THE UNDERGROUND RAILROAD: CRITICAL RACE THEORY, OPPRESSION, AND THE FIGHT FOR EQUITABLE TREATMENT IN THE NORTH CAROLINA HEALTHCARE SYSTEM: A CRITICAL PHENOMENOLOGICAL STUDY

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By

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EXECUTIVE SUMMARY

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This study was a qualitative participatory action research study that focused on the lived experiences of Black women who received prenatal care and gave birth in the state of North Carolina. The study was meant to investigate and address the racism and implicit biases these women experienced from the medical community they encountered, and the often-unintended consequences of those actions and mindsets. A cohort of Black women who received prenatal care and gave birth in the state of North Carolina was assembled to help provide qualitative data for the study through sharing their lived experiences. The women were interviewed using a peer-to-peer method. The Aaron J. White Foundation (AJWF), a Black owned, 501c(3) non-profit organization, will use this study to help create a comprehensive action plan to offer healthcare and healthy living education and resources to Black women and other marginalized communities in North Carolina. This study will add to the existing body of knowledge and offer replicability to like-minded researchers with similar capacity and resources.

MY BLACKNESS GOES BEFORE ME - CHERYL GITTENS-JONES

A steady anger burns within me

Welling up from deep

Deep inside

Three-fifths of a human being

The sacred constitution of the

Red, white and blue

Walking into a room

My blackness goes

My blackness goes

Goes before me

Those of the majority

Not all

Not few

But many

Still do not see

See me as

human

woman

Only

Black

Not as mother

Of a beautiful almond eyed

Sepia skinned

Baby girl

Not as graduate

of

Ivy league

Not as wife

As I

As Me

Someone whose life is

Just as significant

Meaningful

Purposeful

Beautiful

Three-fifths of a human being

The sacred

Sacred constitution of the

The red, white

Red, white and blue

Not removed

Still written in

Indelible ink

To be read

Perused

Overlooked

Excused

Invoked

When I walk in

Into a room in my blackness

Precedes me

You see not I

Not mother

Not woman

Not wife

Just

Black

Nothing has changed

So many things locked in

Racist

Classist

Sexist

Passive aggressiveness

Intellectual sarcasm

Impoverished ignorance

Blatant Alienation

Little has changed

I am

Black and living next door

Behind the same white

Picket fence

Enduring bleached smiles

But not with

Eyes

A steady anger

Burns within me

Welling up from deep

Deep inside

Three-fifths of a human being

The sacred constitution

Of the red, white, and blue

Blackness walking

Walking into

Into the room before me

Dedicated to my brother, Aaron James White.

Everything I do is for you and in your name.

I love you.

ACKNOWLEDGEMENTS

As I end this journey, there are several people whom I would like to extend my sincere thanks and gratitude. First and foremost, I would like to thank my mother, Kim. For my entire life, I have watched you exude the characteristics of resilience and perseverance. You taught me what it means to be strong.

To my Pops, thank you for being everything I ever needed in a father. I am who I am because of you.

To my fiancée Noél, thank you for being in my corner every step of the way of every single journey and obstacle. We can never lose. I love you.

To Dr. Ziskin, thank you for your wisdom, and words of advice. This study does not happen without you.

To Dr. Hatcher, thank you for taking a chance on me. You did not have to, but you did and for that I am forever grateful.

To Dr. Baker, I have not had many Black instructors or teachers over the course of my academic career. So, it was only right that we crossed paths as I close the book on my formal education. Thank you for believing in me, advising me, and listening to me ramble on Zoom calls. I will never forget you.

To Black women everywhere, I see you, I acknowledge you, and I will always say your names.

To Aaron, this was for you, my boy.

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LIST OF TERMS OF ABBREVIATIONS

AJWF: Aaron J. White Foundation

BIPOC: Black, Indigenous, People of Color

BIWOC: Black Indigenous Women of Color

BOD: Board of Directors

CBPAR: Community Based Participatory Action Research

COVID-19: - Coronavirus 19

CRT: Critical Race Theory

NPO: Nonprofit Organization

SDOH: Social Determinants of Health

501(c)3 Internal Revenue Service Tax Exempt Status for Nonprofit Organizations

CHAPTER ONE

THE PROBLEM OF PRACTICE

In March of 2020, most people around the world were "sheltering in place," stocking up on Personal Protective Equipment (PPE) and cleaning supplies or awaiting the latest word from the Center for Disease Control (CDC) on what new preventative measures the country should take to curb the Covid-19 pandemic. The cycle has repeated for the last two years and, for better or worse, the United States has managed to mitigate the harmful effects of the pandemic through vaccines and other preventative measures like wearing masks and social distancing. Unfortunately, more than 1.1 million lives were lost, and there was a disproportionate impact on Black, Indigenous, and People of Color (BIPOC) and their communities. While mainstream media and most of the world is focused on the aftermath of the Covid-19 pandemic, there is another ongoing pandemic happening right now for Black women. Specifically, it is a pandemic that is upending the lived experiences of Black women who choose to have children.

Historically, the United States and world leaders have not shied away from addressing complex problems that plague society (South, 2020). In 1865, the Thirteenth Amendment confirmed the end of slavery of African American men and women: "Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction" (U.S. Constitution). This amendment provided freedom to African Americans, offered them hope for the future, and afforded them the opportunity to focus on their families. Later, World War I opened more possibilities to people of color, providing them with jobs in factories and throughout Southern cities. Although

they began to gain more citizenship, there were still differences in education, health care, housing, and employment between African Americans and Whites (Mintz, 2007). Those differences still exist today, particularly when it comes to racial equity in health care in general, and prenatal and obstetrics care specifically.

For the entirety of the United States' existence, BIPOC have been subject to many forms of bigotry, cruelty, and racism. Toward the end of the 20th century, that racism became more covert as legislation such as the Civil Rights Act of 1968 made public discrimination more difficult. As society began to grow, it transitioned into a period of new age racism and systemic discrimination, and BIPOC, specifically Black women, seemed to remain marginalized. While BIPOC were marginalized, one could argue that Black women are a tier below when analyzing discrimination and racism on a spectrum. Many companies and cities claim to put diversity and inclusion at the forefront of their strategic plans, but BIPOC, especially Black women, still suffer greatly from systemic barriers crafted in the early 19th century.

When looking at the racism and discrimination directed towards the Black community specifically, when examined on a micro level, Black women have historically been fighting their own significant battles on top of the plights and struggles they experience as part of the Black community. The intersection of their identities causes them to walk through this world as, perhaps, the most marginalized identity.

Statement of the Problem

Byrd and Clayton (2000) claimed, “African Americans, since arriving as slaves, have had the worst health care, the worst health status, and the worst health outcomes of any racial or ethnic group in the U.S.” (p. 11S). The foundation of this problem dates to the 17th century when the use of skin color to identify race was first introduced as a human classification system by Francios Bernier, a French physician in the mid 17th century (Ford & Hawara, 2010). Dark-skinned people, especially African Americans, were deemed inferior; that categorization had atrocious effects on the African American community. The lack of significant changes in European ideologies has allowed this problem to persist and affect the current African American community (Byrd and Clayton, 2000).

It is no secret that the treatment given to white people in the healthcare space is starkly different from what is given to African Americans and other members of BIPOC communities, and it predates this country's founding and transcends centuries. In 1899, WEB Du Bois noted that Black people had poorer health in relation to their counterparts and were more susceptible to die from ailments such as dysentery, diabetes, cancer, etc. (Hardeman & Karbeah, 2020). It is imperative that health disparities are not separated from racism and identified for what they are, inequities and pillars of systemically racist systems. The purpose of this study is to tell the story and accounts from the perspective of the marginalized. The movement of relieving the oppressed should come from the oppressed. Over the course of history, data discussing socioeconomic status regarding race and how that can affect a person in a for-profit healthcare system have often been neglected.

This study is going to take this issue and analyze it on a micro level by working with North Carolina based Black women who have had prenatal, birthing, and postpartum experiences in the state of North Carolina. As evidenced by graph number one, the Black maternal mortality rate in the United States is concerningly high when compared to other demographics. Looking at the data on a macro and micro scale (See Figures 1-3), the data and disparities are concerning, to say the least.

Figure 1:

United States Maternal Mortality Rate by Demographics

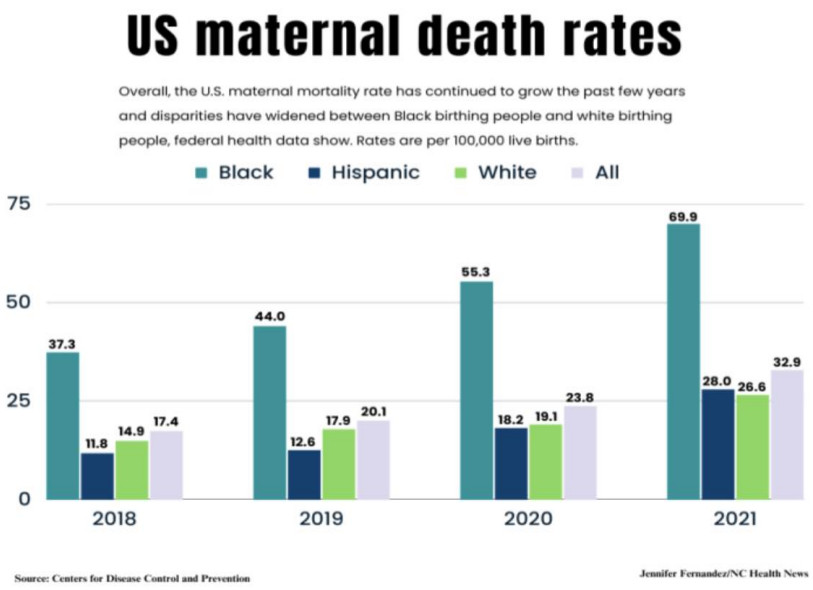


Figure 2:

Maternal Death Rate in the United States and North Carolina

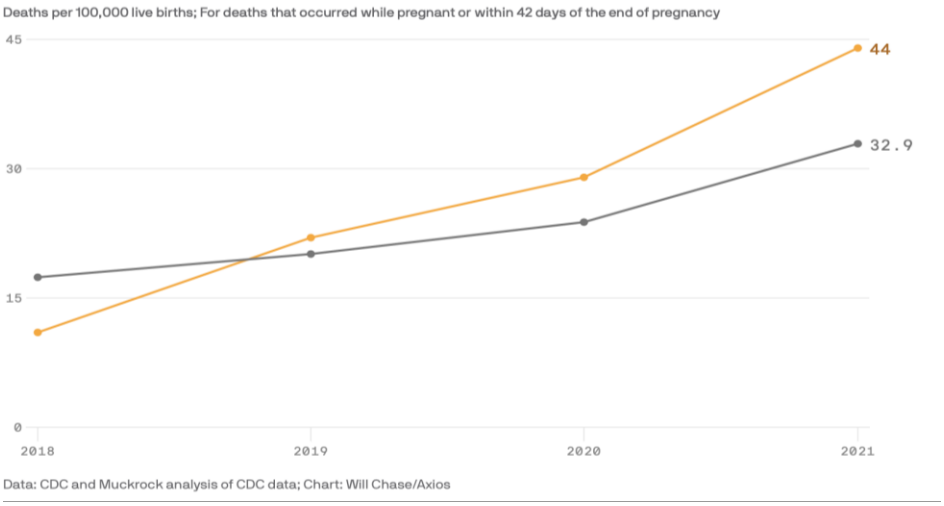
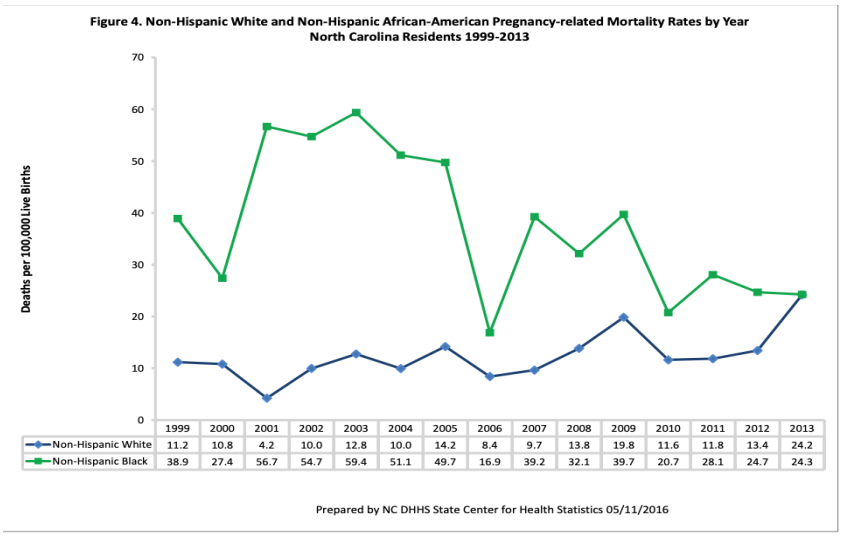


Figure 3:

Pregnancy-Related Mortality Rates in NC by Year 1999-2013



Deficiencies in the Organizational Knowledge Record

Finding information for this study can be deterred by the number of studies available that contradict the goal of the study. The study is looking to inform and interrogate the systems in place that lead to the negative experiences and attitudes that

Black women have with the North Carolina healthcare system. There are many studies and research that don't account for these experiences or the historical relevance of their impetus.

