ACTA SCIENTIFIC CLINICAL CASE REPORTS

Volume 5 Issue 9 September 2024

Literature Review

# An Auto Ethnography Defining the Impact of Racial Disparities on the Black Woman's Maternal Experience through the Art of Storytelling

**Chenelle McInnis and Shanika Lavi Wilson***

*North Carolina Central University, USA*

***Corresponding Author:** Shanika Lavi Wilson, North Carolina Central University, USA.

**DOI:** 10.31080/ASCR.2024.05.0575

**Received:** July 19, 2024

**Published:** August 25, 2024



## Abstract

Maternal mortality, a pregnancy-related death, which is preventable, has continued to ravage the Black family. Tragic and life-changing incidents occur with Black maternal care at a higher increase than in any other race. The significance of ethnographic tale and literature review is to educate individuals, families, communities, and the healthcare system on the disparities that continue to impact the reproductive care of Black women. This paper will examine the effect of implicit bias, lack of access, the lack of a defined support system, the benefit of doulas, and the importance of storytelling of Black women's lived experiences. Dr. Wilson provided an auto-ethnography of her first birth experience.

**Keywords:** Maternal Mortality; Black; Women; Storytelling; Auto-ethongraphy

## Introduction

Black women in the United States face significant disparities in maternal health outcomes, reflecting broader systemic inequities within the healthcare system. Despite advancements in medical care, Black women are three to four times more likely to die from pregnancy-related causes than white women, highlighting the pervasive impact of racism and bias in healthcare [1,2]. These disparities are not merely the result of socioeconomic factors but are deeply rooted in the historical and ongoing mistreatment of Black women in medical settings [3]. Studies show that Black women are more likely to experience severe complications during childbirth, receive substandard care, and have their concerns dismissed by healthcare providers, contributing to poorer health outcomes [2,4]. Addressing these disparities requires a comprehensive approach that includes improving access to quality healthcare and dismantling the structural racism underpinning these inequities.

The proposed study will examine the impact of racial disparities on Black women's maternal health experiences during pregnancy, childbirth, and after birth, a national health crisis primarily ignored. The study will find social determinants associated with a higher maternal mortality rate amongst Black women. It will also document women's maternal experiences during pregnancy, childbirth, and after birth through storytelling. The storytelling will lead to the racial disparity in the ongoing rise of Black maternal mortality rates. It will also try to reveal early historical evidence to aid with defining the root causes of health inequity.

## Scope of the problem

Black maternal health has garnered significant attention in public health research due to persistent and troubling disparities in maternal outcomes between Black women and their white counterparts. Scholars have examined numerous factors contributing to these disparities, including structural racism, healthcare provider bias, socioeconomic status, and the cumulative effects of stress.

Historical analyses, such as those by Roberts [3], have traced the roots of Black maternal health disparities to the legacies of slavery and systemic racism in the United States. These legacies have manifested in a healthcare system that has often been discriminatory and neglectful toward Black women. Roberts [3] argues that the control of Black women's reproductive rights has been a tool of oppression, contributing to the ongoing disparities in maternal health. Similarly, Davis [4] highlights how contemporary racism, in

the form of implicit biases and discriminatory practices, continues to affect the care that Black women receive during pregnancy and childbirth.

Research has consistently shown that healthcare provider bias plays a significant role in the disparities seen in Black maternal health. A study by Taylor [2] emphasized that Black women often report feeling unheard and disrespected by their healthcare providers, which can lead to inadequate care and adverse health outcomes. These experiences are corroborated by findings from a qualitative study conducted by Altman et al. [5], which revealed that Black women often encounter dismissive attitudes and assumptions about their pain tolerance, resulting in delays in treatment and misdiagnoses.

Black maternal health has garnered significant attention in public health research due to persistent and troubling disparities in maternal outcomes between Black women and their white counterparts. Scholars have examined numerous factors contributing to these disparities, including structural racism, healthcare provider bias, socioeconomic status, and the cumulative effects of stress.

Historical analyses, such as those by Roberts [3], have traced the roots of Black maternal health disparities to the legacies of slavery and systemic racism in the United States. These legacies have manifested in a healthcare system that has often been discriminatory and neglectful toward Black women. Roberts [3] argues that the control of Black women's reproductive rights has been a tool of oppression, contributing to the ongoing disparities in maternal health. Similarly, Davis [4] highlights how contemporary racism, in the form of implicit biases and discriminatory practices, continues to affect the care that Black women receive during pregnancy and childbirth.

Research has consistently shown that healthcare provider bias plays a significant role in the disparities seen in Black maternal health. A study by Taylor [2] emphasized that Black women often report feeling unheard and disrespected by their healthcare providers, which can lead to inadequate care and adverse health outcomes. These experiences are corroborated by findings from a qualitative study conducted by Altman et al. [5], which revealed that Black women often encounter dismissive attitudes and assumptions about their pain tolerance, resulting in delays in treatment and misdiagnoses.

