phenomenological approach however it differs in that this approach does not aim to making meaning of an event but to provide a rich straight description of an experience or event (Neergaard, Oleson, Andersen & Sondergaard, 2009). The goal of this study was to collect and present birth stories of Black women and make connections between their stories as well as existing literature. Qualitative descriptive studies are also analyzed in a way that data can be coded and sorted in order to find commonalities and differences within the data obtained. Once these themes have been generated data can be compared to existing knowledge and theory (Miles & Huberman, 1994).

Sandelowski (2000) describes qualitative descriptive studies as the method of choice when straight descriptions of phenomena are desired. Qualitative descriptive studies are typically used when the researcher is inquiring about the “who, what and where” of events (Sandelowski 2000). In this particular study the “who”, Black mothers, and the “where”, in Canada, are known. The “what”, childbirth experiences, is presently unknown. This purpose of this study fits the qualifiers of the qualitative descriptive approach as outlined by Sandelowski (2000).

Inclusion Criteria

Mothers who had given birth within the last 3 years in the GTA, self-identified as Black, and were over the age of 18 at the time of the interview, were invited to participate in this study. Three years was chosen as a cut off time in order to reduce recall problems about their experience. The GTA was chosen because the majority of Canada's Black population resides in Ontario with nearly 40% living in Toronto alone (Statistics Canada, 2019). When this study was being planned, I had intended to interview participants in person. Participants were asked to confirm that they fit the inclusion criteria prior to the interview via email or Facebook messenger when they expressed interest in the study. The age of participants was confirmed again prior to the start of the interview.

Recruitment

Accessing prospective participants for this study was gained through social media and word of mouth. I shared a recruitment poster on two Facebook groups: the "Black Toronto Community Support" and the "Black Mom's Connection". The recruitment poster was accompanied by a note that requested anyone interested in participating in the study to contact me. I also requested in the note for help sharing the poster with others who might be interested in participating. Prospective participants contacted the primary researcher via Facebook Messenger or via email. Comments were turned off on the posts that contained the recruitment poster in order to keep the identity of prospective participants hidden.

Consent

I emailed a copy of the informed consent form and the list of interview questions to the women who expressed interest in participating in my study. Due to the COVID-19 pandemic, participant consent was collected via Google Forms: They were asked for their consent to

participate in the study as well as for audio-recording their interview. Prospective participants were given the opportunity to ask me any questions about the study before signing the consent form and again before starting the interview. I did not ask how each participant found the study information.

Ethics

Ryerson University Research Ethics board approved this research project. Also, permission was obtained by the two Facebook group administrators before posting the recruitment poster. Participants were provided with an informed consent document via email in a word document before they signed a consent form via Google Forms. Participants contacted me on their own. They were emailed a \$25 Tim Horton's gift certificate to thank them for their time in taking part in the study.

Data Collection

Data collection and analysis were completed simultaneously. In order to adhere to social distancing guidelines, all interviews were conducted virtually by phone or via Zoom at a time that was convenient to the participant. I transcribed the interviews as soon as possible after the interview was conducted. Participants were provided with a copy of their own transcriptions and given the opportunity to remove any part of the interview they did not wish to have in the transcription. Participants were asked if they would like to choose their own pseudonym or if they would prefer for me to choose one for them. Participants were given the opportunity to change the pseudonym that I chose for them when they received their transcription via email.

Data collection commenced on May 9th 2020 and the final interview was completed on June 8th 2020. All interviews were recorded using an audio recording device. Interviews varied

in length and lasted between 6 minutes and 70 minutes. Most interviews were roughly 25 minutes long.

Data Storage

All data were labeled with the code number and the pseudonym only. A master list that contained the email addresses and names of participants was kept separate from all other data in a Google Doc that only I had access to. The Google Form that participants asked to sign the consent form was also kept separate from other information in a Google Sheets spread.

Data Analysis

After interviews were completed, each audio file was labeled with both the participant code number and the pseudonym. I then transcribed all interviews and read each transcription multiple times before coding them. The initial codes were used to code the remaining interviews. Possible themes were then considered and revised as I read the interviews again and again. I made notes about connecting and contrasting stories after each transcription. I then created a mind map of all of the themes and sub themes (see Figure 1).

Summary

This chapter outlined the methodology and the study design for this research project. It also outlined the steps taken to design this project as well as its completion. The next chapter presents the results of this study.

Chapter 4: Results

This chapter presents the results of this study followed by an outline of the themes that emerged from the interviews in relation to the two research questions I explored in this MRP. Quotes pertaining to the participants' experiences will be presented along with each theme. First an overview of the participants will be presented then each of the research questions will be answered.

Participants

In total, 30 mothers who gave birth in the GTA took part in this study. The participants' age ranged from 23 to 44 years at the time of giving birth with the average age being 31.5 years. The majority of participants (66.7%) were born in Canada, 16.7% had immigrated from Jamaica, , and the remaining participants had come from other Caribbean countries, one European country, and one African country. The participants were well-educated: 23.3% had a college diploma (23.3%), 40% had a bachelor's degree, 23.3% had a master's degree, 6.7% had a law degree, and 6.7% had a PhD. Most participants were married (70%) or in a common-law relationship (16.7%), and 93% of the participants had their partner with them during the childbirth. The majority of participants (76.7%) had a vaginal birth and 23.3% had emergency caesarean sections. Participant demographics, health care provider, and birth mode, are presented in Table 1.