Audience

The first target audience will be Black women, educators, and the medical community, particularly those working in North Carolina. The research done for this study will provide qualitative, quantitative, and phenomenological evidence. This valuable information is already available to the public in various capacities; however, that information is regularly suppressed.

The second target audience for this study will be Black identifying women, specifically those in North Carolina. When investigating the inequities and suffering experienced by BIPOC people, Black women's suffering must be acknowledged, as they endure the most at the hands of the American healthcare system. For example, Black women experience pregnancy related death at significantly higher rates than any other demographic in the United States (Adebayo, 2021). One of the many reasons this unfortunate set of circumstances exists is the many barriers that limit Black women from quality healthcare. This study will seek to analyze those barriers from a Critical Race Theory (CRT) perspective to understand and elucidate them from a legal standpoint. This study will also seek to inform Black women on the discriminatory practices and policies that prohibit them from receiving quality healthcare and quality of life post healthcare, so they can make informed decisions in the future surrounding pregnancies, doctors' visits, health screenings, etc.

The third target audience for this study will be like minded researchers and organizations with similar research interests, capacities, and resources. Similar nonprofit organizations in North Carolina can take advantage of this study to jumpstart and spearhead similar initiatives.

Overview of Theoretical Framework/Methods/Research Question(s)

The purpose of this qualitative study with a participatory action research design is to explore the lived healthcare experiences of Black women in the state of North Carolina. This study will allow participants to share their perception of and their lived experiences with the healthcare system in North Carolina. As Black women continue to progress in an ever-changing society, the dilemma of socially constructed hierarchies of race, gender, and social class assists in sanctioning racism (Byrd and Clayton, 2001). The primary research question this study will explore is:

- What experiences and perceptions do African American women describe regarding the prenatal and obstetric care they received in the healthcare system in North Carolina?

The sub questions this study will focus on are:

- What barriers, challenges, and opportunities do participants recount experiencing?
- How do participants describe healthcare providers addressing (or ignoring) their concerns as a patient?
- How does the persistence of racist healthcare policies and practices shape the experiences and attitudes described by participants?

Limitations

Limitations in this study could be related to sample bias. For this study, the sample measured will be coming from African American women living in North Carolina, specifically the Piedmont Triad Area. Another limitation is due to my personal intersectional experience. I am an African American cisgendered male who cannot directly relate to the experiences these women are going to recount in this study. This could also lead to a lack of comfortability and rapport built between myself and the participants.

Review of Related Literature

Four themes emerged across the related literature that demonstrate how racism and inequities in the healthcare field impact African American women's attitudes and lived experiences. The first theme in the literature review is experiences of African American women with prenatal and obstetrics healthcare. Next, the literature will address perceptions of African American women. Next, the literature will discuss Critical Race Theory and its application in healthcare. Finally, the literature will discuss the unitended consequences of racism and implicit biases in healthcare. The four themes are listed here:

Phenomenological Thematic Elements

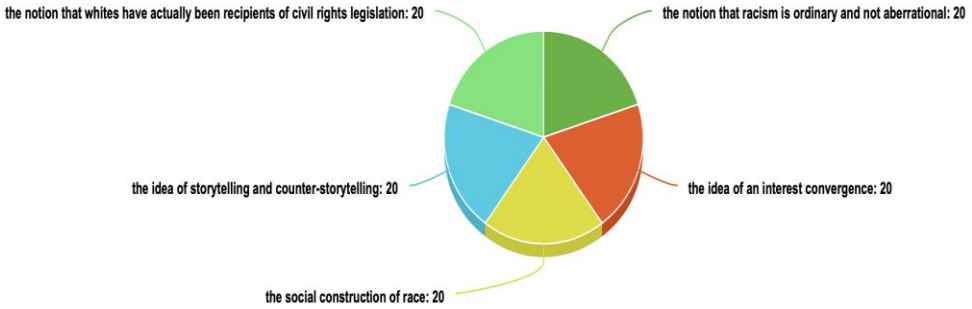
1. *Lived/Healthcare Experiences of African American Women*
2. *Perceptions of Black Women*
3. *Critical Race Theory in Healthcare*
4. *Unintended Consequences*

Framework(s) Informing the Study

The theoretical framework that will inform this study is Critical Race Theory (CRT), which was coined by the world-renowned Dr. Kimberlé Crenshaw. Derrick Bell, an African American law professor, civil rights activist, thought leader, and pioneer, is viewed as the pioneer of Critical Race Theory; however, Dr Kimberlé Crenshaw was the person to formally coin the term in the late 20th century (Crenshaw et al., 2015). CRT is an emerging transdisciplinary framework that originated in the legal field but has always been grounded in social justice (Ford, 2010). Racial scholars and expert proponents of CRT argue racism is the impetus for mortality in BIPOC communities. Racism in and of itself is a public health issue. In short, CRT is an intellectual movement, part of a long-standing human resistance to the status quo and non-progressive systemic movements. Researchers have found that when people think of racism, they never think of the public health field juxtaposed to it. Critical race theorists and racial scholars have concluded that salient public health for all cannot exist if racism and racist structures exist (Ford, 2010). Crenshaw and other scholars have emphasized the importance of intersectionality in CRT which places Black, Indigenous, Women of Color (BIWOC) at a significant disadvantage and vulnerability (Suarez-Balcazar, 2023). The study will be focusing on the history of how the reproductive rights of Black women have been controlled and misused to benefit the dominant white class.

Figure 4:

The Five Tenants of Critical Race Theory



Kawachi et al. (2002) defines health inequality as a "generic term used to designate differences, variation, and disparities in the health achievements of individual groups" (para. 4), whereas health inequity "refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice" (Kawchi et al., 2002, para. 5). Critical race theorists and scholars argue that the pedagogy and language used in trainings and teachings for biomedical health professionals falls short when it comes to explaining and bringing true understanding to the racist systems and structures in place in the American Healthcare System. There are a few medical schools that teach about medical disparities and health inequities, but schools that engage in any sort of critical examination or interrogation of these inequities are rare (Tsai, 2021). This leads to the continuation of the irreparable cycle in the healthcare system. Racial theorists who study health disparities and inequities have also found issues with the Social Determinants of Health (SDOH) (i.e. food, access to healthcare, etc.) exist without being fairly critiqued as to how they ignore power structures that influence them. This inability to contextualize

SDOH around structural realities can leave medical trainees and professionals without proper training and understanding as they embark on important career journeys and serve people of all racial and ethnic backgrounds.

To ensure healthcare professionals are getting adequate training and education, they need an absolute understanding of racial inequities and injustices. Critical Race Theory is necessary to address this issue. CRT is a toolset based in law that is used to interrogate racial inequities and systemic structures, and by training these learners and medical professionals on how to identify marginalization and inequities, future damage can be prevented. Crenshaw (1995) stated BIPOC need to have a clear understanding of the space they occupy so they can better understand how to survive. This applies to medical professionals as well because "... our present predicament gives us such few options, we must create spaces for BIPOC people that are informed by BIPOC people" (Crenshaw, 1995, p. 7).

Related Research

Historical Relevance

It's important to note that notions about race are always going to influence the way race researchers frame their research questions. This influence is personified in the way that Black women have been treated regarding healthcare over the last several centuries. One could find a myriad of discriminatory laws and practices targeting and involving Black women from slavery all the way through Jim Crow and up through the Civil Rights movement. Research studies rarely make the connection between the racism and marginalization Black women have faced since this country's inception and the discrimination they face today. Prather et al. (2018) conducted a study where they found

peer reviewed articles that sought to determine the correlation between historic racism and sexual and reproductive health outcomes. The study found that inadequate social determinants of health and a vast history of racial discrimination, has led to a severely complicated relationship with the healthcare system. Coming to terms with this can help research and medical professionals make more informed decisions when it comes to Black women and their treatment. Prather et al. (2018) concludes the summation of their findings with the statement:

> Addressing sexual and reproductive health through a historical lens and ensuring the implementation of culturally appropriate programs, research, and treatment efforts will likely move public health toward achieving health equity. Furthermore, it is necessary to develop interventions that address the intersection of the social determinants of health that contribute to sexual and reproductive health inequities. (p. 249)

Patricia Hill Collins (2000) believed African American women (she referred to them as "Black women" throughout her text) have vastly different experiences from Caucasian women. Much of her discussion explored the African American woman's plight that began during slavery. Although African American women have evolved in society and advanced from slaves to CEO's and other esteemed leadership positions, as a group, they are still oppressed and unwelcome in many professional circles (Collins, 2000). These findings fall in line with the findings discovered by Adebayo (2021) where the accounts of African American pregnant women were given through in depth interviews where themes were determined. These themes included: institutionalized care – racially insensitive biomedical approach, race, and class; unfair treatment based on

health insurance; and race as a social concept – dismissed pain concerns because a woman is perceived to be a "strong" Black woman who does not feel pain the same as other women in different racial demographics. Adebayo (2021) stated the "themes reveal the experience of racial discrimination toward African American women through healthcare practices that are often seen as "standard" practices, albeit marginalizing minority populations" (Adebayo, 2021).

Social theorists attempt to explain African American women's experiences with "oppressions of race, class, gender, sexuality, ethnicity, nation, and religion" (Collins, 2000, p. 9). African American women are still an oppressed group; yet, not all these women may be oppressed in the same way. For Collins (2000), illuminating African American women's experiences and ideas rests at the nucleus of Black feminist thought. She understood that translating them demands shared leadership between those who have a vested interest in African American women's communities. African Americans, particularly African American women, have an "inside place" where they cope with oppression. Although derogatory names like "mammy" and "mule" are no longer used, limitations still exist (Collins, 2000).

Collins (2000) further discussed the notion of African American women having an "outsider-within" position. This position encourages African American women to form close bonds with each other. These relationships are important to their personal and professional growth. The author noted that historically, African American women's experiences have often been distorted. For decades, they have fought against white males' interpretations of the world.

Healthcare Experiences of African American Women

The Black Lives Matter (BLM) movement (juxtaposed to the Covid-19 pandemic) was a perfect opportunity for racial practitioners and scholars to magnify the issues and plights of BIPOC in the American healthcare system (Blake, 2021). The Covid-19 pandemic, for example, has uncovered a great deal of race-based inequities happening concurrently in the United States. These include, but are not limited to, social distancing guidelines, mask mandates, vaccine mandates, vaccine testing centers, hospitalizations, and Intensive Care Unit (ICU) availability. Many BIPOC people, especially Black people, were and still are at greater risk to the comorbidities that make contracting the coronavirus more deadly (Blake, 2021). BIPOC people experiencing these issues can lead to further issues in their family units, including children suffering from Adverse Childhood Experiences (ACE). ACE are stressful or traumatic events that take place before a child is 18 years old and begin to show themselves at about three years old (Purewal et al., 2016). ACE plague underserved communities at a disproportionate rate compared to their white counterparts. They affect brain development, the immune system, hormonal systems, and many other things that contribute to human development.

Across the United States, BIPOC communities experience systemic barriers that exacerbate disease, illness, and gaps in health care (Waehrer, 2020). In short, ACE are born from adversity and barriers put in place that are most likely to be put onto BIPOC and their children, their children's children, and so on. Research has tied ACE and their prevalence to the continued marginalization and inequity of BIPOC people in the state of North Carolina.

Perceptions of African American Women

One could determine that without much research and thought, Black and Brown people are treated differently in America. 2020 and 2021 demonstrated the disproportionate rates at which BIPOC people were infected with and died from COVID-19 and the egregiously disproportionate rates at which unarmed BIPOC people are killed by law enforcement. In most places we look within American society, we will find systems and laws in place that disproportionately affect BIPOC people. It goes without saying that there is a stark racial divide in the United States. For instance, a study conducted by the Pew Research Center says that Black and White people share very different perspectives on how Black people are treated in America. These different views do not stop at topics like police brutality; Black people and White people have also been found to have differing views on topics like healthcare inequalities and the racial wealth gap.