While structural racism is a critical factor, socioeconomic factors also contribute to disparities in maternal health. Studies such as those by Howell et al. [9] have shown that Black women are more likely to live in areas with limited access to quality healthcare facilities, which can negatively affect their maternal outcomes. However, even when controlling for socioeconomic status, racial disparities persist, showing that the issue is not solely related to economic inequality [9]. This suggests that improving Black maternal health requires addressing both socioeconomic barriers and the racism embedded within the healthcare system.

The phenomenon of maternal mortality among educated Black women is a critical issue that challenges common assumptions about the relationship between socioeconomic status and health outcomes. Research shows that even among Black women with higher levels of education and income, the risk of maternal mortality is still significantly higher compared to their white counterparts. This disparity points to the role of systemic racism and implicit bias in healthcare, which cannot be mitigated solely by socioeconomic advancement. Educated Black women often experience maternal health outcomes that are disproportionately worse than those of less educated white women. A study by Creanga et al. [6] found that Black women with a college degree or higher are more likely to die from pregnancy-related causes than white women without a high school diploma. This startling finding underscores that education and income alone do not protect Black women from the risks associated with pregnancy and childbirth.

The "weathering hypothesis", first proposed by Geronimus [7], posits that the cumulative effects of social, economic, and environmental stressors disproportionately affect Black women, leading to earlier health deterioration and adverse pregnancy outcomes. Recent studies have supported this hypothesis, with Lu and Halfon [8] finding that the chronic stress associated with racism and discrimination contributes to higher rates of preterm births and low birth weights among Black women. The impact of stress on Black maternal health underscores the need for interventions that go beyond the medical model and address the social determinants of health.

Given the multifaceted nature of Black maternal health disparities, scholars have called for comprehensive interventions that address both the social determinants of health and the biases within the healthcare system. Taylor [2] advocates for the implementation of antiracist health policies that explicitly target the reduction of racial disparities in maternal outcomes. Additionally, initiatives

such as community-based doula programs have been highlighted by Kozhimannil et al. [10] as effective strategies for improving Black maternal health by providing culturally competent support during pregnancy and childbirth.

The literature on Black maternal health highlights the complex interplay of factors contributing to racial disparities in maternal outcomes. Structural racism, healthcare provider bias, socioeconomic barriers, and chronic stress all play critical roles in shaping the experiences and health outcomes of Black women during pregnancy and childbirth. Addressing these disparities requires a comprehensive approach that includes policy reforms, community-based interventions, and a commitment to dismantling the systemic racism that permeates the healthcare system.

## Statement of the problem

The persistent disparities in Black maternal health outcomes in the United States are a critical public health crisis, with Black women experiencing maternal mortality rates three to four times higher than those of white women. Despite this alarming statistic, the stories and lived experiences of Black women often go unheard and undervalued within the healthcare system and broader society. This silence perpetuates systemic racism and implicit bias, leading to inadequate care and poor maternal outcomes. The failure to listen to and act upon the voices of Black women not only worsens these disparities but also undermines efforts to achieve equitable maternal health. Addressing this issue requires not only the amplification of Black women's stories but also the implementation of policies and practices that prioritize their health and dignity.

## Justification and purpose of the project

The study of Black maternal health is both timely and critical, given the persistent and alarming disparities in maternal mortality rates between Black women and their white counterparts in the United States. Despite advancements in healthcare, Black women continue to face disproportionately higher risks of pregnancy-related complications and death, a phenomenon that is deeply rooted in systemic racism, implicit bias, and social inequities [2,6]. These disparities are not fully explained by socioeconomic factors alone; instead, they are exacerbated by the unique stressors associated with being a Black woman in a society where racial discrimination pervades multiple facets of life, including healthcare [7,8].

Moreover, the voices of Black women—those most affected by these disparities—are often marginalized or silenced in the discourse on maternal health. This omission denies Black women the opportunity to share their experiences and hinders the development of culturally competent care and effective interventions [4]. Research has shown that when healthcare providers fail to listen to and respect the concerns of Black women, the quality of care suffers, leading to worse health outcomes [9]. Therefore, this thesis explores the intersections of race, health, and narrative by focusing on the importance of hearing and amplifying Black women's stories in the context of maternal health.

Studying this topic is justified by the urgent need to address the structural and interpersonal factors contributing to the maternal health crisis among Black women. By centering their voices, this research aims to contribute to a more nuanced understanding of Black women's challenges in healthcare settings and to inform the development of policies and practices responsive to their needs. This approach is essential for improving maternal health outcomes and advancing social justice and health equity.

The proposed study will review factors that negatively affect Black maternal health. The study will dive deeply into those factors and define ways to assist Black women in exploring safer and more effective maternal health experiences. This study is essential to the maternal health of Black women, more specifically, to decrease the maternal mortality rate by removing barriers and inequities that cause disparities in reproductive care. The study will also link the history of Black women's births and the root causes to eradicate inequities that have long caused dangerous maternal care practices for years.