Name	Age	Children	Origin	Education	Birth Setting	Birth Mode	Care provider	Marital Status	Partner Present
Danielle	35	2	Trinidad	Masters	Hospital	Vaginal	OB	Married	Yes
Melissa	36	1	Barbados	PhD	*Hospital	Vaginal	OB to Midwife	Married	Yes
Elizabeth	26	1	Jamaica	Bachelors	Hospital	Vaginal	OB	Common Law	Yes
Kimberly	28	1	Canada	Bachelors	Home	Vaginal	Midwife	Married	Yes
Natasha	34	1	Canada	Law Degree	Hospital	Vaginal	OB	Married	Yes
Candice	29	2	Canada	Masters	Home	Vaginal	Midwife	Married	Yes
Eva	27	2	East Africa	Bachelors	Home	Vaginal	Midwife	Married	Yes
Chanelle	28	2	Canada	Bachelors	Hospital	Vaginal	OB	Married	No
Kayla	26	2	Canada	Bachelors	Hospital	Vaginal	OB	Married	Yes
Jody	36	2	Canada	Masters	Hospital	Emerg C-section	OB	Married	Yes
Sarah	28	1	Canada	Diploma	Hospital	Vaginal	Midwife	Single	Yes
Carla	34	2	Jamaica	PhD	Home	Vaginal	Midwife	Married	Yes
Angela	26	1	Canada	Bachelors	Hospital	Vaginal	OB	Married	Yes
Venus	31	2	Canada	Bachelors	Hospital	Vaginal	Midwife	Married	Yes
Lauren	32	3	Canada	Diploma	Hospital	Vaginal	Midwife	Common Law	Yes
Kara	33	2	Canada	Masters	Hospital	Emerg C-section	OB	Married	Yes
Georgia	36	2	Canada	Diploma	Hospital	Vaginal	OB	Married	Yes
Latoya	31	2	Canada	Bachelors	Hospital	Vaginal	OB	Married	Yes
Rebecca	37	2	Canada	Master's	Hospital	Vaginal	OB	Single	No
Hannah	25	1	Canada	Bachelors	Hospital	Vaginal	OB	Single	Yes
Bella	28	2	Jamaica	Diploma	Hospital	Vaginal	OB	Common Law	Yes
Denise	28	1	Greese	Masters	Hospital	Vaginal	OB	Married	Yes
Charlotte	44	3	Canada	Bachelors	Hospital	Vaginal	OB	Married	Yes
Lisa	34	1	Canada	Bachelors	Hospital	***Emerg C-section	OB	Married	Yes
Nicole	40	3	Canada	Bachelors	Hospital	***Emerg C-section	Midwife to OB	Married	Yes
Nadia	35	1	Canada	Law degree	Hospital	Emerg C-section	OB	Married	Yes
Renee	39	3	Jamaica	Diploma	Hospital	Vaginal	Midwife	Common Law	Yes
Simone	32	1	Jamaica	Masters	Hospital	**Emerg C-section	OB	Married	Yes
Lucy	23	1	St. Lucia	Diploma	Hospital	Vaginal	OB to Midwife	Common Law	Yes
Dominique	25	2	Canada	Diploma	Hospital	**Emerg C-section	OB	Single	Yes

Table 1: Participant Demographics

*transfer from birth centre

**under general anesthesia

***reported feeling c-section

Racism, Bias and Microaggressions Experienced by Participants

21 out of 30 (70%) participants in this study reported a negative racial interaction with a health care professional during their most recent childbirth experience. These experiences varied in severity and in personal impact for each mother. The first research question (what are the childbirth experiences of Black mothers giving birth in the GTA?) can be answered in this section. The childbirth experiences of Black women in the GTA are largely shaped by their lived experiences and encounters with racism in both their everyday lives and during their birth experiences. Many of the women who did not report having had a negative racial interaction during their most recent birth, had experienced racism during a previous birth or within their community which shaped their future choices. In this section, the experiences of racism, bias and microaggressions will be presented.

Being questioned about insurance coverage

After giving birth women are often transferred into a different postpartum space. The cost of a private room can be expensive and those with private health insurance may use their coverage to cover the cost of a private room. Georgia and Denise both requested a private room before they gave birth but had some difficulty obtaining one because their nurses assumed they did not have insurance coverage.

As soon as I gave birth she was like “do you have coverage?” And I was like, “yes, I gave my information beforehand,” and then she was like, “well, what is it? Just you? Or your husband?” And I’m like, “we both have coverage, you want both information? I gave it to you before I answered the form from the hospital,” and she was like “oh... oh you do?” And my sister was there and my husband was there and they were both like “okay, why is she acting like this with us” “it wouldn’t have been a big deal but with a white person, you know? But with a person of colour like “oh, you’re well off?” “like you have your own benefits?”, like that was a surprise to them but if I was a white person I don’t think that would be a surprise. It probably would’ve been expected. (Georgia)

She said okay the only room we have available is a private room but you need insurance for that so were going to put you in the shared room. And I told her that I already stated I wanted private room and she's like "yeah but it costs like \$400 a night" or something crazy. I was just taken aback like cause like why would you just assume that I didn't- was it because I was Black? Do we look young to you that we just don't have insurance to cover the cost of the private room? It just, that really bothered me. (Denise)

These experiences happened to Georgia and Denise before their babies were even a few hours old. They felt that this should not have been a conversation they needed to have because they had already filled out the necessary paperwork prior to giving birth.

Midwives asking mothers about "accidents" and "adoption"

Lucy and Sarah were both asked questions about their baby that they believe may not have been asked of them if they were not Black. They both felt that in addition to being Black, other intersections of their lives such as age and relationship status also played a role in their experiences with their midwives.

Lucy was 23 years old when she gave birth to her baby and she felt that being a young mother contributed to how she was treated by her midwife. Lucy said that she did not want to say anything to her midwife about her negative comments because she knew she would attend her birth and she did not want to upset her.

She made me feel very like, "Are you sure you want to keep the baby?" Like she kept bringing up adoption. So like whenever I met with her, I felt like she made me kind of second guess my decision. (Lucy)

The time that I have a kind of a raised eyebrows was, and I didn't take it as hard as my partner did but the white midwife, that I had did ask us if my daughter was an accident. (Sarah)

Sarah and her partner had not been together for a very long time before they found out Sarah was pregnant. Sarah said that she felt her midwife asked her if their child was an accident because they are Black and their relationship was so new.

Feelings of being judged by healthcare providers

Many mothers reported feelings of being judgement by the medical staff that they came in contact with during their pregnancy, birth and postpartum. Venus had a challenging delivery and an episiotomy with her first baby and felt self-conscious when asking for pain medication. She also worried that nurses would judge her for agreeing to send her baby to the nursery so she could rest after birth.

It felt uncomfortable to even ask for extra or more pain medication and-- just because you feel like you're getting kind of, not j-- I guess judged. I felt uneasy when the nurses were offering to take the baby so that we should get some sleep. I got offered it twice and I felt uncomfortable about saying yes, just out of fear that they were going to deem me as like a bad mom or an unfit parent. And I just don't think that that is something that any other race experiences, I really don't. (Venus)

Mothers also felt that they were being judged by health care staff based on their marital status. Participants expressed that they were treated better when their spouse was present and not taken as seriously when they were alone.

So my husband would go get some food and he wouldn't be there when the doctor checked me, and then like "are you married? Where's your husband?" And I didn't have my rings on cause obviously my hands are swollen. And when he came back, it was like "oh, you're married? Oh, you have somebody supporting you? Like you have a family member here?" It felt like if I was white and I was in the same situation they wouldn't even say anything. (Georgia)

Mothers felt they were being judged by their care provider when they were discussing things that are typically connected to negative stereotypes associated with Black women such as drug use and marital status.

Mothers felt like a burden to their care providers

Some mothers felt that they were perceived as a burden to their health care providers when they asked questions or expressed concerns. Some were even hesitant to ask for help.