Critical Race Theory

Critical Race Theory (CRT) is a transdisciplinary race equity methodology that seeks to understand and interrogate the intersection between the law and racist systems. The notion of racial groupings and determining peoples' worth based on the color of their skin can be traced back to Carolus Linnaeus's *Natural History* in 1735, and later advanced by many others. Linnaeus classified non-European people as less than unworthy (Ford, 2010). His research and ideas were the basis of further research in the 19th century, specifically in the United States. The contributions of minority people who cared to rebuke these racists findings were subverted. The prevailing framework created by minorities to challenge and interrogate the racist and inequitable structures in the

United States was Critical Race Theory (CRT), which wasn't founded until the 1970's and is still being investigated today. CRT offers the public health space a new paradigm and tools to challenge racist structures, seeing that the public health field is quite antiquated and in need of challenging. On the heels of the Civil Rights Movement (which the country was only several years removed from), CRT emerged in the minds and discussions of Black lawmakers after years of attempting to understand institutionalized racism.

Unintended Consequences

Huey, T. Chen (2020) conducted a study with a team of researchers at a nursing college in the Southeastern region of the United States. This study opened with the acknowledgement of the fact that racial minorities are disproportionately represented in the field of nursing. The author states that according to US Census information, that even though racial minorities make up 38% of the United States population, they only make up about 19% of registered nurses in the country (Chen et al., 2020). There is an understanding that an increase in racial minorities in the nursing field would improve care overall. However, the attrition of minorities, due to socioeconomic variables like income and education levels, can impede that.

The purpose of the program in question is to increase the retention of racial minorities in an Undergraduate Baccalaureate Program for nurses (BSN) at a nursing college in the Southeastern United States. Students in this college progress through full time curriculum in cohorts taking 15-17 credit hours (Chen et al., 2020). Even though the college is diverse, the graduation rates for racial minority students was 21% lower in 2015 compared to White students (Chen et al., 2020). An evaluation for this program was

conducted with the goal to retain 20 diverse junior-level nursing students. A 1-year intervention program was established to retain these students through specific dimensions: social support, academic support, financial support, empowerment, and responsibility (SAFER) (Chen et al., 2020). The evaluators for the program were from a different college but attended the same university. The evaluators worked with actual nursing stakeholders to better structure the program evaluation. The evaluation also deals with the idea of unintended consequences and whether the issue with the number of minority students can be purposefully counteracted.

The study dealt with the theme of unintended consequences. It is unintended for the racial minorities at this university to have such a disproportionate retention rate. I will be using this theme to make a lateral investigation regarding the mortality rate of Black women in healthcare. I intend to assess the unintended consequences regarding implicit racial bias in the healthcare system.

The theme of unintended consequences in the medical field has been researched and well documented. Unintended consequences of racism in healthcare can lead to marginalized people to suffer disproportionately. Ramona Rhodes (2021) conducted a study that assessed racial disparities as a result of unintended consequences. She detailed how there are disparities we can see across the entire healthcare system. We can look at the disproportionate amount of Black nursing home residents who are diagnosed with schizophrenia on a yearly basis (Fashaw-Walters et al., 2021). We can also look at something like the unintended consequences of coronary artery bypass graft report cards. In this scenario, we see physicians purposefully avoiding high risk patients so they can improve their personal ratings. In many cases, we see these physicians avoiding ethnic

minorities and marginalized identities because they are disproportionately at risk (Werner, Asch, & Polsky, 2005).

Unintended consequences are, often, influenced and reinforced by existing familiar organizational structures (Olson et al., 2022). When looking into the healthcare and medical field, we have a long, well documented history of structural racism that has not only been reinforced by hospitals, but also by the universities that are creating these medical professionals. An anonymous expert on systemic racism was asked how we can address structural racism in organizations, and they provided a thought-provoking response which asks the question: concerning racism when are we going to turn rhetoric into reality (Suarez-Balcazar et al., 2023)?

Positioning the Study as an Action Research Study

My research study is a Participatory Action Research (PAR) based study. I believe that PAR is a method which prioritizes the people who are most impacted by the problem at hand, thus making them the leaders in framing the question. Participatory Action Research affirms that "normal" everyday people have important things to contribute. In the case of my study that is dealing with marginalized populations, it is important to work in tandem with the members of the study. Andrea Dyrness (2011) explains that while "activist research often tries to shift the balance of power by changing how research is used" (p. 203), such research does not necessarily change the research process.

In contrast, she argues that participatory research assumes that "ordinary people also produce knowledge that is useful in struggles for change, and [that] the research process itself could be an important arena for making change" (p. 203). PAR aims to

make the research process more democratic and collaborative. The study will ultimately be in collaboration with some members of the community identifying as Black women who have become pregnant within the last calendar year.

PAR seeks to change the world by analyzing lived experiences. Participatory Action Research is reflective in nature and is linked directly to action to be influenced by history, culture, context, and nuance (Baum et al., 2006). Participatory Action Research is more of a democratic process aimed at having a clearer focus on the needs of the participants (Savin-Baden & Wimpenny, 2007). This type of research aligns with my problem of practice because there is documented research around PAR focusing on my area of interest. Baum (2006) described work done by Howard-Grabman to understand and tackle work around maternal and neonatal health in Rural Bolivia (Baum et al., 2006).

Site or Population Selection

The organization at the center of this study is a 501(c)(3) nonprofit organization based in Greensboro, North Carolina. It is a small, Black owned and operated 501(c)(3) certified nonprofit organization that has spent the last four years working with marginalized communities across the Carolinas. At its core, the organization is a family foundation dedicated to helping the marginalized. The organization was founded in honor and memory of Aaron James White, a rising senior at the University of North Carolina who, at the age of 20, died in Wake Forest, North Carolina from a malignant Grade 3 Astrocytoma tumor. The Aaron James White Foundation (AJWF) began with a commitment to benefit the communities that Aaron spent his life in. The organization has two offices located in Greensboro and Charlotte, North Carolina, and this is where

external stakeholders reside. These stakeholders are members of the marginalized communities we look to serve as well as the governing organizations we apply to for our grant funding.

The organization operates with a predominately Black board of directors that handles everything for the foundation on a day-to-day basis. In total, 12 people comprise the team of directors, advisors, and consultants. The structure is top down with the CEO, Creative Director, and President presiding at the top, with the Board of Directors and Executive Director on the next level, and finally, the volunteers and consultants on the bottom level. These responsibilities include, but are not limited to, marketing, social media, brand and web development, project planning, onboard, consultations, etc. Work is divided evenly amongst the eight board of director members. The organization has five core focuses/pillars that our work is centered around: community health & wellness, patient advocacy, social & racial equity, financial literacy, and education & career development. In the short time that our organization has existed we have implemented racial equity building programs for Black owned businesses, supplied scholarships to 11 college students from eight different states, crowdfunded over $50,000 from our community, and conducted other projects that illustrate our commitment to making our community a better place.

The leaders of the organization, the Executive Director, Creative Director, and the President, establish a culture of care and transparency amongst the Board of Directors, consultants, and volunteers because there is a direct correlation to leadership behavior and job satisfaction (Tsai, 2011). The organization keeps a daily line of communication and meets regularly. The mission statement of the organization is to identify and mitigate

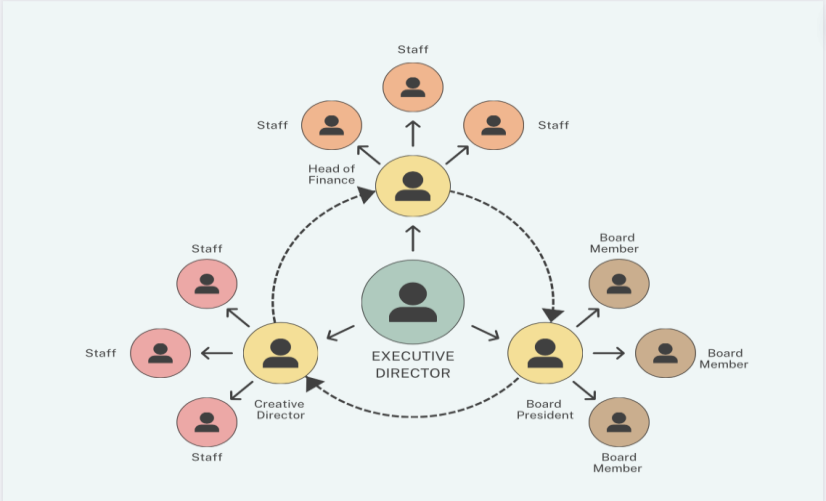
adverse barriers to marginalized communities and alleviate the plights of Black, Indigenous, and People of Color (BIPOC) in the Carolinas. We execute this mission through career and education development, patient advocacy, social and racial equity training. Throughout the year we seek grant funding from private and public organizations so that we can implement programs in the community.

Figure 5:

AJWF Organizational Logo

Figure 6:

AJWF Organizational Structure



Researcher Role & Positionality

I currently possess access to the site because I am currently the Executive Director of the day-to-day operations of the organization. I am a founding member of the nonprofit and was given the role of Executive Director in 2018. Additional access needed on my part will be through coordination efforts to assemble a cohort of women.

Seeing that I serve as the Executive Director, I will not need any additional access to the organization. This role gives me the power to preside over all organization volunteers, consultants, and staffing. I coordinate meetings for the Board of Directors and facilitate all grantmaking endeavors. Lastly, I am responsible for presiding over all organizational programming. As a researcher, I will take on the role of participant recruitment and reviewing and analyzing the interview transcripts. I am dealing with people and material that is going to be sensitive in nature and it will be my job to lead with an empathetic and listening mindset. I will contact the women I will be interviewing

and build a rapport with them. I will acknowledge my role as a researcher by being open from the beginning of all research events and communication with participants.

From my participants, I will be taking their anecdotal experience and information about how they have been impacted by the healthcare system during their respective prenatal, birthing, and postpartum experiences. It is my understanding that they may not have ever had the opportunity to discuss the negative experiences and thoughts they have had surrounding their healthcare. Currently, with the participants on site, I have a relationship as a respected member of the community. My plan is to continuously build rapport with the participants and members on site. I plan on maintaining the rapport that I build with participants by keeping an open and honest line of communication. I will also be considering my positionality as a cisgendered male conducting the research that is involving women and sensitive information. It is important that I am always aware of this positionality.

Ethical & Political Considerations

In this study, I need to take ethical considerations into account. The fact that I will be requesting anecdotal information regarding medical histories and experiences from the participants can open the door for ethical considerations. I can ensure the integrity of the study by keeping an open line of communication with the program participants and members of my respective organization. I will study the results in an ethical way by doing my due diligence with transcription methods and reporting the findings back to the group participants. I will use consent methods fairly by obtaining the same levels of consent in the same manner from all research participants. There are also ethical considerations regarding my role and position in the organization. I serve as the

Executive Director of the organization meaning that I will need to ensure that I am maintaining the integrity of not only the project but the organization. I will be assuming a large undertaking regarding researcher responsibility.

I will show the utmost respect for the site and the participants by maintaining a professional level of confidentiality, respect, integrity, reliability, and trustworthiness. I will take proper steps to ensure that the participants will not experience any negative effects from the study. I will maintain caring relationships with the participants by keeping a constant line of open communication. I will keep the interest of the participants at the forefront of the study by making sure all voices are equally heard.

Data Collection Methods

Since I am using a phenomenological narrative approach for my study, I will use a peer-to-peer participatory interview technique for the data collection process. 10 African American women who have had prenatal, birthing, and postpartum experiences in a hospital that is part of the Novant Healthcare System in the state of North Carolina will be interviewed. Interviews will be limited to two participants at a time for a total of five groups of women. Since Covid-19 is still a concern for many people, interviews will be held through Zoom. Each interview session will last approximately 1-2 hours. I want to allow enough time for participants to tell their stories without feeling rushed. The interview questions will be semi-structured and open-ended to ask foundation questions and allow the participants to offer details of their experience. I will include instructions with the interview questions to encourage participants to be clear and offer as many details as possible, so I don't have to hold additional interviews. The interviews will be recorded through the Zoom platform, and each question will be timestamped. I will

download the video recordings and the interviews will be transcribed through the Zoom platform.

The interview questions will focus on the barriers and opportunities that exist for African American women seeking to obtain prenatal and obstetrics healthcare services through Obstetrician-Gynecologists (OBGYN) in the Novant Healthcare System in North Carolina. Participants will discuss how they were treated during prenatal doctor visits, during labor and delivery, and during follow-up visits. Some (or all) of the participants may not be comfortable discussing intimate details of their experience in front of a group or with a male interviewer, so participatory interviews are the best approach for my study. Participatory interviews where the women interview each other will allow me to use in-depth questions about the study participants' lived experiences during their pregnancy and giving birth to their child(ren). Furthermore, the interviews will be presided over and moderated by a Black, female identifying member of my organization. I believe that it is imperative that the intersectionality of the women's identities is considered and respected during this study. So, I will remove myself from the interview moderation to respect their identities and make them comfortable. However, I will be presiding over the data analyzation process. This will be conveyed to the participants at the beginning of each interview. The consent form will convey that all their information including identifying factors will remain confidential.