This study will serve as an autoethnography and a literature review on how social workers should support Black Maternal Health. "An autoethnography is an autobiographical genre of academic writing that draws on and analyzes or interprets the lived experience of the author and connects researcher insights to self-identity, cultural rules and resources, communication practices, traditions, premises, symbols, rules, shared meanings, emotions, values, and larger social, cultural, and political issues" [17]. The proposed study will also examine the impact of racial disparities on Black women's maternal health experiences during pregnancy, childbirth, and after birth—a national health crisis primarily ignored. The study will identify social determinants associated with a higher maternal mortality rate among Black women. It will also document women's maternal experiences during pregnancy, childbirth, and after birth through storytelling. The storytelling will highlight the racial disparities in the ongoing rise of Black maternal mortality rates and try to reveal early historical evidence to assist in defining the root causes of health inequity.

The study of Black maternal health is both timely and critical, given the persistent and alarming disparities in maternal mortality rates between Black women and their white counterparts in the United States. Despite advancements in healthcare, Black women continue to face disproportionately higher risks of pregnancy-related complications and death, a phenomenon that is deeply rooted in systemic racism, implicit bias, and social inequities [2,6]. These disparities are not fully explained by socioeconomic factors alone; instead, they are exacerbated by the unique stressors associated with being a Black woman in a society where racial discrimination pervades multiple facets of life, including healthcare [7,8].

Moreover, the voices of Black women—those most affected by these disparities—are often marginalized or silenced in the discourse on maternal health. This omission denies Black women the opportunity to share their experiences and hinders the development of culturally competent care and effective interventions [4]. Research has shown that when healthcare providers fail to listen to and respect the concerns of Black women, the quality of care suffers, leading to worse health outcomes [9]. Therefore, this thesis explores the intersections of race, health, and narrative by focusing on the importance of hearing and amplifying Black women's stories in the context of maternal health.

Studying this topic is justified by the urgent need to address the structural and interpersonal factors contributing to the maternal health crisis among Black women. By centering their voices, this research aims to contribute to a more nuanced understanding of Black women's challenges in healthcare settings and to inform the development of policies and practices responsive to their needs. This approach is essential for improving maternal health outcomes and advancing social justice and health equity.

The proposed study will review factors that negatively affect Black maternal health. The study will dive deeply into those factors and define ways to assist Black women in exploring safer and more effective maternal health experiences. This study is essential to the maternal health of Black women, more specifically, to decrease the maternal mortality rate by removing barriers and inequities that cause disparities in reproductive care. The study will also link the history of Black women's births and the root causes to eradicate inequities that have long caused dangerous maternal care practices for years.

This study will serve as an autoethnography and a literature review on how social workers should support Black Maternal Health. "An autoethnography is an autobiographical genre of academic writing that draws on and analyzes or interprets the lived experience of the author and connects researcher insights to self-identity, cultural rules and resources, communication practices, traditions, premises, symbols, rules, shared meanings, emotions, values, and larger social, cultural, and political issues" [17]. The proposed study will also examine the impact of racial disparities on Black women's maternal health experiences during pregnancy, childbirth, and after birth—a national health crisis primarily ignored. The study will identify social determinants associated with a higher maternal mortality rate among Black women. It will also document women's maternal experiences during pregnancy, childbirth, and after birth through storytelling. The storytelling will highlight the racial disparities in the ongoing rise of Black maternal mortality rates and try to reveal early historical evidence to assist in defining the root causes of health inequity.

## Literature Review

The journey to motherhood should be joyful, and motherhood is one of the most critical transitions in a woman's lifetime. However, the journey of the Black woman to motherhood has been threatened, and women of color remain at significant risk. The traumatic birth experiences of Black women have become a substantial focus of recent research, as these experiences often highlight the broader systemic inequities within the healthcare system. The literature reveals that Black women are disproportionately affected by traumatic birth experiences, which are usually exacerbated by racial discrimination, implicit bias, and a lack of culturally competent care. Storytelling has emerged as a powerful tool to document and share these experiences, serving as a form of healing and a means to advocate for systemic change.

The journey to motherhood should be joyful, and motherhood is one of the most critical transitions in a woman's lifetime. However, the journey of the Black woman to motherhood has been threatened, and women of color remain at significant risk. The traumatic birth experiences of Black women have become a substantial focus of recent research, as these experiences often highlight the broader systemic inequities within the healthcare system. The literature reveals that Black women are disproportionately affected by traumatic birth experiences, usually exacerbated by racial discrimination, implicit bias, and a lack of culturally competent care. Storytelling has emerged as a powerful tool to document and share these experiences, serving as a form of healing and a means to advocate for systemic change.