Sometimes when nurses and doctors see you they automatically feel like you are a burden to them when you express your health concerns to them. They don't take it as seriously ---

like this is what we're suffering from this is what needs to be done like it's our body we know what's going on and it's not a joke. (Bella)

I definitely think that in general, when you ask a question sometimes you feel like you're-the answer is like you're bothering them. I feel like sometimes when we ask a question 'here we go again she's asking this'. (Charlotte)

In the hospital when you call for a nurse they just always sound irritated. When my medicine was running out in the epidural, to call them they're like "oh, ok"- I felt like I was always bothering them. So like if they were, I guess a little more accommodating I wouldn't call that much I feel like it would be more comfortable I guess. It was always like a bother if I called them like I need something. (Georgia)

Mothers felt hesitant to ask for help from a health care professional when they felt that person did not want to help them. Mothers felt that being Black contributed to how willing medical professionals were willing to help them.

Mothers were rushed and told they would need unnecessary interventions

Some participants reported feeling rushed into accepting unnecessary interventions without being given ample time to making an informed decision. While these mothers were "told" they "needed" they were able to birth their babies without the suggested intervention.

Bella experienced "being told" that she would have to have a c section because the nurse felt she was not progressing fast enough.

One of the head nurses who said like oh if the baby doesn't come at a like certain time we're going to have to do an emergency c section with you...I felt more like it was trying to rush me. It had only been 9 hours I heard women been in labour for 24, 36 hours before right? (Bella)

Similarly, Denise said that the doctor who attended her birth immediately suggested forceps or vacuum extraction.

The doctor came in and, he was very impatient. He told me "ok listen, either forceps or a vacuum cause this baby is not budging". (...) I said no, no, no, I was like adamant about not using it. I just kept pushing and I think within like 5 minutes my son was born. (Denise)

Melissa planned to have her baby at a birth centre but when her water broke her midwives found meconium and she was transferred to the hospital. An OBGYN was called in for a consultation. Immediately after arriving to her room, the doctor had told her that she would probably need a vacuum extraction. After confirming that there was nothing wrong with her or her baby, Melissa decided to advocate for herself to avoid an unnecessary intervention.

And she's like, " well, it could be the difference between, you know, 30 minutes of pushing, or three minutes of pushing. I was like, well, I'll take the 30 minutes of pushing. She was like, "well, if something changes, you know, then it's gonna be something that we have to do. (Melissa)

In all of these cases, the mothers felt that they were being rushed by their health care provider because they did not want to wait for them to deliver naturally. The suggested interventions were not presented to the mothers as an option, nor were they given sufficient information to make an informed choice about the suggested intervention.

Being dismissed or not being listened to by their healthcare providers

Another concern expressed by participants was that they were often dismissed: their pain was dismissed, their feeling/need to push was dismissed; and other requests were dismissed. For example, Latoya mentioned that when she was giving birth she felt a “pop” in her pelvis. Following this she was in serious pain and could not walk. Since it was her second baby she knew that there was something wrong. She asked her nurse to get a doctor to check her out but no one ever came. She had then called her OBGYN’s office and the receptionist said that doctor would come to see her but no one ever came. Finally, just before she was discharged, a doctor came and watched her walk and told her to go to physio but did not offer any other support. At the time of the interview (seven months post-partum), Latoya was still in pain:

I personally feel if it was a white person they would have been quick to help her but that's just what I think. I think, that maybe because I'm Black they probably could have

thought that I was overexaggerating. I feel that if it was a white woman in my position they would have helped her. That's how I felt. (Latoya)

Hannah also reported that her labour progressed quickly and when she felt the urge to push, the nurses did not believe her because they felt that not enough time had passed. Hannah wished that the nurses had believed her when she told them how she was feeling.

I told them, the contractions are really strong so the baby is coming I need to push, but it was like they didn't believe me cause I guess it was prior to checking me like probably 10 minutes before I'm telling them that you know, I need to deliver now. They said I was probably only about like 5 or 6 cm so they didn't believe me and the fact that I was already ready to push and I think that one thing is that as a woman I feel like you personally will know when you're ready right um regardless of them actually checking you I feel like you, your body knows so that was one thing that was unfortunate I just wish that the nurses were there to listen to me rather than tell me no, no, no, you're not ready. (Hannah)

Venus felt that nursing staff spoke to her husband rather than to her because he is white. Health care professionals regularly referred to him as a “good dad” and praised him for being present when their child was in the NICU. Venus, who was also present was not given the same such praise.

I definitely felt [that I was] probably like in better hands because he was there. I also noticed how like if somebody was talking to me, they would kind of like default to him. (Venus)

Candice had a successful home birth but her primary midwife didn't think that she would be able to give birth at home because her baby was not in a good position. She did not try to help Candice during labour and relied on the student midwife to support Candice. The primary midwife did not call for the second midwife to come because she assumed they would ultimately transfer to the hospital. Candice felt also judged by her midwife because she was enrolled in school and did not intend to take time off after her baby was born.

So she [the student midwife] is calling for her preceptor, calling for her, she wasn't even interested. She was in the living room and she was just very nonchalant about the whole thing. Finally, the student screamed, she's "she's crowning!" And she comes running

into the room and she's like "okay, where are you- what've you done?" They had paged a second midwife, one for mom, one for baby, but because she had thought you know I was gonna be transferred to hospital, you know, this wasn't gonna materialize into anything. I think [the baby] had been out for maybe half an hour when the second midwife showed up. (Candice)

Kimberly chose to have a home birth because she previously had negative experiences within hospital settings. At two weeks postpartum, Kimberly was in a lot of pain so her midwife advised her to go to the emergency room to get checked out.. When she was there, a doctor asked her if she wanted to be swabbed for gonorrhea and Kimberly declined. The doctor asked everyone to leave the room and asked her again if she would like to be tested for gonorrhea. Kimberly informed the doctor that she had done STI testing during her pregnancy and did not need to do it again. Having a doctor she did not know conduct a vaginal exam made her uncomfortable and feel vulnerable. After the exam was completed the doctor told Kimberly that she had gone ahead and done a swab for gonorrhea without Kimberly's consent "just in case she wanted it". Kimberly was furious told the doctor to throw the swab in the garbage.

"I feel like if this was a white woman and she said no, then that would be "no". I don't know why my no is not good enough or is not an educated enough answer for her. So, she's thinking like, "oh maybe she doesn't understand", or making assumptions about my relationship, I don't know, I could not believe that that had just happened to me. I was like, "I told you no, because I told you I had testing done earlier a few weeks before I gave birth. And even if I didn't have testing, if I say no, it's no. Long story short, it was a traumatic experience at the hospital." (Kimberly)

Nadia had hoped for a birth with minimal interventions but ended up having an emergency caesarean. When she arrived at the hospital for her induction she was informed that she was not allowed to eat in case she needed to have a caesarean section. She felt coerced by the doctors and nurses into accepting one intervention after the other until she eventually reluctantly consented to the caesarean section. When she asked why she needed the intervention the medical staff felt she needed she wasn't given information that made her feel comfortable with the

decision. Nadia, who is a lawyer, felt that the staff showed bias towards her and thought she was stupid because she is Black. After her surgery, nursing staff complimented how nice and neat her incision looked. Nadia said that she felt like she wasn't actually a part of the process during her birth. She requested to have minimal intervention but spent the majority of her labour telling doctors and nurses to leave her alone. Nadia said in her interview that after she told her friends and family about her birth she discovered that her experience was not unique.