I am confident in using this peer interviewing method because not only will I be able to ensure the comfortability of my participants, but I will also be ensuring that their lived experiences are brought to the forefront. Enacting this sort of data collection method is unique in that it strips away the power dynamic of typical data collection and

research methods (Bulutoglu et al., 2021; Zhu, 2019). It takes an interesting approach in that it empowers the participants and, in a sense, turns it into their study, too. Participatory Action Research is a method that can empower marginalized groups, disrupt the balance of power and challenge authoritative power (Gouin, Cocq, & McGravin, 2011; Paradis, 2000).

Data Analysis Procedures

In terms of data cleaning and member checking, I will send each participant a copy of the transcripts and ask her/them to review it for accuracy. I will use Riverside software to transcribe the qualitative data from the interviews. All participants will be given pseudonyms, and any identifying characteristics will be removed from the transcripts to maintain anonymity. All audio files will be destroyed once the dissertation is completed and approved.

Procedures to Address Trustworthiness, Credibility, and Transferability

The credibility of my study will be determined by my representation of the participants' views. Guion (2002) described triangulation as "a method used by qualitative researchers to check and establish validity in their studies" (p. 1). There are various types of triangulations; however, I don't currently see the value in using multiple approaches to my study. My primary measure of credibility will be to review the transcripts for each interview and look for similarities across the participants' experiences.

In terms of transferability, I believe the findings of my study will be easily transferred to other healthcare networks. I will use rich descriptions, details, and

participant quotes that offer a clear narrative of their lived experiences so that interested parties can determine if the information is transferable.

To ensure dependability, I will provide a detailed description of the research methods I use. I will also discuss how the participants were chosen for the study, the interpretation and presentation of my findings. That way, another researcher can follow my steps and repeat my study. I could also conduct the study with a trial group and compare the results from their interviews with the results of the interviews from the primary group.

I will analyze my biases and positionality by taking honest notes about my feelings and insights after reviewing the transcripts for each interview. I anticipate parts of the transcripts will be difficult to digest because I will always have different experiences. The questions I share with the participants for the interview will allow them to tell their stories in detail, without interruption. I will only ask follow-up questions when appropriate, and those questions will be asked through email for documentation purposes. To address trustworthiness in this study I am taking steps to make this a Participatory Action Research study. Because of my commitment to action research and PAR as well as the comfortability of my participants, I am ensuring that data collection methods are set up so that I am not present for the interview processes. Participants in the study might feel awkward or uncomfortable sharing these incredibly intimate experiences with a cisgendered male. There is a possibility that not every participant of the study will feel uncomfortable disclosing this information to me directly; however, I want to take the necessary precautions to mitigate that possibility.

Summary

Throughout American history there have been what seems like an endless barrage of systemic barriers placed in front of BIPOC. Through a lens of critical race theory and a phenomenological approach, I am seeking to investigate and gain knowledge on the lived experiences of Black women as it pertains to the North Carolina Healthcare System. Through a series of one-on-one interviews and surveys I hope to obtain rich and honest experiences from these Black identifying women which I will use to craft a narrative that will help us make more sense of the marginalization they face every day.

CHAPTER TWO

RESULTS OF RESEARCH

The purpose of this critical phenomenological study is to highlight the experiences of Black North Carolinian women as it relates to their experiences in the healthcare field when pregnant and giving birth. Through this study Black women's maternal healthcare experiences are illuminated for better insight and understanding and to counter the worldview that is reflected by privileged and non-marginalized groups. When assessing the most beneficial and productive way to conduct this qualitative research, I developed a Community Based Participatory Research (CBPR) approach through peer-to-peer interviewing methods. For this qualitative study, we interviewed 10 Black women who have given birth in the North Carolina healthcare system.

A community based participatory action research-based design was chosen because studies have shown that CBPAR has been increasingly used as an important strategy for eliminating racial and ethnic healthcare disparities by engaging community members in the research process and design (Israel, et. al, 2005). The crux of community based participatory research is for scientific researchers and members of the community to collaborate in addressing diseases and conditions that are disproportionately affecting marginalized or health disparity populations. Per the National Institute of Minority Health and Health Disparities (2018), CBPR has two main aims:

- To address the need for improved transdisciplinary and intervention research methods and approaches addressing health disparities.
- To strengthen the science of community engagement in addressing health disparities in socially disadvantaged population groups. (para. 2)

The research study will add to the literature about African American women and their experiences as mothers receiving prenatal care and giving birth in the state of North Carolina. The study will explore the experiences and perceptions of African American women on their treatment by the doctors and nurses chosen to care for them while they were pregnant and while they gave birth. The findings of this study may provide insight into what can be done to address the unique needs of African American mothers.

The Method

Peer-to-peer interviews, also known as co-researcher interviews or collaborative interviews, involve conducting interviews between peers or equals rather than a traditional researcher-participant dynamic (Gifford et al., 2021). Participants in peer-to-peer interviews "are more likely to engage in more open debate with peers/insiders and engage in more in-depth discussions and with greater candor, especially if dealing with sensitive topics" (Byrne et al., 2015, para. 12). The impact of peer-to-peer interviews on phenomenological research can be significant and can influence various aspects of the research process and outcomes:

- Rapport and Common Ground: Participants might feel more comfortable and more likely to speak openly and honestly about their experiences during peer-to-peer interview because they are talking to someone else who shares similar experiences and/or background.
- Empathy and Open Discussion: Participants may feel a deeper sense of empathy throughout the interview process. Both parties can relate to each other's experiences, so they may be willing to discuss information they have never shared before.

- Expertise by Experience: Participants are experts on their lived experiences; therefore, their views are authentic and valid. Their knowledge can enrich the research findings and allow the researchers to gather diverse perspectives. (Devotta et al., 2016; Payne-Gifford et al., 2021)

Despite the potential benefits, it is essential to recognize that the use of peer-to-peer interviews in phenomenological research is not a widely used method and it may not be suitable for all research questions or contexts. Some of the challenges include:

- Maintaining Objectivity: Researchers must remain objective and be aware of their own biases and how those biases can affect research outcomes.
- Novice Interviewing Skills: Participants are not skilled interviewers, so researchers may need to offer additional guidance before or during the interviews and ask clarifying questions while examining interview recordings and/or transcripts.
- Researcher Detachment: Peer-to-peer interviews may grant access to deep insights and experiences, but the researcher may feel detached from the research because they are not an active participant in the interview. (Byrne et al., 2015; Devotta et al., 2016)

The specific research objectives, the nature of the research topic, and the potential implications of adopting this approach were carefully considered before the peer-to-peer interview approach was adopted. The use of peer-to-peer interview methods for this action research study can offer a novel approach to the epistemology/methodology that is much needed for this area of study.

Participants

Ten (10) participants were interviewed for this study. All participants are Black, cisgendered, female identifying and have had prenatal, birthing, and postpartum experiences in North Carolina. All participants were contacted via email where they were asked to give their consent to their participation. They provided their consent through a detailed consent form, and they were informed that their identities would remain confidential, and their real names would be replaced with pseudonyms. All participants have given birth to at least one child in the state of North Carolina and can speak candidly, honestly, and openly about their experiences as pregnant women in the North Carolina Healthcare system.

Interview participants were given pseudonyms from letters of the alphabet (A-J) to protect their identities. The participants were broken up into groups of two and split into five different groups.

Table 1:

Initial Participant Profiles

Pseudonyms	Racial/Ethnic Identities	Number of Children	Labor Complication or C-Section
Olivia	Black/African American	2	Yes
Nova	Black/African American	1	Yes

Harper	Black/African American	1	Yes
Zara	Black/African American	3	Yes
Quinn	Black/African American	1	Yes
Aria	Black/African American	2	Yes
Chloe	Black/African American	5	Yes
Mia	Black/African American	1	Yes
Skylar	Black/African American	1	Yes
Isabella	Black/African American	2	Yes

The interviews were not time restricted, and the participants were encouraged to speak freely for as long as they needed to. This is evidenced by the varying times illustrated in

Table 2:

Peer-to-Peer Interview Groupings and Time Durations

Peer to Peer Group	Interview Duration	Group Label
Olivia & Nova	38:34	AB
Harper & Zara	1:20:42	CD
Quinn & Aria	1:23:10	EF
Chloe & Mia	1:49:01	GH
Skyla & Isabella	56:07	IJ
Total Interview Duration	06:07:34	
Average Interview Duration	73:06	

Qualitative and Phenomenological Data Collection

Participant recruitment began during the Spring of 2023. Participants were recruited and vetted through social networking through our nonprofit organization social channels. Potential participants were contacted via email where the purpose of the study was explained to them in detail. The email contained an anecdotal portion of myself explaining who I am, my background, education, and personal motivations for running this study. Attached to the email was a consent form, list of interview questions and my

personal contact information (email and phone number) for the women to reach out to me should they have had any questions, comments, or concerns.

Participants were also informed that the semi structured interview process would take place over Zoom where they would be paired with another participant and moderated by a female identifying member of my organization. In the email I explained that the choice to have a female moderator was to ensure their comfortability because traumatic and personal information related to the pregnancy, birthing, and postpartum experience would be shared. I identify as a cisgendered male, so I thought it would be best to not be present during the interview to ensure the integrity of the interview process and the study. Several of the participants told me this approach to the interview made them more confident and comfortable with their participation in the study. The qualitative data was then collected by way of a peer-to-peer interview style.

Interview Questions

1. How did you feel about your prenatal care experience leading up to the birth of your child?
2. Did you feel like your concerns and questions were addressed adequately by your healthcare provider during your pregnancy? Please Elaborate.
3. How did you choose the hospital where you delivered your child? Was it a difficult decision?
4. Can you describe your experience during labor and delivery? Did you feel like you were treated respectfully and with dignity?
5. Were you given pain relief options during labor? If so, were you given enough information to make an informed decision about which options to choose?

6. Did you feel like your healthcare provider communicated clearly with you throughout your labor and delivery? Were they responsive to your needs?
7. Were you given the opportunity to have a support person or doula present during your labor and delivery? If so, how did they contribute to your experience?
8. Were you satisfied with the level of support you received from the nursing staff during your hospital stay? Did you feel like they were attentive to your needs?
9. Did you experience any complications or unexpected events during your hospital stay? How were these handled by the healthcare team?
10. Looking back on your hospital experience, is there anything you wish had been done differently?
11. Do you feel there was any correlation between your hospital experiences and your identity as a Black woman?
12. Do you believe that your healthcare providers were adequately prepared?

Summary and Evaluation of Qualitative Findings

In total, all five semi structured peer-to-peer interviews lasted for a combined 6 hours, seven minutes, and 34 seconds. The average interviews were approximately 73 minutes and 6 seconds. The shortest interview was 38 minutes and 4 seconds, while the longest interview was 1 hour, 49 minutes, and 1 second. Once each interview ended the audio and video files were downloaded and saved to an encrypted external drive that only I can access. The files were run through an artificial intelligence decoding service through a software named Riverside where the audio files were turned into PDF files with timestamps. This artificial intelligence service was used to transcribe the files and nothing else. After transcription of the files was complete and all files were saved onto an

external hard drvie, the use of this service ceased. Once the files were transferred to PDF format, they were read, edited, and transcribed. Each transcript was color coded thematically into emerging themes and juxtaposed with the themes that were listed in Chapter 1. Some quotes pulled from the interview may be repeated when analyzing them thematic due to some quotes fitting multiple themes:

Phenomenological Thematic Elements

Lived/Healthcare Experiences of African American Women

Perceptions of Black Women

Critical Race Theory in Healthcare

Unintended Consequences

Theme 1: Lived/Healthcare Experiences of African American Women

Many darker-skinned patients, especially Black patients, get the wrong diagnosis or are ignored. This idea matches arguments that refer to Black people as being "superhuman" and needing less pain medicine because they can handle more pain, which comes from an incorrect belief rooted in history (Rodriguez-Knutsen, 2023). A wrong diagnosis can affect a person's recovery or survival, and sometimes patients are denied access to basic healthcare.

When people must focus on important things like rent, childcare, gas, or groceries, buying private insurance is too expensive, especially when there's a large pay gap in the country. This, along with other problems like less access to medical care and working in jobs that are health risks, meant that Black, Hispanic/Latinx, and Native American people had more COVID-19 cases, hospitalizations, and deaths during the worst of the pandemic. History shows that blame often falls on victims in medicine, along

with expensive medicine and unequal care, which can make seeking medical help feel scarier than other health issues (Rodriguez-Knutsen, 2023).