## Traumatic birth experiences among black women

Feelings of powerlessness, fear, and neglect frequently characterize traumatic birth experiences among Black women. Studies, such as those by Altman et al. [5], have documented that Black women often experience dismissive attitudes from healthcare providers, inadequate pain management, and a general sense of being disregarded during labor and delivery. These experiences are not only distressing but also contribute to long-term psychological impacts, including postpartum depression and post-traumatic stress disorder (PTSD) [10,11]. These experiences are not only distressing but also contribute to long-term psychological impacts, including postpartum depression and post-traumatic stress disorder (PTSD) [10,11]. Furthermore, the cumulative effect of these traumatic experiences can exacerbate existing mental health conditions, leading to a cycle of ongoing distress that extends well beyond the childbirth process.

Racial disparities in maternal healthcare contribute significantly to these traumatic experiences. Black women are more likely to undergo interventions such as emergency cesarean sections, which are often performed under stressful and urgent conditions, heightening the potential for trauma [9]. Furthermore, the fear of not being listened to or respected by healthcare providers often compounds the trauma, leading to a pervasive mistrust in the healthcare system [4]. Furthermore, the fear of not being listened to or respected by healthcare providers often compounds the trauma, leading to a pervasive mistrust in the healthcare system [4]. This mistrust can discourage Black women from seeking necessary prenatal and postnatal care, thereby exacerbating the disparities in maternal health outcomes.

## The role of storytelling in healing and advocacy

Storytelling has been identified as a critical avenue for Black women to process and articulate their traumatic birth experiences. Through storytelling, Black women can reclaim their narratives, validate their experiences, and connect with others who have had similar encounters [12]. Sharing personal stories is a form of emotional catharsis and a powerful tool for advocacy and social change.

In response to the pervasive inequities within the healthcare system, Davis [4] argues that storytelling allows Black women to challenge the dominant narratives in healthcare that often marginalize their voices. By sharing their experiences, Black women bring attention to the systemic issues within the healthcare system, such as implicit bias and the lack of culturally sensitive care, that contribute to their traumatic birth experiences. These narratives can influence public discourse, inform policy, and inspire reforms to improve maternal healthcare for Black women.

The storytelling process also provides a communal space for Black women to support one another, fostering a sense of solidarity and collective healing. As demonstrated by the work of Black maternal health advocacy groups, such as the Black Mamas Matter Alliance, storytelling is central to raising awareness about Black maternal health disparities and mobilizing efforts to address these issues at local, state, and national levels [13]. This strategic use of storytelling not only amplifies the voices of Black women but also serves as a powerful catalyst for policy change and community engagement.

## Intersectionality and the complexity of traumatic birth narratives

The literature also emphasizes the importance of considering intersectionality in understanding the traumatic birth experiences of Black women. Black women's narratives often intersect with other identities, such as socioeconomic status, immigration status, and sexual orientation, which further complicate their experiences of trauma in childbirth [14,15]. These intersecting factors must be considered when analyzing and addressing the full scope of their traumatic birth experiences.

Intersectional storytelling helps to capture the nuanced realities of Black women's lives, ensuring that the diversity of their experiences is recognized and addressed. Lopez [15] highlights that by bringing these intersecting identities into their narratives, Black women can better advocate for comprehensive and inclusive healthcare solutions that address their specific needs.

The literature on Black women's traumatic birth experiences underscores the significant impact of systemic racism, implicit bias, and inadequate care on maternal health outcomes. In listening to Black women's lived experiences during pregnancy, childbirth, and after birth, it has become a common theme for Black women to share similar narratives about their maternity care experiences. Telling their lived experience reveals that Black women across the U.S. continue to be ignored while attending office visits, during childbirth, and postpartum. Storytelling can also aid in improving women's reproductive health and hearing the narratives of women who survived and from family members of those who did not can be valuable to the advocacy of doulas during Black maternal care. Storytelling is a powerful method for Black women to process their trauma, advocate for change, and build community. By amplifying these stories, researchers, advocates, and policymakers can better understand and address the disparities in maternal healthcare that contribute to the ongoing crisis in Black maternal health.

## Theoretical framework

The Maternal Morbidity Measurement (MMM) Framework provides a comprehensive approach to understanding and addressing the disparities in Black maternal health outcomes. This framework is particularly relevant in the context of Black maternal health, where traditional metrics like maternal mortality rates often fail to capture the full scope of adverse maternal experiences. The MMM Framework emphasizes the importance of considering both severe and non-severe maternal morbidities, recognizing that Black women are disproportionately affected by a range of complications during pregnancy and childbirth that do not always result in death but significantly impact their health and well-being [9]. By utilizing the MMM Framework, researchers and policymakers can better identify and address the various factors contributing to maternal morbidity among Black women, including systemic racism, implicit bias in healthcare, and the social determinants of health. This framework allows for a more nuanced and equitable analysis of maternal health outcomes, ensuring that the experiences of Black women are accurately represented and that targeted interventions can be developed to reduce these disparities.