"Sometimes I look back and I get upset with myself, and now I feel like I'm gonna cry. Uh, I get upset with myself because I'm like, 'Maybe I should have fought harder.' I didn't think this was gonna be an experience where I've had to fight." But, um, yeah, maybe I was just too tired by that point. But after a certain point, I was just like, 'I'm done.' Like, 'You guys have broken me and I just-- I just can't fight anymore.'" (Nadia)

Nadia also expanded on how she felt during her birth and why she requested interventions be explained to her before they were performed.

They were working on me. I didn't feel like I was a part of the process. If you can explain something to me, like then it makes me feel safe. (Nadia)

When Kimberly was in active labour during her home birth, a midwife who she had never met before wanted to do fetal monitoring during a contraction. Kimberly does not like to be touched by people she doesn't know and told the midwife to stop but she did not.

So she's checking the fetal heart rate, and I don't know her, and she's getting like real up-close and personal with me. And, and, and it was just a moment where I did not want to be touched at all. So I said, I don't want this. And she's like, "Well, you don't understand. I have to check the heart rate." I was like, "Oh, I'm, in the middle of contraction right now and I'm like okay maybe she didn't hear me. And I said, "I do not want this." And she's like, "Well, I have to." And she forced the thing on me. (Kimberly)

Mother's pain, the feeling of the need to push and declining interventions and procedures were ignored by health care professionals. Mothers felt that these experiences happened to them because of their race.

Mothers had difficulty getting admitted to the hospital

Mothers were also concerned about being sent home from the hospital when they were in labour. Elizabeth was sent home multiple times when she was in labour and was told conflicting information by doctors regarding getting admitted to the hospital. One of the times Elizabeth was sent home she had already been given a bed to rest in and a dose of morphine. Elizabeth was in labour for 3 days before a doctor who had originally said she could stay but didn't admit her before her shift ended, checked her in to the hospital.

It [my race] had me thinking. So laying there I was kinda upset at the time and I was just like, oh my gosh you know maybe if I was white, that male doctor would have been a little bit more understanding or maybe if my partner was white, cause he's darker than me. . And I just thought that you know maybe if my partner wasn't there it would have been a little bit more... it would have gone a different way and probably wouldn't have sent me home. (Elizabeth)

Sarah was told by a midwife at the hospital that she wasn't far enough along in labour to be admitted even though another midwife sent her to the hospital after her prenatal appointment at the clinic. When she returned to the hospital in active labour she was not able to speak and had a difficult time checking in. The first nurse was a white woman and the second was a Black woman.

"She's telling me to go home. So I did, I should have stayed. So we went back to the hospital and my midwife wasn't present the nurses, upon getting there, I couldn't really speak I was in so much pain but I still had the bracelet on from when I was there earlier so I kind of just like I just went to the window of a nurse put my wrist through to kind of like show her like this is my information. The first nurse was not receptive but she's kind of like what are you doing? But another nurse came and she took over and brought me into the room." (Sarah)

Although being sent home from the hospital when not in active labour is a common occurrence for all women, for Elizabeth and Sarah, being Black made this normal occurrence more difficult for them overall.

Mothers were told their baby needed formula

Not only did mothers advocate for themselves, they also advocated for their children. Rebecca and Denise had negative encounters with nurses who wanted to give their babies formula. A nurse told Rebecca that her baby could not be discharged until he had pooped and suggested formula would help move his bowels. Rebecca did not want her child to have formula and had a brief argument with a nurse about it.

She's like, "but why wouldn't you give him formula?" I said, "I don't want to give him formula! Like I do not want to give baby formula." And the nurse, the look on her face was as if to say like what's wrong with me for not accepting formula in case of him not pooing." (Rebecca)

Denise was also hesitant about giving her baby formula but she was told by a nurse that her son would have "mental problems" and "brain development issues" if she didn't. The nurse force-fed him formula from a cup and did not stop when Denise and her husband asked her to.

She was literally forcing him to consume this cup, not even in a bottle, and I asked her "why can't he have it in a bottle?" and she was like "cause he will get confused by the nipple and we don't want to confuse him so we have to give it to him in the cup". So, this hours-old baby and he's like dribbling and choking and my husband was like can you stop please, and she was like no he needs some he needs some in his system. It was just totally traumatic watching her force feed him this formula. (Denise)

The nurse used fear tactics to convince Denise and her husband to give their baby formula. She did not use informed consent when interacting with this family. The nurse has an understanding of nipple confusion and used the cup in order to support further breastfeeding success however force feeding the baby and not stopping when asked was a traumatic start to Denise's breastfeeding journey and it took a lot of effort for her to be successful after this rocky start.

Factors Contributing to a Positive Birth Experience

Not all aspects of the participants births were negative. Family support, religious community support, continuity of care, midwifery care, minority or Black health care providers

and information sharing were listed all aspects of positive birth experiences. Mothers also offered advice for other mothers and reflections on their future birth plans to be which will be shared in this section. The second research question (What factors do Black mothers believe contribute to their childbirth experiences?) will be answered in this section.

Mothers felt a sense of support from family members

Mothers indicated that feeling supported by family members and their spouse was important to them. For Chanelle, having her family members with her in the hospital gave her a sense of feeling protected, and contributed to a positive childbirth experience for her. Angela also felt a sense of support from her husband, friends, and family members. Their ideas are captured in the following quotes:

So, I think that definitely just having that family support was like really played a role in them being very attentive and it was very positive. I think that was like a protection. Without it like I don't know like what my experience would have been. (Chanelle)

My husband was helpful, my sister was very supportive, and my mother was supportive, my grandmother was- like my whole- my aunts, they were all supportive of me giving birth and the moments leading up to that. They would give me their advice. Also, friends, I would ask my friends for their advice too. (Angela)

Melissa felt comforted knowing she and her husband had planned the birth together and talked about which kinds of interventions she would be comfortable with. When it came time for her to advocate for herself against an unnecessary intervention, Melissa felt supported to know her husband was there with her.

So, he was also informed [about the birth plan] I could feel him beside me ready to back me up in the event that we [she and the baby] needed that. (Melissa)

Having a sense of support from family members was very important for the mothers in this study. This support contributed to feelings of safety and protection which in turn contributed to positive aspects of their birth.

Feeling a sense of support from religious communities

For some, a sense of support came from their religious communities and their church family. Jody, Melissa, and Simone described how prayer and faith played a part in their birth experiences:

In terms of like praying through things, like, through the procedure before going in there and just like even myself lying there and praying as well and support from my church family you know they say it takes a village to support moms as well so I felt really supported by my faith community. (Jody)

My faith was a part of that as well in terms of praying you know, just everything is going to be okay or how things are going to or just pausing to pray for peace and calm. My husband praying, in the process as well. So drawing on that offered a sense of calm and peace through the process and just being in a very positive frame of mind. (Melissa)

My faith was really strong and kind of knowing that she would come out, she would overcome all these health challenges, which she did, so I knew. (Simone)

When asked about which other factors might have contributed to their childbirth experiences, these mothers felt very strongly about the role religion played in their experience. Praying before birth helped mothers feel comfortable and supported.