Unfortunately, women often experience medical gaslighting when talking about their health, where doctors dismiss their worries as just being emotional or psychological, regardless of the seriousness of their symptoms. This happens more to BIPOC patients, who are often seen as drug addicts looking for drugs and denied the medication they need. These false assumptions can lead to catastrophic results: women deal with worse effects from medicine, get diagnosed with heart disease later than men, and women who have heart attacks are more likely to die from them because the symptoms aren't widely known or discussed as they are for men (Rodriguez-Knutsen, 2023). With these issues in mind, it's no wonder that only 34% of women think healthcare in America is better than average, while 61% of women under 50 think it's just average or worse. Aria reflected on being wrongly diagnosed with gestational diabetes:

> In my first pregnancy, I had gestational diabetes, and I was diagnosed earlier than usual because usually they test us during the end of our seventh, eighth month. But I started gaining weight really fast… I was 19 when I got pregnant, 20 when I had my daughter, and I was considered to be in tip-top shape beforehand. So they thought that maybe I had multiple gestations, but saw there was only one baby. So then they tested me for gestational diabetes early. But even after I was diagnosed, there was just no information provided afterwards of how to prevent myself from being on insulin or anything else. It was just like, okay, yeah, we have pregnancy-induced diabetes. Here's a meal plan. Have a good day.

She goes further and describes what happened when she went into labor:

> So that Saturday we went into triage. I'm saying, you know, there's, there's feces in my underwear. They're telling me it's absolutely not possible it was blood, it's probably just mucus. And I'm saying again, this is not my first child. I know the difference. They did not have a culture. They did not do an ultrasound. They didn't do anything other than strap me up to monitor the contractions and his heart rate. And they were like, oh, his heart rate is just dropping with the contractions. Well, I know that's normal. Sometimes, especially since we're right at the end. But I was there 30 minutes and sent home. When I checked in Tuesday for the C-section within 30 minutes of checking, again, his heart rate had dropped very dangerously low. So they took me in earlier than what was planned for the C-section. And as soon as they opened me up, they said, Oh, we see meconium. Which is what I was afraid of when we went in a couple of days before. So, at that point, you know, of course everything was rushed. My husband was livid, he's cursing the doctor out!

Skylar also shared her experience, particularly about doctors being overly concerned with her weight:

> I actually didn't have the most positive prenatal experience like starting out. And surprisingly, my first provider was a Black woman. And I was very intentional about selecting a Black woman just for that representation and a number of other reasons understanding the Black maternal health experience. I actually ended up leaving that provider just because I didn't

> really feel supported. I felt like a lot of times when I would have my prenatal appointments, they were very rushed. I wasn't given like a ton of time to like ask questions. Something else that was just really challenging for me as a Black woman with that provider was there was a constant kind of focus on my weight. And I know like, you know, with pregnancy.

She continued:

> You want to make sure that like, you know, you don't gain, you know, too much weight because it can, you know, have certain health complications for you and the baby. But naturally you are going to gain weight. And so even when I was just kind of putting on, you know, a couple of pounds that just naturally were coming as I was growing my daughter, every appointment it was constant. Your BMI is too high. Your BMI is this. And like, it I don't know, it just made me feel, you know, a certain type of way. And then on top of like not feeling like I had the time and space to ask questions and get thoughtful responses, I ended up leaving that provider.

Isabella noted doctors were overly concerned about her weight too:

> They were so focused on my weight and not really anything else that I didn't feel like I could ask anything else unless it was about how to lose weight. Yeah.

Chloe also shared her experience that highlighted how she was treated when she had a White doctor during her first pregnancy versus having a Black midwife during her third pregnancy:

> So when I told my doctor that I would be trying to have a natural birth

> and breastfeed, she tried to discourage me from even going that route. She was like, no, you're gonna have a C section and you're not gonna breastfeed, it's not gonna happen. Like even her dad got visibly frustrated with the conversation. After that, I didn't realize I could have just changed doctors. I stayed with her the entire pregnancy with my first one and it was, it was not good. I didn't like it at all and I was only 17 so I didn't like it. It was not fun for me. But on the flip side, my third daughter, I had a black midwife and she was great. She was excellent. I wish I could have had all my kids with her but she moved away when I had my last two. But aside from that, she was great. She really listened to me and she paid attention. This time. She talked to me and she happened to go to church with me. Well, to my old church. So we clicked, but it was pretty good. That one was pretty good out of all five of mine. Those are the two that stand out.

Black Americans say that the main reason for worse health for Black people is not getting good healthcare. Many also think other things play a role, like bad environments in Black communities and hospitals not caring about Black people's well-being. Home and work environments also seem to be a factor. For instance, many people think Black people have worse health than non-Black people because they live in areas with more health problems from the environment, and others think it's because they work in jobs that are bad for their health (Funk, 2022).

Young Black adults say that hospitals and medical centers not caring about them is a big reason for worse health, while older Black adults think the same but less often.

While Black adults mostly like the care they get, most say they've had at least one bad experience with doctors or healthcare providers at some point (Funk, 2022). About 3 in 10 Black adults say they've felt rushed by their healthcare provider and about 3 in 10 say they were treated worse than other patients, recently or in the past. Among Black men, older men are more likely to report bad experiences, while younger men are somewhat less likely (Funk, 2022).

In the U. S., women under 49 are more likely than older women or men to say they've had a bad experience in a healthcare visit. This is similar for Black men, although younger and older Black men are closer in their views than Black women. Many Black adults think a Black healthcare provider is about the same as other health workers when it comes to care quality, while some think Black providers are better, and very few think they're worse (Funk, 2022).

Among the 31% of Black Americans who prefer to see a Black healthcare provider for regular visits, most think they're better at looking out for their best interests, taking symptoms seriously, treating with respect, and giving high-quality care (Funk, 2022). About 4 in 10 Black women under 49 think a Black provider is better at looking out for their best interests, compared to more than half who think they're about the same as other providers (Funk, 2022). Quinn shared a healthcare experience where she felt mistreated:

> So I had this pain underneath my ribs. And for a while, it was like, maybe it's gas. So we did all of the, you know, the appropriate avenues for that. And it ended up not being gas. And they were like, maybe it's the way that she's sitting. And that was fine as well. And so they kind of

narrowed it down after I was complaining for multiple appointments. You know, I can't drink water. It's always after I eat, lying down doesn't help. Medicine doesn't help. And they determined that it was something with the baby and my gallbladder. And it was severe enough to where it would bring me to tears every time I had ingested something. My gallbladder just wasn't able to process it properly. And I had no issues prior to the pregnancy with my gallbladder. So it was really weird. And it had taken many of these appointments and calls and, you know, portal messages for them to finally get me in contact with a specialist who then transferred me to a surgeon. But by the time we got to that point. The surgeon was like, well, you're at the end of your second trimester. I can't operate on you anymore. So it just kind of was like, yeah, be uncomfortable. So sad. And I mean, bless his heart. He looked at me, he was like, why are you here? I can't, I can't do anything for you right now. But it had just taken so much to get it escalated to that point that I feel like if we would have addressed it in the beginning, at like 12, 13 weeks, it could have been.

She further remembered:

> But my mom was just insistent on indulging in every single craving that I had. And I craved a lot of fruit, but they did not inform me of what fruits and vegetables do to my sugars, so I'm eating all these fruits thinking I'm being healthy and I'm making things worse. Oh no. Like I didn't know strawberries, you know, are like high in sugars. I didn't know, so I'm, you know, not really taking care of myself in the manner that I should. And I

> ended up having to be hospitalized twice, because my numbers were so high, but even still there was no conversations, there was no counseling as to what to do to prevent things from getting worse. It was just, okay, now your numbers are high, let's put you on insulin, and we're gonna send you home after a few days. And then that was just it.

Skylar also had a similar experience:

> Even when I was just kind of putting on, you know, a couple of pounds that just naturally were coming as I was growing my daughter, every appointment it was constant. Your BMI is too high. Your BMI is this. And like, I don't know, it just made me feel, you know, a certain type of way. And then on top of not feeling like I had the time and space to ask questions and get thoughtful responses, I ended up leaving that provider.

Theme 2: Perceptions of Black Women

During the interviews, there were many stories about how Black women are viewed in healthcare and many of the sentiments shared reflect how other women of color feel as well. They're often seen negatively, which leads to insufficient care. Sometimes the biases of healthcare workers can also lead to proper care due to fear or impressions. Throughout history, the atrocities that have been committed towards BIWOC in healthcare were due in large part to there being a “desirable race” (Suarez-Balcazar et al., 2023). Participant D spoke about this when asked, “Do you feel that there was a correlation between your hospital experiences and your identity as a black woman?” She responded:

> I absolutely feel that, absolutely. And then like being an obese black woman as a new layer, because everything that you're experiencing is related to you being fat. Like if my toe is numb and I'm not diabetic, it has absolutely nothing to do with me being fat. Figure out why… because my brain is like, figure out why my toe is numb. Like, that added a whole new layer. And I remember having that conversation with one of the physicians who was also, she was a person of color, not a Black woman. And I was just telling her, and I was just like, so much of everything that I'm experiencing is related to my being obese.

Olivia also shared her experience:

> I feel like everything was fine. Yeah. I don't think I had any experiences. And in fact, I think because I was a black woman, people respected me. I didn't get questioned or pushed back a lot. And maybe that could have been from fear of people seeing me as combative, but in my case, it worked in my favor.

A couple participants recalled where they took precautions to alleviate any potential issues due to race by preselecting Black doulas or Black healthcare providers within the hospital. Participant B shared:

> I don't feel as though I was treated poorly because of my race. I also made it the point to have a Black OB-GYN. And so, that was helpful, but I don't think, I felt like I was treated wonderfully. I did have a lot of white nurses and other people. But I made sure my doctor was Black. So I feel as though I had a great experience even though I was Black.

Quinn reflected:

> It made me feel like I was being dramatic in what was going on with me when in reality because of the catheter not being in my body, my bladder had burst. Oh, my goodness. And they didn't do what I felt like they should have done if I was listened to in the beginning.

Skylar noted:

> I think, I mean, it could have been a number of factors, but I don't think she expected, you know, me to probably have done research on potosin on my own and be able to question what she was telling me as far as potosin being perfectly safe and being something that, you know, pretty much is like a standard of care and that they typically, you know, do, and that there's really no negative outcomes that come with it. I don't think she really expected me to kind of have a knowledge base. And I don't think she also expected maybe me to advocate for myself and just her rudeness. I just, yeah, I just don't think she expected, you know, me to kind of come in the way that I did. And so, I don' know it that's, you know, me being a Black woman. I don't know if that's me kind of like, you know, just being that patient advocacy, but I do not think, and I could be wrong, but I do not think that she would have thrown her gloves in the trash and threw her hands up and sucked her teeth to a White patient. I really don't. Cause I think folks, you know, they pick and choose who they gonna, you know, give certain responses to and I cannot imagine that she would have done that. But I could be wrong.

Theme 3: Critical Race Theory in Healthcare

As previously stated, the idea of CRT places significant emphasis on the idea of intersectionality which states that there are multiple facets of our identity. When looking at BIWOC we see this idea fully fleshed out. Looking at things through the Critical Race Theory lens, which focuses on race and racial mistreatment in social research, experts find different types of cultural value in communities of color. They also criticize the idea that people of color are culturally "worse off" compared to White individuals (Madden, 2015). This theory is strongly tied to action guided by these ideas and can be used to understand the structural reasons behind racial unfairness in society and to work towards fixing them. In the field of medicine, this means carefully thinking about why people perceive race as a biological difference and why they easily use it to explain health differences between people, while ignoring the impact of politics and society (Zewude and Sharma, 2021).

Medical research informed by this theory has grown over the last ten years. It has shown how racism affects how doctors treat patients in various medical fields, from general care to specialized areas like rheumatology and obstetrics. However, there hasn't been much talk about how to integrate this theory into the medical profession itself. By seeing race as a societal idea, teachers in medical settings can encourage awareness of race to prevent spreading harmful ideas. For example, thinking that Black bodies can endure more pain, which is a misconception that has caused wrong pain relief recommendations for many patients (Zewude and Sharma, 2021).

In medical school teaching, it's important to carefully unpack how "race" is used as a stand-in for the underlying reasons behind health issues, like poverty and unequal

access to healthcare and education. Focused public health efforts, like a recent project by the Black Doctors COVID Consortium, aiming to vaccinate Black community members with busy schedules or online challenges, can make it easier to access healthcare and slowly rebuild trust in the healthcare system (Zewude and Sharma, 2021). Everyday racism puts a big burden on doctors from racialized backgrounds to prove to colleagues and supervisors how racism affects them personally at work. Critical race theory encourages focusing on the experiences of these doctors and shifts from looking at intent to looking at impact (Zewude and Sharma, 2021).