The Maternal Morbidity Measurement (MMM) Framework is the selected framework because it reflects the importance of using a woman-centered approach; maternal morbidity risks are cyclical, the effects of maternal morbidity can last a long time, even beyond postpartum, social, and economic phenomenon, and the environment can influence lived experiences. It includes meaningful groupings of maternal morbidity and strongly associates with other WHO guidance [16]. The Maternal Morbidity Measurement Framework can define the effect of maternal health across the life course, and the framework lays a foundation for intervention and prevention. According to Filippi et al. [16], the National Institute of Health has developed a plan to identify needed studies and additional efforts to address the antecedents and consequences. The NIH's research will enhance health disparities, increase understanding of MMM's social determinants and risk factors, improve antepartum, intrapartum, and postpartum care, and manage complications [16]. It will also define environmental risk factors to provide insight into psychological exposures, including stress, discrimination, and caregiving [16]. Lastly, it will help understand coping behaviors in women with severe maternal morbidity (SMM) and families experiencing maternal mortality and investigate the potential effects of implicit bias on the healthcare system regarding pregnancy [16].

## Methodology

The selected project focuses on creating a screening tool designed to address the barriers Black women face during reproductive care, with an emphasis on storytelling. This tool will help find and combat the injustices that contribute to the high mortality rate among Black women by centering their narratives and lived experiences. It will explore and highlight concerns shared by Black women, assessing the impact of implicit bias, limited access to care, and the absence of a dedicated support system during reproductive care. Additionally, the tool will examine the benefits of engaging doulas, midwives, and other birthing professionals who align with the cultural needs of Black women. Finally, it will emphasize the power of Afrocentric storytelling, using the lived experiences of Black women, both past and present, to dismantle barriers in maternal care and reduce maternal mortality rates.

The screening tool will be developed with feedback from Black mothers, including, but not limited to, students, professors, and Black Maternal Health organizations. Input from the screening tool will help implement interventions that will help decrease traumatic birth experiences and increase maternal health outcomes during pregnancy, childbirth, and postpartum for Black women. The device can help identify evidence-based interventions, such as trauma-formed care, that could help address the issues.

## Rationale for developing a screening tool

A screening tool will serve as a means to access a broader range of Black women who can share their lived experiences through pregnancy, childbirth, and postpartum. Some women may not express concerns until they have an opportunity to do so in a safe space, and they may not realize that their experiences are essential to others who might encounter similar situations. Black women telling their stories will empower and encourage others to advocate for themselves when they feel dismissed. Screening is an integral part of preventive medicine, as screening tools ideally identify patients early enough to provide treatment, avoid or reduce symptoms, and improve population health outcomes at a reasonable cost [17]. The screening tool will encourage other researchers to use this method to collect data, explore, focus, and deliver knowledge to those in the medical profession. The tool will assist in documenting lived experiences during prenatal and postnatal care to create policies addressing implicit bias, lack of access, and insufficient support systems within the healthcare system. It will also document the benefits that doulas and midwives can provide in decreasing the Black maternal mortality rate by offering the necessary care and support during maternal care. The data collected from the questionnaires will include pertinent information about stories told by Black women who experienced trauma during prenatal and postnatal care, which often resemble the historical treatment of Black enslaved women many years ago.

## Key stakeholders and resources

Several stakeholders have been identified as contributing to the creation of this tool. These include Black women friends, students, and professors from North Carolina Central University, Department of Social Work (Dr. Shanika L. Wilson, D.S.W., M.S.W., LCAS, and Dr. Charity Watkins, Ph.D.), who can all attest to lived maternal experiences. Maame, Inc., the National Black Doulas Association, Equity Before Birth, Emerald Doulas, and SisterSong were also asked for feedback on the development of the tool.

Stakeholders named were provided with the screening tool and asked to provide feedback. Questions asked of key stakeholders included demographic, targeted, and open-ended questions. Demographic questions included: (1) How do you identify? and (2) What is the highest level of school you have completed or the highest degree you have received? Targeted questions included: (3) Were your health concerns considered by the health professionals during and after childbirth (i.e., pain management, follow-up appointments were scheduled, and further necessary treatment was administered promptly)? Open-ended questions included: (4) If you were not satisfied with your birth experience, were you given access to medical support? (i.e., social work professional, hospital administrator, birthing center administrator, etc.) Please explain in detail.

Storytelling is important because it allows people to tell their experiences. Narrative therapy is a form of storytelling where a client develops their narrative as a story that they created and carry with them throughout their life. "Narrative therapists help their clients put together their narrative. This process allows the individual to find their voice and explore events in their lives and the meanings they have placed on these experiences. As their story is put together, the person observes and looks at it with the therapist, working to identify the dominant and problematic story" [18]. Narrative therapy can be effective in bringing more awareness to the Black Maternal Health crisis. For this study, Dr. Wilson wanted to share an autoethnographic experience of her first birth story.