Mothers had a preference for continuity of care

Ten mothers chose midwives to be their health care provider. Mothers who chose midwifery care expressed that they did so because they either wanted to ensure continuity of care or, because a midwife was recommended to them by a friend or family member who had used midwifery care in the past. Two of the mothers who chose midwives actually attended one prenatal appointment with an OBGYN before deciding to switch to a midwife for the remainder of their pregnancy. Lauren who had previously had two babies under the care of an OBGYN decided that she wanted a midwife for her third baby.

That's kind of why I went with the midwife. When I had the nurse experience, hospital and the OB they did not listen to me, and the OB is kind of just like next, next, next, I

didn't like it. I was never totally traumatized and I just aligned myself with better professionals so that I would allow myself to enjoy the experience, which I did!. (Lauren)

Most women expressed that they would prefer to have continuity of care through their prenatal care and their birth. They felt that it was important to have a connection and a relationship with their healthcare provider. All of the participants who had a midwife as their primary care provider at the time of giving birth experienced continuity of care. Only 3 of the 20 participants who choose an OBGYN as their care provider experienced continuity of care. Georgia, who was one of these three participants, felt more comfortable because her doctor knew her and her history of pregnancy loss.

So my doctor who I gave birth with, she knew me, she knew the problems I was going through. I had a very... I had a lot of miscarriages and I had an ectopic pregnancy and I had to I guess be watched a bit closer and I had to have, ultrasounds every week and take medicine for BP, take medicine, just progesterone pills to make sure like I wouldn't lose the baby that kind of stuff, so my doctor was there when I gave birth and that made me feel more comfortable. (Georgia)

Charlotte also had continuity of care with her OBGYN for all three of her children.

Yes, yes he delivered the baby. He delivered all three of my kids and one of the nurses was shocked when I said that, she was like really? So I guess I'm very lucky. (Charlotte)

Hannah expressed that having a connection with her doctor during pregnancy would have made her birth experience better.

I feel like if you had a doctor where you could like obviously to talk to and you know, express how you feel it would have been a lot more better so some of the experience, some of the problems I was experiencing during my pregnancy like I end up either going to like a local hospital or I went to a walk-in doctor, I never actually called my specific doctor that was assigned to me to say hey I'm having like issues or whatever the case was there was like no connection. And I think if I had that connection, my overall experience would have been so much better. (Hannah)

Mothers had a preference for Black or racial minority care providers

Several mothers mentioned using Google searches to find a health care provider who was either Black or a racial minority and to check the ratings of the prospective care provider before

scheduling their first appointment. Angela and Carla did extensive research when trying to find a care provider that was just right for them.

I was looking for somebody who was a racial minority. I was looking for that specifically. I went on the website and I looked at some reviews and I actually just went to a few doctors and just kind of had like an initial interview with them. (Angela)

So actually when we first interviewed with a midwife there, the person we interviewed with was quite nice and we were excited to work with her. (Carla)

For Simone, having a Black doctor was a very important aspect of her experience.

My OB was Black for a reason. I was purposeful in seeking that out because I think she would have been able to understand culture and to what role it plays and, you know, understand the Black experience and especially with Black moms and understanding and navigating, certain trajectories along the birth. So I think that was extremely wise on my part. (Simone)

Many mothers in this study reported having a preference for a health care provider that was Black or at least a part of a different racial minority group. For Venus having someone that looked like her attend to her at her birth made a difference in how she felt physically and emotionally.

I did like actively notice is that there was at least one Black nurse that came--like a Black female nurse that came in afterwards. It just sort of instantly made me feel a little bit more like comfortable. Whereas with my first experience, like there wasn't even any like Black mothers around me. As soon as she [the Black nurse] walked in, I felt my shoulders relax, like my jaw unclenched as soon as I just saw somebody that, you know, could maybe understand me just a little bit more. (Venus)

Mothers felt that it was important to them to have someone who looked like them near them during their labour and delivery.

Information sharing and open communication

Mothers in this study felt that being able to communicate with their health care provider was important. This communication included honest conversations and conversations about their birth preparation. When Nicole was diagnosed with gestational diabetes it was no longer

possible for her to be cared for by midwives. Nicole felt supported by her midwives during her transition to care with an OBGYN.

And my midwives, I wish I had her [the midwife] through the whole thing but she came when she found out, she came and she said we can't do this no more, this is more medical than what we do. They were very honest with me. (Nicole)

Angela had a good relationship with her OBGYN and she appreciated that her care provider valued communication and honest conversations.

She [the OBGYN] would talk to me and actually listen to what my concerns were, she wouldn't really brush off any concerns that I had. She actually took them seriously and she wanted me to be honest with her. (Angela)

When Sarah went into labour she knew that what she was feeling was normal because she had conversations with her midwife during her prenatal appointments.

When my water broke, and I wasn't able to speak when I was in the bedroom. I knew then [that she was in active labour], because one of my midwives had told me, she was like 'when its time you won't be able to speak just trust me you won't be able to speak' so that helped cuz' I knew it was time and I knew that I didn't need to panic and that it wasn't bad. It was just normal, you know. So, they gave me information that did prepare me for what was coming. (Sarah)

Kimberly made sure to have important conversations with her midwife about why she chose to have a home birth during her pregnancy. It was important to Kimberly for her health care provider to be on the same page as her in respect to her birth plan.

I chose to have a home birth cause I hate hospitals. I, like, I get panic attacks anytime I walk in there, even if I'm visiting someone else, like, I just can't stand the smells, the sounds. I spent a lot of time in hospital when I was a teenager, and it was just really traumatic and like I'm really over it. So, I knew for myself that giving birth in a hospital, um, I would not feel comfortable. And I knew that, like, I would kind of jokingly tell my midwife like, "I'm not going unless it's an absolute emergency. And even then, I'm still not going." Because I-I just don't feel good in that kind of institutional space. (Kimberly)

Communication with health care providers was important for mothers who wanted to build relationships with their care providers. These conversations contributed to mother's being

able to speak free from judgement with their health care providers and to trust the information they were receiving from them.

Advice for other mothers

Some of the mothers who participated in this study wanted to offer advice to other expecting or future mothers. Their suggestions included seeking midwifery care, hiring a doula, advocating for oneself and educating oneself on both birth and breastfeeding.

For Sarah and Kimberly, having a negative encounter with one of their midwives did not stop them from having a great birth experience and encouraging other Black women to seek midwifery care.