Examples from history, like the Tuskegee syphilis study and research making assumptions about Indigenous people, have made racialized individuals lack trust in medical research (Zewude and Sharma, 2021). This theory calls for a shared duty to move beyond simple ideas about health and look at the societal reasons behind racial inequalities. Study participants know how marginalized communities are treated when they look for medical help. As she described her experience, Zara noted:

> I hate to say this, but there is a difference with marginalized communities and how they approach healthcare than communities that weren't marginalized because my providers who were either persons of color or Black or from a marginalized community say, you know, and I'm saying this from perception, maybe members of the LGBTQIA plus community, they tend to take healthcare a little bit more serious in how they provide healthcare… versus my White nurses and especially White female nurses. Oh my gosh. And I'm gonna say this, they sucked. They, and that is literally the only adjective I have, they sucked.

She continued:

> You're in a hospital. You cannot sit here and tell me if you were not a Black woman, that that experience would have gone different. Like, if you were not Black, that would have been a completely different experience. Yeah. Because, and I think part of that is, it's like they don't hear you until you get to that point where it's like, okay, you're not hearing me this way, let's try this way. But now that you're at that point, then they box you into, yeah… no, that's not how that works. Yeah. You're not hearing me when I talk to you this way and you think I'm not gonna advocate for myself or continue. So I'm gonna have to be a little bit more stern to let you know, no, I'm not, that's not what I said. I said what I said. Like when I say, I was thankful for my mom. So she was the support that was in there.

Quinn echoed similar concerns:

> During delivery, that was a little bit different where I felt like we had concerns and those concerns weren't being taken seriously. And I know we get into it a little bit later, but… I had asked for an epidural when we were downstairs before they had gotten me to my room. And so the doctor had met me and the anesthesiologist met me up at the top, gave the epidural, that went perfectly fine. And the nurse came in to do my catheter and that particular nurse was a travel nurse and she was kind and respectful and everything. But she, for whatever reason, couldn't get the catheter in the way that it was supposed to be done. So she put it in, she took it out. She put it in, she took it out. She did that about three times

> before asking for help. And it was genuinely uncomfortable, even with the epidural. So someone had come in and put the catheter in. And during that time I was kind of voicing like, okay, like, can we find someone else? Can we do something else? What else? What else have we got going on here? And by this point, because I had gone to the hospital the day before, I was exhausted and we hadn't even started pushing anything just yet. And it ended up being that for whatever reason, and I can't really remember, the catheter came out and stayed out for the duration of my delivery. They're putting all these fluids into me. I think I had like three or four liters of fluids and nothing was coming out. And in one of the stages where the catheter was still in, it was bright red blood coming out into the bag rather than urine. And so during this time we're expressing that something's not right. And this is where I felt like it kind of took a switch where I wasn't treated with respect and I wasn't treated with dignity.

The experiences the participants shared are not isolated. Roeder (2019) noted

> The CDC now estimates that 700 to 900 new and expectant mothers die in the U.S. each year, and an additional 500,000 women experience life-threatening postpartum complications. More than half of these deaths and near deaths are from preventable causes, and a disproportionate number of the women suffering are black. (para. 8)

Black mothers are often monitored less and ignored when they try to voice their concerns. They may also be sent home without proper education, especially when they have concerning symptoms (Roeder, 2019).

Theme 4: Unintended Consequences

A common thread that was weaved through the interviews was the unintended consequences of medical professional's biases and their impact on the experiences of Black women in the healthcare system. Spears and Schmader (2021) noted that "African American and Hispanic physicians account for a mere 6 percent and 5 percent of medical school graduates, respectively, and account for 3 percent and 4 percent of full-time medical school faculty" (p. 23). This leads to a profession with an overwhelming disproportion of people that can hold implicit biases and put African American women in danger. This lack of representation was a primary concern and discussion point for several of the participants. In most of the conversations, the women talked about how there were implicit biases of healthcare providers that manifested themselves in negative attitudes and poor treatment of the participants. For example, Zara shared her experience in getting a sonogram:

> The sonographer's telling us like, you know, her heart beats good, these kinds of things. The physician comes in and bedside manners completely go out of the window and just says to me, "Well, we couldn't see certain chambers of the baby's heart because you're overweight." And I'm like, ma'am, what are you talking about? We just saw her heart beating on the screen. And like, now I'm like, is she saying that my child is dead because you just told me we couldn't see her heart because you're overweight? No explanation. She comes in and says it and walks out. At this point, I'm like, because my husband's name is Michael, I'm like, Michael, what does that mean? So after that, the sonographer comes in and she's like, "Okay…

> you know, whenever you guys are ready, she said, you're okay." And I'm like, no, I'm not okay. I'm not okay at all. And I told her what the training physician said. She was like, "Um, because you know, they're not really allowed to say much." Right, you're not supposed to say anything.

Zara is not alone. When discussing the maternal mortality rate and mistreatment of African American women, their experiences are often the result of a consequence that was unintended. All 10 women disclosed they had either some sort of pregnancy complication or unintended birth by c-section, which is frequently the result of a pregnancy complication. Unfortunately, African American women have a much higher risk of giving birth by cesarean section than other women. Huesch and Doctor (2015) noted several reasons for this disparity:

1. Observed and unobserved indicators that may lead to a cesarean are overlooked or misunderstood.
2. Communication obstacles between African American women and their physicians and/or hospitals may cause them to have different experiences than other women.
3. African American women may have care preferences that cause medical staff to treat them differently.
4. Women are often grouped together based on race/ethnicity and sent to the same hospital where they have similar experiences.

Zara also shed light on another noticeable bias that non-Black people will hold towards Black people. It is no secret that overweight and obese people have an automatic negative connotation associated with them in American society. There is a stigma towards being

overweight and obesity that is pervasive in American culture, and African American people suffer from it most (Puhl and Huer, 2010). Puhl and Huer (2010) describe how, often, in this society, overweight or obese people aren't just treated differently, but they are often blamed for their weight and health status. Participant D, further describes this line of thinking and mistreatment in her experience during a sonogram:

> One of the training physicians, she comes into the room and my husband and I are there. Now, mind you, we can see everything that's going on on the screen. The sonographer's telling us like, you know, her heart beats good, these kinds of things. Today physician comes in and bedside manner completely goes out of the window and just says to me, “Well, we couldn't see certain chambers of the baby's heart because you're overweight.” And I'm like, ma'am, what are you talking about? We just saw her heart beating on the screen. And like now I'm like, is she saying that my child is dead because you just told me we couldn't see her heart because you're overweight. No explanation, she comes in and says it, and walks out.

Skylar shared a similar experience:

> I had a subchorionic hemorrhage. And yeah, so basically what happens is I think it's about how your placenta kind of attaches and positions itself. And if it can leave like a pocket where you'll have kind of blood flowing out almost as if you're having a menstrual cycle. And for me, I had that for a few months throughout my pregnancy. I raised it to my providers at both those practices. And I just felt like no one took me seriously as far as what was going on. You know, being pregnant and you see that blood flow,

> you're thinking I'm losing my child, like every single time, especially when it's heavy. And so it was really scary. And they just kept telling me, oh, you just, you just have some, you know, old like blood just, you know, in your vaginal canal and it's just coming out. And that just never made sense to me. I'm like, no, like I know my body. I know this is not supposed to be happening. Like, hopefully this isn't like two TMI but like soaking like a pad like that's not normal. And so like those providers they did not listen to me and I ended up going to the hospital I want to say maybe two or three times on my own and I finally maybe on the third time I went to the hospital it wasn't the one I delivered it but actually it was the one I delivered I'm sorry the one I delivered at that hospital. They had really good providers there. They listened and actually ended up being able to diagnose my hemorrhage. And it ended up resolving on its own, but that was just a huge thing for me during my pregnancy. Like no one I felt like was listening or taking it seriously about what was happening to me. So yeah, similarly did not get that support.

Having tests and other procedures that should be routine often cause Black women to feel inadequate and helpless. Zara, many Black women feel invisible, as if their feelings and concerns do not matter. Most doctors claim to treat all patients equally, but that approach can be detrimental to Black women, as

> That approach only works if every patient has the same background, resources and access to medical care. To realize health equity—achieving equal health outcomes for each patient—requires healthcare professionals

> to consider a broader set of factors—culture, socioeconomic, and a patient's level of social support to offer the right treatment" (PR Newswire, 2021, para. 4).

Harper also shared an anecdote from both her prenatal experience and the pregnancy experience where there was different treatment from healthcare staff based on both position, race, and gender:

> If I go back, I probably would have asked for two of the nurses to not be my, for me not to be under their care. You know they switch shifts and stuff like that? One of them was an older lady and she had glasses, I don't know her name, but she had no bedside manner and wasn't really listening to me when I said, oh, I think I might need some more pain medicine and we'll just see in a few da-da-da-da-da… And that's how I felt about my experience with that one RN that sent me home beyond dehydrated. God and karma came back for that one. Cause at one of my appointments, it ended up being a male. He wasn't any scrubs or anything. And he talked to me and was like, how's your experience been overall? I was like, it's been pretty like with the practice. I was like, it's been pretty okay, except for this one incident told him all about it. And he was like, wait, really? And I was like, yeah. And he was like, oh, I'm gonna have to talk to her. And I was just laughing off like, oh, coworker, coworker. No, he was one of the owners of the practice. Oh wow. And I got out through my nurse. My nurses during my pregnancy though. They were black and I rocked with them heavy. And she was saying how apparently that RN had many

> complaints. So over like a year. So I don't know how she said her job. But yeah, so just saying all that because RN like girl, okay.

This qualitative study gave a voice to Black women who have had prenatal, birthing, and postpartum experiences in North Carolina while also highlighting the pervasive and systematically racist systems and beliefs that are within our healthcare system. The qualitative findings are consistent with the themes presented with some outliers. After evaluating all the qualitative data from the interviews, it was determined that the phenomenological experiences of these Black women were in line with all five of the proposed themes. These findings have been highlighted here.

Procedures to Address Trustworthiness, Credibility, and Transferability

Data collection for this study consisted of collecting responses from the semi structured peer-to-peer interview process (see Appendix E). These questions and probes were meant to conjure a conversation between the partner participants where they would disclose their phenomenological experiences as it related to their birthing stories. Using a peer-to-peer interviewing method was meant to strengthen the participatory action research methodology. The questions were meant to get an accurate understanding of not only the birthing process but also the pre-birthing process and the postpartum process. The participants were meant to convey the level of support they felt or lack thereof. The questions were also meant to gain an understanding of at what level the participants felt that race played in their birthing experience and any complications they encountered whether they were physical, emotional, or mental. I used thematic elements surrounding critical race theory and its tenants to guide the line of questioning used in the interviews.

Trustworthiness

The trustworthiness of this study is gauged by my ability as a researcher to be self-aware of the intersecting identities that I hold. As a person who identifies as Black, I can experience medical racism and discrimination. The motivation behind this study was born out of my brother's passing which was a situation in which I believe my family experienced medical racism and inadequate care over a six-month process. However, I am a cis gendered male, thus I cannot relate to the experiences of the women who have participated in this study. I wanted to establish that line of trust at the very beginning of the process.

Credibility

Participants were made aware from initial contact that they could give or withdraw their consent to participate in this study at any time. They were well within their rights and autonomy to withdraw from the interview if they saw fit. They were well informed about their ability to not answer any questions that made them uncomfortable or uneasy. The interviews were peer focused and self-guided, so participants were able to answer the questions and discuss at their own pace. They were made aware at the beginning of each interview that there was no time limit, and this is evidenced by the resulting time limits of the interviews all being different. The shortest interview time was approximately 38 minutes while the longest interview was almost two hours long.

Transferability

The direct quotes and personal anecdotal experiences prove the transferability and external validity of the study. The data findings were influenced by the thick, rich, descriptions given by all participants of the study (Hesse-Biber, 2017).

Dependability

The dependability of the study was gauged by a future researcher's ability to replicate this research which would be more than possible if the researcher is provided the adequate resources and network to operate in. This study was conducted in a way that like-minded researchers with similar capacity and resources would be able to replicate the study in the future.