## Dr. Wilson's birth story

Our first labor and delivery experience was so traumatic that I am surprised that we have three children in total. I have been married since 2011, and since that year, everyone has asked my husband and me when we would have children. As the years began to pass, I started to wonder if having children was in the cards for us. We were pleasantly surprised in October 2015 when we finally got pregnant with our first baby. We purchased every book on labor, delivery, parenting, babies, and childhood. We even hired a doula and took a labor and delivery class. Unfortunately, no book, class, or story would prepare us for our first labor and delivery experience. My hopes were to have a peaceful and joyous birthing experience.

I went into the hospital on July 5, 2016, and my son was not born until July 7, 2016. First, I had to argue and scream with the nurse that the catheter she was trying to insert caused me much pain. The nurse thought I was being dramatic and that my pain could not be as bad as my screams. After 35 minutes of yelling in agony, my husband intervened, letting them stop and find an alternative. The medical staff did not hear my voice. On that day, the nurses and I both found out that I could not use a size 16 catheter and that I must use a size 14 catheter, and it is knowledge I have shared with each labor and delivery team since. After being in labor for more than 19 hours, my wife broke, and while having horrible contractions, my son would not begin the birth journey. After 19 more hours of pain and having an epidural put in incorrectly twice, it was finally installed correctly, and I received some pain relief. My son moved to 4cm and refused to budge. He began to experience symptoms of distress. I was told that my epidural had to be changed to a spinal tab due to my upcoming C-section. Finally, after a total of 42 hours of labor, I had a C-section and gave birth to an eight-pound bouncing baby boy. Due to the distress he experienced during my lengthy labor and delivery process, he did not eat for six hours. He was whisked away to the N.I.U "neonatal intensive care unit" without informing my husband and me why, how long he would be there, and what he would need to do to be released. We have found that it is customary for some newborns not to eat for 24 hours before that level of intervention is needed. Despite eating the next day, our son was not released from the NICU for three days, additional days mu h advocating and proof that he was eating, gaining weight, and thriving. Almost eight years later, it is safe to say that he is a happy, intelligent, dinosaur-loving, and healthy kid with asthma, eczema, and allergies to peanuts, tree nuts, eggs, dairy, cats, and mold.

After we began to reflect on my labor and delivery experience, we vowed to be intentional during future labor and delivery experiences. I know my patient's rights and have an advocate in the room when I cannot advocate for myself; lucky for me, mine is my husband. I also had a doula to help me navigate. I began to read all I could about the Black Maternal Mortality Crisis as well as the Black infant Mortality Crisis. I decided that there was no awkward moment or conversation that would stop me from making sure that both my unborn child and I were safe. I realize there is nothing wrong with letting a medical professional know that you are

in pain or uncomfortable moving forward with a specific type of treatment. I ask medical providers, including the nurse, the anesthetist, the doctor, and other medical staff members, how they plan to keep me safe. I share my medical experience and history with my providers and ask that they put it in my chart. I did not want to become a part of the Black Maternal mortality statistic; therefore, I am not afraid to address unconscious bias or ask medical providers if they would believe my disclosed pain or if I had to prove it. I hate to say it, but we have had to switch doctors during my second and third pregnancies because my husband and I did not feel my unborn children, or I would be safe under the care of that medical team. I am glad to say that now, we are parents to an almost 8-year-old, 4-year-old, and 2-year-old. There is nothing wrong with making sure you are safe.

## Discussion

The use of storytelling and autoethnography in addressing the Black maternal health crisis goes beyond simply documenting experiences; it actively engages with the cultural, historical, and social contexts that shape Black women's interactions with the healthcare system. These narrative approaches enable a more comprehensive understanding of the complex factors contributing to the disparities in maternal health outcomes, including the pervasive impact of systemic racism, implicit bias, and social determinants of health. By listening to and valuing the stories of Black women, healthcare providers can begin to dismantle the barriers that often lead to inadequate care and adverse outcomes.

A screening tool developed with a foundation in storytelling and autoethnography can serve as a vital resource for medical providers. It equips them with the ability to ask questions that go beyond the standard clinical inquiries, probing into areas that may reveal underlying issues affecting the patient's health and well-being. Such a tool encourages providers to explore the patient's personal and cultural background, the quality of support they receive, their experiences with bias in healthcare, and their preferences for care. By facilitating these conversations, the tool ensures that Black women are not only heard but also actively involved in their care decisions, fostering a partnership between the patient and provider.

Moreover, this approach can lead to the identification of systemic issues that need to be addressed at the institutional level. As medical providers collect and reflect on the data obtained through this screening process, they can advocate for changes in healthcare practices, policies, and training that specifically aim to reduce disparities and improve outcomes for Black women. Thus, the integration of storytelling and autoethnography into the design of a screening tool not only enhances individual patient care but also contributes to broader systemic change, ultimately working towards eliminating the Black maternal health crisis.