I can't stress enough that I really had a great birth experience. Even the midwife who was tactless when she asked that accident question was so amazing so like I don't know it was just a really really good experience I enjoyed how personalized like going through this with midwifery was and I wish more Black women would choose it. Not just a doctor and a doula but actually midwives. (Sarah)

It was beautiful. It was very peaceful. It was calm. It was exactly what I had envisioned it to be. Be it with some blips in the road, but, overall, it was really beautiful. (Kimberly)

Nicole also wants to warn other mothers that they should learn more about birth because sometimes things don't go as planned.

It's good to get my story out there. Because some people don't know. They think it's this nice positive vibe and sometimes it ain't as positive as you think. I think just understanding the risks involved for everybody and mental health involved too as well. Definitely need to advocate for that as well. (Nicole)

Simone had an emergency c-section under general anesthesia and classified her childbirth experience as traumatic. After her difficult birth, she struggled with breastfeeding her child and felt a sense of guilt associated with not being able to feed her baby. Simone attributed this challenge to her traumatic birth and separation from her child. Simone wished she was better

prepared for breastfeeding challenges before giving birth and wants more prenatal breastfeeding information to be available for mothers.

I would say I was not prepared for it [breastfeeding] and it was like battling the guilt of not being able to produce enough milk for your child to survive and then, you know [having to be] okay with that And so I think way more information needs to be put out there for moms about that 'cause I was not prepared at all. (Simone)

The advice mothers shared were shared in hopes of helping other women who are pregnant or will become pregnant in the future. Mothers recommended midwifery care and prenatal education on birth and breastfeeding as important things to consider.

Mothers were reflective about their experiences

In addition to advice, mothers also reflected on their birth experiences. They spoke about things they would do differently in the future if they have more children and things they wish they knew before giving birth. Many of the mothers who had negative childbirth experiences expressed that they would find a new care provider and/or choose a new birthplace if they were to have more children in the future.

Kayla did not enjoy her hospital experience and wants to have a third child so that she can have a more positive experience.

I'm like let me have a third so I can have a home birth and a doula! And a Black one!... I think I would do something more personal, more intimate, more nurturing. I'd kinda go along those lines. (Kayla)

Elizabeth, who primarily lives in Jamaica, came to Canada to give birth so that her child would be able to have dual citizenship like she does. She had a very negative childbirth experience and does not want to have a hospital birth in Canada again.

Overall, it was just it was the worst experience ever. And overall, I don't even think that I would have another child at a hospital in Canada. [or, I would have] the midwives and probably would give birth at home if I had to. (Elizabeth)

Hannah said that she would find a new health care provider if she has another baby in the future in order to ensure continuity of care.

I would definitely do my research in terms of like, if I was to find a doctor would they be literally with me throughout the whole entire like pregnancy up until the day I was delivering rather than having like multiple different doctors checking up on me and then having a random doctor deliver my baby. (Hannah)

Kimberly and Venus were both reflective of what it means to give birth as a Black woman and the unique challenges they face.

I can find words to sort of advocate for myself, but I think about people who can't advocate for themselves, and it shouldn't be the responsibility of the person giving birth to advocate for themselves. It's something that should be common sense, a basic human right. We shouldn't have to be the ones fighting to make sure that we're treated equally and like decent human beings. (Kimberly)

You're supposed to be able to trust your doctors. And especially like when you're going through something as crazy as childbirth, you should feel protected and you-- it should not be a place where, or a space where race is even a factor at all. (Venus)

Mothers thought carefully about their childbirth experiences and the factors that contributed to them. They also contemplated whose responsibility it is to support them in having a birth experience free from judgment and racism.

In conclusion, the results of this study were organized into themes that emerged in connection to the research questions. The childbirth experiences of Black mothers in the GTA are largely shaped by racism, bias and microaggressions they receive from medical professionals during the pregnancy, birth and post-partum. These racist encounters ranged from microaggressions to ignoring explicit requests from mothers. The factors that contribute to Black mothers' childbirth positive experiences are family and religious support, a preference for continuity of care and minority or Black health care providers as well as communication and information sharing with health care professionals.

Chapter 5: Discussion

In this chapter, I will discuss the findings of my study in relation to the literature. The findings will be discussed in relation to the CRT tenets covered in the literature review as well as the two research questions. I will then highlight areas for future research and reflections from this study.

First, a look at the participant group and their disassociation from several assumptions associated with Black women. Some of the stereotypes about Black mothers include that they are young, single and uneducated, that their children were unplanned or that they had them just to collect government money. These of course are just stereotyping and are not true descriptors of Black women. This is the case with this group of participants as well. The participants in this study were very educated. All 30 mothers had at least a college diploma however the majority have a bachelor's degree or higher. The average age of the mothers was 31.5 and the majority were married or in a common law relationship. Black women deserve supportive care regardless of their marital status, education level, sexuality and age.

Racism, Bias and Microaggressions Experienced by Participants

Seventy percent of participants had negative interactions with nurses, doctors and midwives that they felt were directly related to being Black. From being questioned about insurance and their relationship status to procedures being performed without their consent, most of the mothers in this study indicated they had at least one negative experience related to racism. Despite these negative encounters some of the participants still classified their overall experience as positive because the birth of their child outweighed those negative experiences. The overall experiences of participants in this study were shaped by racist encounters they experienced during this pregnancy and birth. For some their experiences were also shaped by experiences they had prior to giving birth within the health care system or in society in general. Feelings of

judgement from health care professionals were not always felt because of something the health care professional had said or done but because of internal feelings that were shaped living in a Black body.

Even the nine participants who claimed that they did not experience racism during their recent birthing experience had had negative experiences with previous births and had taken steps to minimize racist encounters during their birth. Interestingly, when asked how their race contributed to their experience overall, some these mothers did not think that their race contributed to their experience. Even though they had taken steps to avoid negative experiences, they did not think that being Black contributed to their childbirth experience. They did not make the connection that they had a positive experience because they took steps to make it more positive because of their past negative experiences which were related to their race. However, this was also not the case with all participants with positive experiences: some were indeed aware that their positive experiences was influenced by their choices.

For some mothers, talking about race was difficult. They didn't want to "play the race card" or "put that on her" when talking about negative experiences related to their race. Some were hesitant to say that what had happened to them may have been due to race because the person perpetrating the racism did not outwardly say something that was racist or specifically indicate they were treating the mother poorly because she is Black. This may be explained by Delgado and Stefaniec (2017) who describe a tenet of CRT as "racism as normal". They outline that because racism is "normal" or "ordinary" it is difficult to address and label. In addition to this normalcy associated with racism, some do not have the language to accurately describe the racial inequities they experience.

Another CRT tenet that can be applied to this section is differential racialization and anti-essentialism (Delgado & Stefanic 2017). The experiences of mothers in this study were all unique yet connected in many ways. While most of the mothers were subjected to racism, bias and/or microaggressions, not all felt this was true for their own personal story. We see through the quotes shown in this study that not all women have the same childbirth experiences and there is no one singular “Black experience”. Similar to anti-essentialism, Black women are also subject to differential racialization. For example, Elizabeth wondered if her Black partner had not been with her if she would have had a better experience while Venus felt that she was treated better by medical professionals because her husband is white.