Table 3:

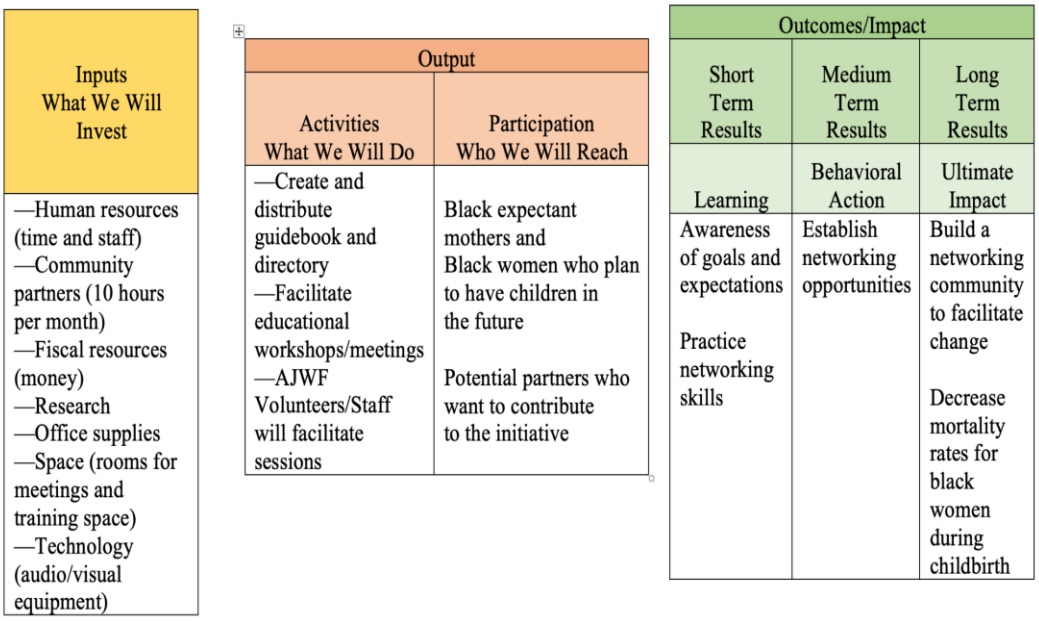
Interim Action Plan: The action plan devised by the organization grew out of the findings of the research conducted. The action plan contains programming that will seek to address the problem of practice directly.

Objectives and Outcomes (What)	*Tasks (How)*	*People (Who)*	*Time (When)*	*Location (Where)*	*Resources*	*Funds*
GOAL 1 Guidebook and directory for expectant black mothers	Create a pregnancy and labor and delivery guidebook and directory produced by the Aaron J. White Foundation (AJWF) that can meet the specific needs of Black expectant mothers who are looking for doctors,	AJWF Board of Directors will partner with the National Black Doulas Association, Triangle Doulas of Color, and Equity Before Birth, three nonprofit organizations that prioritize the health and well-being of expectant Black mothers. National Black Doulas Association and Triangle Doulas of Color focus on education and training,	September 2024 - December, 2024 to gather information and create the guidebook and directory.	The AJWF office in Greensboro, NC.	Space - $0 free at AJWF office (Office supplies, copy, print, scanning, faxing) Technology - $100 per month (Canva, internet)	Sending guidebook and directory to FedEx Print & Copy Services 100 books @$3.00, ea = $300 Will apply for grants through the Merancas Foundation, Inc. to fund the cost of creating, publishing, and distributing the guidebook and directory, and pay for operating costs.

	therapists, doulas, midwives, and other assistance.	and Equity Before Birth focuses on providing financial support. The goal for all three organizations is to improve Black maternal health and decrease mortality rates.				
GOAL 2 Increase community awareness and support for Black expectant mothers.	Expand research efforts and community outreach beyond the Triad Region of North Carolina to the whole state of North Carolina.	AJWF Board of Directors	Ongoing	The AJWF office in Greensboro, NC, and other meeting spaces around the state of NC.	Research to find other nonprofit organizations like the National Black Doulas Association and Equity at Birth that focus on providing information, resources and financial assistance to Black expectant mothers, as well as travel and meeting expenses.	Will apply for grants through the Philip L. Van Every Foundation and the NC Community Foundation - Healing Communities Fund to fund the cost of research, travel expenses, publishing, and distributing the guidebook and directory.

Figure 7:

Logic Model for Nonprofit Educational Programming



Inputs What We Will Invest	Output		Outcomes/Impact		
	Activities What We Will Do	Participation Who We Will Reach	Short Term Results	Medium Term Results	Long Term Results
			Learning	Behavioral Action	Ultimate Impact
—Human resources (time and staff) —Community partners (10 hours per month) —Fiscal resources (money) —Research —Office supplies —Space (rooms for meetings and training space) —Technology (audio/visual equipment)	—Create and distribute guidebook and directory —Facilitate educational workshops/meetings —AJWF Volunteers/Staff will facilitate sessions	Black expectant mothers and Black women who plan to have children in the future Potential partners who want to contribute to the initiative	Awareness of goals and expectations Practice networking skills	Establish networking opportunities	Build a networking community to facilitate change Decrease mortality rates for black women during childbirth

Fiscal Resources

As a nonprofit organization, monetary resources are typically obtained in non-traditional ways. There are no set pay periods or guaranteed revenue that is allocated to the organization. Rather, the organization obtains its funding through grassroots fundraising, donations from organizational sponsors (weekly, monthly, or yearly), and grant funding from the state government, national government or other nonprofit organizations that exist to fund like-minded organizations. In 2020 our organization worked closely with the Dogwood Health Trust organization based in Asheville, North Carolina. Their organization was looking for partners to conduct racial equity programming in Western North Carolina which is one of the more rural and impoverished parts of the state. We partnered with them to provide job readiness training and racial equity training to businesses in the area.

For this ongoing programming contributing to our action plan, we will be seeking funding from several North Carolina entities. These entities include, but are not limited to, The Z Smith Reynolds Foundation, The Dogwood Health Trust Foundation, the State of North Carolina department of nonprofit funding, and individual donors. We have an ongoing relationship with a Greensboro based consulting company — Healing in Authenticity who we work with to decide which grantmaking endeavors the organization will pursue on a month-to-month basis. The goal for this programming plan is to acquire approximately $300,000 in funding to be spread out over three years for a total of $100,000 per year.

CHAPTER THREE

ANALYSIS OF IMPLEMENTATION

Kenny (2013) noted, “Black women have some of the poorest health outcomes relative to other racial groups (p. 8). Unfortunately, Black women are likely to have negative experiences, even when their white counterparts have positive experiences with the same injuries and the same doctors. Furthermore, when they have negative experiences, Black women are often left with limited options for compensation (Baker, 2022). Despite the myriad medical advancements over the last several decades, racial disparities and blatant prejudice still exist in the United States healthcare system. One of the purposes of this study was to add to the existing body of knowledge around this issue of the racism that is so pervasive in our healthcare systems. There were five themes utilized in this study that were meant to not only place emphasis on the lived experiences of pregnant Black women, but to also highlight the intersections of their lives and how those intersections place them at further risk. These intersections are, but are not limited to, Blackness, female identifying, North Carolinians, etc.

The five themes of this study are as follows:

- *Lived/Healthcare Experiences of African American Women*
- *Perceptions of Black Women*
- *Critical Race Theory in Healthcare*
- *Unintended Consequences*

Implementation of Action Plan

When considering the implementation of the action plan I must consider the barriers to success that we as an organization may encounter. As a nonprofit organization

the COVID-19 pandemic has halted or stifled many organizational practices and operations over the last several years. Much like the rest of the world, ours has begun to open a lot of its operations to be customer and partner facing in the last year or so but seeing that we are a smaller organization, the pandemic has affected us differently, relatively speaking.

Considering the political and social climate of the United States and the state of North Carolina is something else I am considering. When doing racial equity work, one must be cognizant of the barriers to success including the people who believe there is no value in this work, and it is counterproductive. The state of North Carolina, like many conservative leaning states, is currently embroiled in a battle of racial and gender-based equity. What makes the current social and political makeup of this state so pertinent to the work that is being done by my organization is that marginalized populations (most notably women of color) are at the biggest risk of being harmed. Constituents and stakeholders:

Black identifying women in North Carolina

Pregnant Black identifying women in North Carolina

Statewide Healthcare organizations

Statewide Nonprofits and Sponsoring Organizations

Allies Partners and Champions:

Nonprofit Funding Organizations dedicated to racial equity

Potentially the Dogwood Health Trust & The Z Smith Reynolds Foundation

Potential Organization Programming Resources

Financial: Potentially $50,000-$100,000 in grant funding per fiscal year

Human Capacity: An 11-person board of directors, volunteers, and consultants working within the AJW foundation

Opposition and Barriers

The people opposing these advocacy efforts are against social justice and racial equity

Medical Professionals: Unintended Consequences

Their efforts are both overt and covert

The barrier of the unwillingness of the opposing organizations and people to undo their biases and learning

Ally Power Grid for the Z Smith Reynolds Foundation: The Z Smiths Reynolds organization is a nonprofit funding organization whose goals align with the goals of our organization, and they would be a potential funding source for our programming.

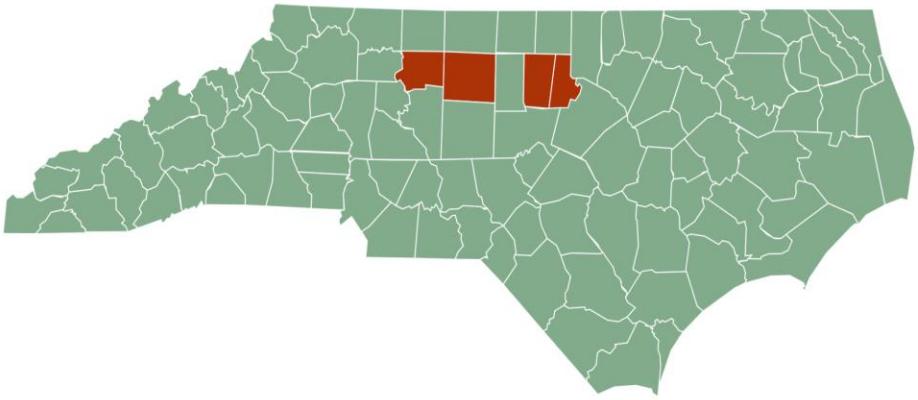
Figure 8:

Ally Power Grid

Type of Power	Power Appraisal: How much of this power do they have?	Benefits: How will this power be used?
Members: 17 person staff	17 person staff	Decision making
Money: $783,000 / 2022 revenue	$783,000 / 2022 revenue	Funding organizations
Credibility:	High level of credibility in the nonprofit space	The ability to continue deployment
Appeal:	High level of competition amongst orgs	Diverse net cast across orgs
Network:	Extensive and organized	Wide reach across orgs
Reputation:	High reputation for toughness	Ability to fund
Skills:	Special skills in grantmaking and funding	Ability to fund high performing programs
Newsworthy:	Very	Publicity

Figure 9:

Intended Programming Counties (Forsyth, Guilford, Orange, Durham)



Creation of Pregnancy and Labor & Delivery Doula Access Network

When assessing how we want to approach our action plan, we knew as an organization that we want to help decrease the rate of Black maternal mortality and morbidity, and we also want to improve the healthcare experiences of Black pregnant women to decrease the number of unintended consequences. A recurring topic in the interview sessions was the need for Black women to have options when it comes to prenatal and maternal healthcare. Many women use doulas as an alternative to traditional obstetric care, and the study participants noted that they would have used a doula if they had been educated about the benefits of having that kind of specialized and individualized care. Quinn noted,

> But I will say that my doula was magical. I was super, super nervous about labor delivery and all the things. I actually met her at, she was leading one of the WakeMed classes that we had attended. And we liked her so much that we interviewed a couple of people and she was one of them and we ended up hiring her. And she just made the experience so much better. It was great to talk to the doctors or talk to the nurses, but she really did a

> great job of serving as a buffer between us and the medical team and explaining, okay, this is some of what's going on. This is what this means, obviously to an extent because she doesn't have medical background. So when we got to the blood in the catheter, she was unsure of what that meant entirely, but was able to kind of guide me into asking questions and getting clarifications in the moment, especially when we got to the C-section. She was wonderful when it came to pain management. Before the epidural, she was great with the pushing. And in terms of knowing how to push, I truly believe that a lot of what she did saved my daughter.

Skylar also shared her experience:

> I had my husband and I had a doula. And I would say that having both of those folks to support was something that I would do absolutely again if I had to. The ways in which they contributed is one, you know, just kind of being a sounding board and having people to turn to like when I felt scared or when I just, I just couldn't even think, because I'm in so much pain and you got people coming in and out the room asking you all these questions. They were very much just kind of that balance I needed throughout that really challenging labor process. And they were really helpful too, just dealing with the physical pains of labor. So they both massaged my back and let me kind of hold on to them and sway. So they provided support.

To support Black women in the state of North Carolina in their prenatal, birthing, and postpartum experiences, our foundation plans to partner with organizations like the National Black Doulas Association and the Triangle Doulas of Color. Both organizations are on a mission to educate Black women about prenatal and maternal healthcare and connect them with Black doulas who can assist them before and during labor and delivery and offer resources that can help them during the postpartum phase and beyond. We also

plan to partner with organizations like Equity Before Birth, a non-profit organization that seeks to remove economic barriers by providing financial assistance to Black mothers who want to use Black midwives, doulas, and other birth assistants. Building these relationships is part of an overall goal to decrease the Black maternal and morbidity rates.