### Implications for social work practice

The integration of storytelling and autoethnography into a screening tool for addressing the Black maternal health crisis holds significant implications for the field of social work. Social workers, who often serve as advocates, counselors, and connectors within the healthcare system, are uniquely positioned to leverage these narrative approaches to promote health equity and social justice for Black women.

By incorporating storytelling into practice, social workers can better advocate for Black women's needs within healthcare settings. Understanding and conveying the personal narratives of Black women allows social workers to challenge systemic racism and implicit biases that contribute to disparities in maternal health outcomes. This advocacy is not limited to individual care but extends to influencing healthcare policies and practices, ensuring that they are more inclusive and responsive to the lived experiences of Black women.

The use of a screening tool grounded in storytelling and autoethnography equips social workers with the necessary insights to provide culturally competent care. It allows them to explore the cultural, social, and historical factors that shape Black women's experiences with reproductive care. This understanding enables social workers to tailor their interventions more effectively, addressing the specific needs of Black women and helping them navigate the healthcare system with greater support and confidence.

Social workers play a crucial role in interdisciplinary teams within healthcare settings. The insights gained from a storytelling-based screening tool can be shared with other healthcare providers, fostering a more holistic and informed approach to care. Social workers can use these narratives to educate and sensitize medical providers about the unique challenges faced by Black women, promoting a more empathetic and comprehensive approach to maternal care across the team.

The traumatic experiences that Black women often encounter during pregnancy and childbirth can have profound impacts on their mental health. Social workers, through their expertise in mental health support, can use the information gathered from the screening tool to provide targeted interventions that address both

the emotional and psychological needs of Black women. This approach can help in preventing and treating conditions like postpartum depression and PTSD, which are often underdiagnosed and undertreated in Black women.

Ultimately, the integration of storytelling and autoethnography into social work practice aligns with the profession's commitment to social justice. By centering the voices of Black women and actively working to dismantle the systemic barriers they face, social workers can contribute to the broader movement for health equity. This approach not only improves individual outcomes but also contributes to the transformation of the healthcare system into one that is more equitable, just, and responsive to the needs of all women.

In summary, the implications for social work are profound. By embracing these narrative approaches, social workers can enhance their advocacy efforts, promote culturally competent care, support interdisciplinary collaboration, address mental health needs, and advance social justice—all of which are crucial for addressing the Black maternal health crisis.

**Appendix A:** Black Maternal Health Survey

1. How do you identify?

- Woman
- Gender Non-Conforming
- Trans Person
- Other - Please specify

2. What category best describes you?

- White (Eg: German, Irish, English, Italian, Polish, French, etc.)
- Hispanic, Latino, or Spanish origin (Eg: Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, etc.)
- Black or African American (Eg: African American, Jamaican, Haitian, Ethiopian, Somalian, etc.)
- Asian (Eg: Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.)
- American Indian or Alaska Native (Eg: Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.)
- Middle Eastern or North African (Eg: Native Hawaiian, Samoan, Chamarro, Tongan, Fijian, etc.)
- Other race, ethnicity, or origin

3. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., G.E.D.)
- Some college but no degree
- Associate degree
- Bachelor degree
- Graduate degree

4. Are you now married, widowed, divorced, separated, or never married?

- Married
- Widowed
- Divorced
- Separated
- Never married

5. Which of the following categories best describes your employment status?

- Employed, working 1-39 hours per week
- Employed, working 40 or more hours per week
- Employed, working 40 or more hours per week
- Not employed, NOT looking for work
- Retired
- Disabled, not able to work

6. Age at the time of birth.

- 18-23
- 24-49
- 30-35
- 36 and older

7. Were you insured during childbirth?

- Private Insurance
- Medicaid
- VA Health
- Out-of-Pocket
- Other - Please specify

8. Where did your labor take place?

- Hospital
- Home
- Birthing Center
- Other - Please specify

9. Did you have a doula/midwife present during labor?

- Doula
- Midwife
- Other - Please specify

10. Were you satisfied with your choice?

- Yes
- No, please specify:

11. Did you have a cesarean section?

- Yes
- No - Vaginal Birth

12. Was your cesarean section planned or an emergency?

- N/A
- Planned
- Emergency

  Please specify (i.e., due to medical reasons, age, diabetes, S.T.I.)