This can be understood in the context of intersectionality, a CRT tenet described by Delgado and Stefanic (2001). Intersectionality is a term coined by the Black feminist scholar Kimberly Crenshaw to understand/capture how a person’s different identities contribute to their privilege or oppression (Crenshaw, 1988). As can be seen in this study findings, these cooccurring identities, contribute to the treatment that Black mother’s received during their pregnancy, labour, and post-partum period.

Obstetric violence or abuse during childbirth includes disrespectful and abusive treatment during childbirth (Bowser & Hill, 2010). This can include, physical and verbal abuse, humiliation, lack of confidentiality, failure to obtain informed consent, refusal to give pain medication, violation of privacy, refusal of admission into a health facility and neglectful care to name a few. Adolescents, unmarried women, women who are of a lower socioeconomic status, immigrants, women from ethnic minority groups and women who are HIV positive are more likely to experiences abusive and disrespectful treatment (Bowser & Hill, 2010). Many of the stories documented in this study can be classified as obstetric violence. The factors that

contribute towards abuse in childbirth are: individual and community attitudes, national laws and policies, lack governance and leadership, lack of standardization in service delivery and factors pertaining to provider characterises such as provider prejudice (Bowser & Hill, 2010). Provider prejudice is a potential contributing factor to disrespectful care that manifests as discriminatory behaviour based on negative assumptions of the woman about her race, age, marital status, education level and socioeconomic status (Bowser & Hill, 2010). It is clear that the intersecting identities of the participants in this study contributed to their childbirth experiences.

The theory of internalized oppression may offer a glimpse into understanding why doctors and nurses treat labouring mothers poorly. Dr. Teeomm Williams (2012) outlined in his doctoral thesis Dr. Barbara Love's Pillars of Oppression model. Within this model there are two pillars: oppressive factors which includes powerful individuals, powerful institutions as well as culture the second pillar being internalized oppression.

Powerful individuals within the health care system would be the those at the top of the "food chain" such as hospital executives, presidents and vice presidents. Powerful individuals are the ones who are in control of hospital policy and are responsible for the overall culture created in that environment. Powerful institutions for example are the education system, laws and hospitals. These types of institutions legitimize and normalize the power structure within the maternity care system making it difficult to question or critique. In some cases we may not even think there is anything worth challenging at all because we are conditioned to believe that is "just the way things are". Finally, within the pillar of oppressive factors is culture. Within this section of culture we can include the culture that we have within our province and country that doctors know best and should not be questioned. Within this section we can also include the belief that

many hold that traumatic births don't matter and a mother should just be happy that she and her baby are physically healthy.

The second pillar is internalized oppression. Internalized oppression refers to when people who are in the middle and the bottom of the power structure believe that they are inferior to those who are above them. It can be applied to those who are subordinate (those who are oppressed) and the dominant (those who are oppressors). People who are in the middle of this power structure can be classified as both the subordinate and the dominant depending on the particular relationship in question. For nurses, resident doctors, and midwives they are in the middle of this power structure with mothers, partners and babies being below them and doctors, hospital lawyers and presidents being above them (Williams, 2012).

This concept of internalized oppression cause those in the middle to internalize the oppression they experienced by those above them and inflict oppression on those below and equal to them. According to this theory those who have internalized oppression are often not aware of it. They do not realize the trauma they feel from being oppressed is transferred again down to those below them in the power structure. They subconsciously believe that those who are below them or equal to them are inferior and oppress them in an attempt to get higher up the food chain. This may be one explanation for why nurses, resident doctors and midwives treat labouring mothers and their babies poorly.

One way that health care professionals exercised their power over the labouring mother was with threats or suggestions of caesarean. Some of mothers reported that they felt rushed and hurried by nurses who said they were going to need a caesarean section if they did not progress faster. Similarly the suggestion or threat of using forceps or vacuum to speed up the pushing phase.

Out of the 30 mothers in this study, seven had emergency c-sections. Two of those seven reported being able to feel parts of the surgery. It is unclear what the cause of this happening to these mothers or how often this happens in general. Staton et al, (2007) reported that the pain of Black people is underestimated more often than that of white people. This may lead to inadequate amounts of pain medication. It is unclear if these two mothers were not given the correct amount of pain medication because of provider bias or other factors.

A study conducted in the US in 2016 found that Black mothers are 9 times more likely to be offered formula by hospital staff than are white mothers (McKinney et al., 2016). In this study 3 mothers reported being offered formula by hospital staff. As shared in the results, Denise and Rebecca shared that they had negative experiences with giving their children formula, while Jody reported that she appreciated that she was given options.

The CRT tenet of storytelling was used to amplify the voices of Black mothers in the GTA. Their experiences, feelings and concerns should be viewed as valid. The experiences of the participants in this study may be viewed as insignificant to those who believe that a healthy mother and baby are the only important outcomes of childbirth. For the participants in this study how they felt and how they perceived their care were important. The use of storytelling in this study is very important for bringing to light stories that would not otherwise be told.

Factors contributing to a positive birth experience

The mothers in the present study listed family support, religious and community support as well as high quality care provider communication as factors contributing to a positive childbirth experience. Similarly, a study conducted with 10 Black mothers in Nova Scotia found support to be a common theme associated with their birth experiences (Etowa, 2012). For participants in the present study, feeling supported by their partner, family and larger community

were important to them. Three mothers indicated wanting more support from their place of employment and colleagues was also important to them as they felt the stress of their jobs contributed to their pregnancy and birth experience. Having supportive care may be related to feelings of safety which helps women feel a sense of control in managing their labour (Karlstrom, Nystedt & Hildingsson, 2015).

Mothers in this study expressed that open communication and information was important to them. Feeling heard and not feeling that their questions were a burden was also important. For example, Nadia said that having information makes her feel safe and having information given to her by her health care team is important to her. A study conducted with mothers of colour living in Wisconsin, USA, found similar results. Participants in that study valued care that was tailored to their individual needs which was listed as a factor in quality prenatal care (Coley et al., 2017).

Participants sought out care providers who they felt would be supportive and understanding of them as a Black woman. This preference may be explained by the concept of racial concordance. Racial concordance refers to the patient, in this case any health care professional (doctor, midwife, nurse etc.) having a shared identity regarding their race. Racial discordance occurs when the patient and the health care provider do not share racial identity. Racial concordance is associated with higher levels of patient satisfaction and a better perception of their care. (Saha, Komaromy, Koepsell, & Bindman, 1999). Most mothers in this study reported having a preference for a health care provider that was Black or at least a part of a different racial minority group. For Venus having someone that looked like her attend to her at her birth made a positive impact on how she felt physically and emotionally.