13. Was your cesarean section pushed on you against your wishes?

- N/A
- No
- Yes, please specify:

14. How would you describe your health at the time of childbirth?

- Poor
- Fair
- Good
- Very Good
- Excellent

15. Do you feel you received adequate access to care during your pregnancy?

- Yes
- No, please specify:

16. Do you feel you received adequate access to care during childbirth?

- Yes
- No, please specify

17. How was your childbirth experience?

- Poor
- Fair
- Good
- Very Good
- Excellent

18. Were your health concerns considered by the health professionals during and after childbirth (i.e., pain management, follow-up appointments were scheduled, further necessary treatment was administered in a timely order)

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree, please specify:
- Strongly disagree; please specify:

19. During your birthing experience, did you feel fully supported by your healthcare provider?

- Yes
- No, please specify:

20. Was your partner with you during childbirth?

- Yes
- No

21. Did you feel supported by your partner during childbirth?

- Yes
- No, please specify:

22. During your birthing experience, do you feel healthcare providers were open and honest?

- Yes
- No, please specify:

23. During your birthing experience, did you experience any bias or microaggressions from the nurse, doctors, doula, midwife, or other healthcare professionals?

- Yes
- No, please specify:

24. If you were not satisfied with your birth experience, were you given access to medical support? (i.e., social work professional, hospital administrator, birthing center administrator, etc.) Please explain in detail.
25. The art of storytelling can be a powerful resource that reveals elements and images of Black women while encouraging others through lived experiences of childbirth. Do you feel revealing your story will benefit the fight to improve Black maternal care? Please explain in detail.

**Appendix B**

Opened Ended Questions to Facilitate the Conversation.

- Can you walk me through your birth experience, from when you first found out you were pregnant to the moment you held your baby for the first time?
- What were your expectations or hopes for your birth experience, and how did reality compare to those expectations?
- How did you feel about the care you received during your pregnancy and childbirth? Were there any moments that stood out to you, either positively or negatively?
- Can you share any challenges you faced during your pregnancy or childbirth that you feel were specific to your experience as a Black woman?
- What role did your support system—family, friends, or healthcare providers—play during your pregnancy and childbirth?
- Were there any moments during your birth experience where you felt your voice was not heard or your concerns were dismissed? How did you navigate that?
- How has your birth experience affected your views on the healthcare system, particularly regarding maternal care for Black women?

- Looking back, is there anything you wish you had known or done differently during your pregnancy and birth?
- How has your birth experience shaped your identity as a mother and as a Black woman?
- What advice or words of wisdom would you share with other Black women who are pregnant or planning to give birth?

## Bibliography

1. Centers for Disease Control and Prevention (CDC). "Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths". (2020).
2. J Taylor. "The Black Maternal Mortality Crisis in the U.S.". *American Journal of Public Health* (2020).
3. DE Roberts. Killing the Black Body: Race, Reproduction, and the Meaning of Liberty, Vintage, (2017).
4. DA Davis. Reproductive Injustice: Racism, Pregnancy, and Premature Birth, NYU Press, (2019).
5. MR Altman., *et al*. "Listening to Women: Recommendations for Improving the Experience of Childbirth in U.S. Hospitals". *Journal of Midwifery and Women's Health* 65.2 (2020): 224-231.
6. AA Creanga., *et al*. "Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010". *American Journal of Obstetrics and Gynecology* 210.5 (2010): 435.e1-435.e8.
7. A T Geronimus. "The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations". *Ethnicity and Disease* 2.3 (1992): 207-221.
8. MC Lu and N Halfon. "Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective". *Maternal and Child Health Journal* 7.1 (2003): 13-30.
9. EA Howell., *et al*. "Black-White Differences in Severe Maternal Morbidity and Site of Care". *American Journal of Obstetrics and Gynecology* 214.1 (2016): 122.e1-122.e7.
10. C L Dennis and E Hodnett. "Psychosocial and Psychological Interventions for Treating Postpartum Depression". *Cochrane Database of Systematic Reviews*, (2007).
11. M P Thomas., *et al*. "Assessing Risk Factors for Postpartum Depression: A Comparison of Mothers With and Without Severe Maternal Morbidity". *Journal of Women's Health* 30.5 (2021): 748-755.
12. CN Michaels. "The Role of Narrative in the Reproductive Justice Movement: Black Women's Stories of Pregnancy and Childbirth". *Journal of Women's History* 30.2 (2018): 82-105.
13. Black Mamas Matter Alliance, Advancing Holistic Maternal Care for Black Women, (2018).
14. K Crenshaw. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics". *University of Chicago Legal Forum* 1989.1 (1989): 139-167.
15. L Lopez. "The Importance of Intersectionality in the Mental Health Care of Women of Color". *Psychiatric Times* 33.9 (2016): 29-31.
16. V Filippi., *et al*. "What is Maternal Morbidity? The Need for an Accurate Reflection of Pregnant Women's Health". *Best Practice and Research Clinical Obstetrics and Gynaecology* 43 (2018): 21-30.
17. N Iragorri and E Spackman. "Assessing the Value of Screening Tools: Reviewing the Challenges and Opportunities of Cost-Effectiveness Analysis". *Public Health Reviews* 39.1 (2018): 1-20.
18. A Clarke. "Narrative Therapy: Overview, Techniques, and Benefits". *Verywell Mind* (2023).