Some mothers indicated that although they would prefer to have a Black health care provider, they would be happy with a health care provider of any race as long as their care was

respectful. Most mothers in this study indicated that they have a preference for continuity of care because they would prefer to not have a stranger attend to them during their labour and delivery. The mothers in this group have a preference for connection with their health care provider and find that difficult to do when the person who attends their birth is not the person who cared for them during their pregnancy.

Continuity of care has been associated with a positive childbirth experience (Perdok et al, 2018; Dahlberg & Aune, 2013). In this study, 10 mothers had midwives and experienced continuity of care within the midwifery model of care. Of the 20 participants who had an OBGYN only 3 mothers had continuity of care. Two of them were scheduled inductions and the 3rd happened to go into labour when her doctor was on call. Mothers reported a dislike for strangers coming into their birth space at a time they felt most vulnerable. Mothers who chose midwives often cited the preference for not giving birth with strangers as a reason for choosing this model of care.

In conclusion, the experiences of Black mothers giving birth in the GTA are largely shaped by racism, microaggressions and bias. Their experiences and their perceptions of their experiences are also shaped by their past experiences and beliefs. Factors that contribute to a positive childbirth experience are a sense of support, continuity of care, midwifery care, Black or minority health care providers and open communication with health care professionals.

Chapter 6: Implications and Conclusion

Implications for Future Research

This qualitative study presents the experiences of 30 Black mothers in the GTA. Although most of Canada's Black population is in Toronto and the surrounding areas future research should also focus on the experiences of Black mothers living outside of these areas where racial concordance with their health care provider would be more difficult to achieve.

Future studies should also focus on the childbirth experiences of Black people who are a part of the LGBTQ+ community, the experiences of Black transmen and nonbinary people.

In this study 28 of the mothers had their partner with them during their birth. Future studies should focus on the experiences of the father/partner during the birth of their child. Understanding the needs of partners/fathers in order to better support the laboring mother may improve outcomes and experience quality for the family as a whole. If mothers are experiencing racism Black fathers may feel they are unable to speak out about their partners' poor treatment for fear of being viewed as aggressive. For example, mothers in a study conducted by Sacks (2017) were viewed as aggressive for denying interventions; it is possible this perception would extend to fathers as well.

The average age of participants in this study was 31.5 and none of the participants were considered adolescents at the time of their child's birth. Future studies should actively recruit younger mothers in order to understand the needs of Black adolescent mothers.

Future studies should also seek to understand how Black mothers plan for their birth. The majority of participants in this study did not attend childbirth education classes and many reported feeling blindsided because of their lack of knowledge.

Comparing the experiences of Black mothers to that of health care provider perceptions may also support the understanding of provider bias and obstetric violence. Surveying health care providers about their attitudes and beliefs as well as their knowledge on race may also help to support curriculum and policy changes.

Future studies should also examine the impact of a negative or traumatic childbirth experience on parent-child bonding for both the mother and the father. They should also examine the long term outcomes related to social and emotional health for children whose mother experienced a negative, difficult or traumatic childbirth.

Scope and Limitations

The majority of mothers who participated in this study found the information about the study in a Facebook group that is exclusive for Black mothers, or Black people in the GTA. This implies that the majority of the participants in this study are already actively seeking to be a part of a group of other Black people in their community. This may be why the theme of racial concordance was so important for this group. It is unclear if those mothers who felt uncomfortable talking about race came from outside of these Facebook groups and therefore are not comfortable in talking about racism.

While qualitative research is important for gathering stories of participants, it does not allow us to create statistics and apply these experiences to the larger population. Future studies should include a quantitative component in order to reach a larger group of people and get a more accurate representation of issues facing Black women in the GTA.

This research was conducted during a global pandemic and during the protests surrounding Black Lives Matter and the death of George Floyd. For women who may have had a traumatic experience it may have been difficult for them to share a difficult story on top of all

that was going on in the world. The pandemic may have actually made participating in this study more accessible for mothers. Most of the interviews were conducted during the day during children's nap times, something that would not be possible if participants were at work.

It is also important to consider which voices may still be missing from this study due to the pandemic. Participating in this study required access to technology which would have made it difficult or impossible for some mothers who would have liked to participate in this study. In order to participate in this study participants would need access to an email address and a phone or computer. During the pandemic the public libraries in the GTA were closed so Black mothers with no access to these items at home on a regular basis would not be able to participate. In addition a mother with a controlling or abusive partner at home with them during the pandemic might not have felt comfortable participating in this study.

Many of the mothers who participated in this study reported that they want to participate in this study because of a negative experience they wanted to share. It is possible that the mothers who had a good experience or a neutral experience did not want to participate in the study because they didn't feel they had anything "worth" sharing. Some mothers asked what I was "looking for" or "hoping to hear" before the beginning of the interview assuming that I was only looking for negative stories about Black childbirth experiences. They were assured that I did not have an agenda for this study, and I was just genuinely interested to hear their story, good or bad. This may be a contributing factor to the disproportionate amount of negative stories recorded for this study.

Reflections

Research examining the childbirth experiences of all people who give birth in Canada is a very under researched topic. There are currently research posters for a large national study on

childbirth experiences called the RESPCCT study, and a study on the children experiences of transgendered people giving birth in Canada as well as a comparative study on the prenatal care experiences of Black people in Canada and Jamaica. It is hopeful to see that there is ongoing research pertaining to childbirth in Canada and the experiences of marginalized populations.

I am incredibly grateful to the 30 mothers who shared their story with me and supporting this research project. Many of them commented that they wish there was more information out there about the childbirth experiences of Black mothers and they wanted to contribute to this project to help bring about a change. We also need to take a step back and decide who's responsibility it is to bring about this change. Black mothers should not have the added pressure of negating a system that is bias towards them.

Recommendations

This study brings to light some of the challenges Black women face when giving birth. In order to minimize some of these challenges, recommendations related to educations, policy and research can be made. Accessible opportunities for childbirth education as well as lactation education would help support Black women in being able to advocate for themselves and their children. Comprehensive education on racial disparities in addition to the lived experiences of Black people would be beneficial for health care providers in supporting Black mothers. Racial bias training for health care professions would also support them in reducing provider bias. Policies pertaining to women giving birth should allow for the time

Conclusions

This study highlights the need for more understanding from healthcare professionals regarding the needs of Black women and their families, the pervasiveness of racism, bias and microaggressions within the maternity care system as well as outlining the elements of what

Black mothers consider to be factors that contribute to a positive childbirth experience. Investing in research, services and education programs may help support Black women during labour and delivery as well as early infant care. Health care professionals also need to engage in reflective practices to reduce practitioner bias in order to prevent and ultimately eliminate racist behaviors and beliefs. Working together with health care professionals, policy makers and mothers to create a birth culture free from bias, racism, judgment and microaggressions is important for helping mothers and babies have positive first moments together. These relationships are essential for building healthy families and communities as a whole.

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