Healthcare Racial Equity Trainings

Our organization has experience with obtaining the necessary capacity and resources to develop training and educational courses. From 2020-2021, we worked closely with an organization in Western North Carolina to develop job training and résumé building educational courses. The 17 western most counties (See Figure 10) in North Carolina are some of the most impoverished and underserved communities in the state. This was especially apparent during the COVID-19 pandemic. For the action plan for this study, we will use a similar geographical approach and focus on the central part of North Carolina. We will partner with organizations like the Racial Equity Institute and the Greensboro Health Disparities Collaborative. These organizations focus on educating and training other organizations and community members about racial equity with the goal of eliminating racial disparities in all areas of the Black community, but with an emphasis on healthcare racial equity. The counties that will be targeted for these programs will be Forsyth, Guilford, Orange, Durham (See Figure 6).

Figure 10:

Previous Programming Area in Western NC

Anticipated Findings

Due to our organizational structure and the parameters in which we are currently operating, I anticipate that our initial program will not have a high level of participation. I anticipate that African American women will be interested and intrigued that the program exists and the visibility the program will give to their lived experiences and plight. I am aware that with the findings of this study, my organization will not be able to change the issue(s) that we are studying, at least not completely. To combat the risk of low participation numbers, we will be operating in metropolitan areas with high general populations, and with high populations of African American women specifically.

Communication Plan

The communication plan for the program will first determine the plan of action for the plan amongst the foundation's board of directors and organization consultants. Our communication plan will consist of meeting with and discussing our plans with

different stakeholders at different times. The length of these meetings, the level of communication, and the things discussed in these meetings will depend on the type of stakeholder that we are meeting with. For instance, there will be ongoing communication with the Foundation's board of directors and executive team to plan, implement, and execute the plans that we have for ongoing programming.

Evidence and Data Sources

There will be surveys sent to all stakeholders with specific questions to assess the quantitative and qualitative outcomes of the programming. I will seek the assistance of the Executive Members of my organization's board of directors to assess the results of the surveys to determine if the program was successful and what are the opportunities, we have to make it better in the future. To assess program success, room for improvement, and effectiveness, I will solicit the evaluations of the program's participants. Participants will be evaluated with a survey asking five questions using a rating scale - Not Effective; Somewhat Effective; Effective; Very Effective; Extremely Effective.

Validity and Reliability of Evaluation Assessments

We will establish the reliability of the evaluation assessments by ensuring that what we set out to measure will be measured and assessed thoroughly and comprehensively. Validity is determined by the overall value of the assessment that is constructed and given out. The executive members of the organizations will all have a say in ensuring that there is a high level of validity in constructing the evaluation assessment.

Implications for Practice and Future Research

Implications for Practice

In this section I will implement two practice implications: (a) Allocate resources in the organization's strategic plan for the long-term life of this joint programming initiative and (b) Allocate resources towards hiring a full time Chief Racial Equity Officer (CREO) to the organization's staff.

Implication1: Allocate resources in the organization's strategic plan for the long-term life of this joint programming initiative

Implication 2: Allocate resources towards hiring a full time Chief Racial Equity Officer (CREO) to the organization's staff

As previously reported in this document, the organization has a set structure where the board of directors presides over executive staff. The Executive Director leads all volunteers and staff members and presides over funding for all programming. In the future, it will be necessary that the BOD is reformatted in a way that allows an executive position to be added. We will be looking to add a person with an extensive background in consulting and racial equity training to ensure that all organizational programming that involves education in the realm of racial equity and antiracism is effective, valid, and reliable. In the past, the organization has utilized the services of external consultants and racial equity professionals depending on the program type and location. It has worked in the past but for the organization's future and effectiveness of ongoing programming we will need an internal officer fulfilling these duties and functions.

Implications for Future Research

The findings of this study have important implications for further research in this field and concerning the issue of racism in the medical field and the life-threatening experiences that Black women face in the prenatal, birthing, and postpartum processes. There is ongoing research and developments in the study of racism, racial equity, implicit biases, and how these affect patients with marginalized identities every day. My overall goal for this study was to bring awareness to these issues and phenomena and add to the ongoing, existing body of knowledge.

Further research can delve deeper into the phenomenon of unintended consequences in the medical field and how they are reinforced by implicit biases regardless of intellect level. As I discussed in my thematic breakdown in chapter one, it is often unintended for minorities to experience racism and implicit biases. If we were to screen every labor and delivery nurse or doctor in the state of North Carolina, we would far too many instances of a pregnant Black woman who died in their care. While these tragic outcomes are most likely framed and understood as unintended consequenes, the literature and research show that there were more likely than not implicit biases and acts of covert or overt racism that contributed to the death of that Black woman. The goal is to educate and bring awareness to these issues, but the overall goal is to help these medical professionals turn rhetoric into reality. Addressing this issue cannot be done by AJW alone. The purpose of this study was not to end racism or discrimination tomorrow because that would be unrealistic. However, out of this study came an action plan that will seek to address the problem of practice and systemic racism directly. This study and the action has and will build community amongst like minded individuals in the NC

healthcare community. Through this study, a network of women with interwoven experiences and stories was connected and their experiences were heard and validated.

Limitations

This study adds to the existing body of knowledge in a major way. Perhaps the biggest limitation to this study is that the sample size for the study could have been larger. There are approximately 1.1 million Black women living in the state of North Carolina and with a study sample size of 10 Black women, detractors could say that this is too small of a sample size to speak for the entire Black female identifying population.

Another limitation is the study could be classified as restrictive to other minority groups of females identifying individuals such as Latina women, Asian women, or Indigenous women. As I have shared throughout this study there is existing research that suggests that all groups of women of color experience discrimination and racism in different capacities in society. Not including their experiences or input in the study could be deemed as unfair or a limitation. The study mentions BIWOC on a handful of occasions, but the main focus is ultimately, Black women.

Lastly, a limitation that would be faced with the implementation of the organizational programming is the ongoing COVID 19 pandemic. As previously stated, the pandemic has restricted our organization's ability to work in a complete capacity during the last several years. Pandemic restrictions have been lifted in the state of North Carolina for over two years now but our organization, along with many healthcare providers and organizations have remained vigilant in protecting ourselves and being safe. When attempting to collaborate with healthcare providers as stakeholders for programming implementations, we may face setbacks due to their changing capacities.

Conclusion

When discussing and reflecting on the concept of intersectionality, I believe that it is important to place certain emphasis on the intersections of the Black woman's identity and the identities of BIWOC. Medical advancements have far surpassed what we thought we could accomplish and rapid growth in the field of healthcare is happening daily. In this current moment, the world is still experiencing the real time effects of a global pandemic that started in March of 2020. Due to medical advancements and collaboration, vaccines were quickly developed to combat the virus. In comparison, despite the advancement in medical technology and the welcoming of racial equity beliefs and practices, Black women are still dying at alarming and disproportionate rates in prenatal, birthing, and postpartum settings. So often, decisions are being made on behalf of marginalized communities without our input. How many racial equity statements and curriculum are being curated by BIPOC? I deemed it imperative for this study to center the voices and lived experiences of Black women. The study provided irrefutable qualitative evidence that the lived experiences of Black women are valid and should garner more attention. This study brought together a group of 10 brave, intelligent, courageous, and powerful Black women who have been through a substantial amount of trauma who were able to provide the qualitative data for this research. The health, wellbeing, and prosperity of marginalized people is something I base my work on. That is what my organization bases its work on, and I am eager to see what comes of the work we continue to do in this field.

Implications for Other Organizations

How Study Helped Respond to Problem of Practice

The primary research question that study aimed to explore was:

- What experiences and perceptions do African American women describe regarding the prenatal and obstetric care they received in the Healthcare System in North Carolina?

The sub questions that this study focused on were:

- What barriers, challenges, and opportunities do participants recount experiencing?
- How do participants describe Healthcare providers addressing (or ignoring) their concerns as a patient?
- How does the persistence of racist healthcare policies and practices shape the experiences and attitudes described by participants?

The overall findings for this study are as follows:

FINDING 1:

- The unintended consequences of implicit biases and racism can lead to the suffering of Black women in healthcare

FINDING 2:

- Racial equity education is imperative for medical professionals

FINDING 3:

- The lived experiences of Black women are filled with rich and thick knowledge that should be studied and understood

Implications For the Field Or Similar Organizations

- Implication 1: High levels of replicability
- Implication 2: Enriching of the existing body of knowledge

After completing this study and reflecting on the work and the results and all the data, I believe that the problem of practice was responded to and expounded upon. As previously stated, this is a study that is unique in a way that the problem it addresses will most likely never be truly solved. Frankly, I believe that it is impossible to solve this problem. Problems as pervasive as racism, misogynoir, and anti-blackness are centuries old and ingrained in our society. The solutions are shrouded in awareness and investigation. I believe that we can't solve these issues in their entirety; however, we'd be remiss if we did not strive to be the 99.999%.

REFERENCES

Abramovitz, M., and Blitz, L.V. (2015). Moving toward racial equity: The undoing racism workshop and organizational change. *Race Soc Probl* 7, 97–110 (2015). https://doi.org/10.1007/s12552-015-9147-4

Adebayo, C. T., Parcell, E. S., Mkandawire-Valhmu, L., & Olukotun, O. (2022). African American women's maternal healthcare experiences: A Critical Race Theory perspective. *Health Communication,37*(9), 1135-1146. doi: 10.1080/10410236.2021.1888453.

Baker, M. B. (2022). Made whole: The efficacy of legal redress for black women who have suffered injuries from medical bias. *Harvard Civil Rights - Civil Liberties Law Review, 57*(1), 321.

Baum, F., MacDougall, C., Smith, D., (2006, October). Participatory action research. *Journal of Epidemiology and Community Health*, *60*(10), 854-7. doi: 10.1136/jech.2004.028662.

Byrd, W. M., & Clayton, L. A. (2001, March). Race, medicine, and healthcare in the United States: A historical survey. *Journal of the National Medical Association, 93*(3), 11S-34S.

Byrne, E., Brugha, R., Clarke, E., Lavelle, A., & McGarvey, A. (2015). Peer interviewing in medical education research: experiences and perceptions of student interviewers and interviewees. *BMC Research Notes, 8*(1). https://libproxy.ecpi.edu:2242/apps/doc/A541620533/AONE?u=lirn55593&sid=bookmark-AONE&xid=63818247

Chen, H. T., Morosanu, L., Bellury, L. M., & Kimble, L. (2020). Multiwave formative

evaluation of a retention program for minority nursing students: Intended effects, unintended consequences, and remedial actions. *American Journal of Evaluation, 41*(1):71-88. doi:10.1177/1098214018803595.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). New York: Routledge.

Crenshaw, K. (1995). *Critical Race Theory*. New Press.

Devotta, K., Woodhall-Melnik, J., Pedersen, C., Wendaferew, A., Dowbor, T. P., Guilcher, S. J., Hamilton-Wright, S., Ferentzy, P., Hwang, S. W., & Matheson, F. I. (2016). Enriching qualitative research by engaging peer interviewers: a case study. *Qualitative Research, 16*(6), 661-680. https://doi.org/10.1177/1468794115626244

Fashaw-Walters S. A., Bynum J., Thomas, K., & Shiremean, T. (2021). Disproportionate increases in schizophrenia diagnoses among black nursing home residents with ADRD. *Journal of the American Geriatric Society, 69*(12), 3623-3630. https://doi.org/10.1111/jgs.17464

Ford, C. L., & Airhihenbuwa, C. O. (2010, April). Critical Race Theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health, 1*(Suppl1), S30–S35. doi: 10.2105/AJPH.2009.171058.

Ford, C. L., & Harawa, N. T. (2010). A new conceptualization of ethnicity for social epidemiologic and health equity research. *Social Science & Medicine*, *71*(2), 251–258. doi: 10.1016/j.socscimed.2010.04.008

Funk, C. (2022, April 7). *Black Americans' views about health disparities, experiences with healthcare*. Pew Research Center.

https://www.pewresearch.org/science/2022/04/07/black-americans-views-about-health-disparities-experiences-with-health-care/

Gouin, R., Cocq, K., & McGavin, S. (2011). Feminist participatory research in a social justice organization. *Action Research, 9*(3), 261–281.

Guion, L. A. (2002, September). Triangulation: Establishing the validity of qualitative studies. *University of Florida: Institute of Food and Agricultural Sciences, 1-3*. https://sites.duke.edu/niou/files/2014/07/W13-Guion-2002-Triangulation-Establishing-the-Validity-of-Qualitative-Research.pdf

Harrell, T., Howell, E. A., Balbierz, A., Guel, L., Pena, J., Janevic, T., & Gorbenko, K. (2022). Improving postpartum care: Identifying opportunities to reduce postpartum emergency room visits among publicly-insured women of color. *Maternal & Child Health Journal*, *26*(4), 913–922. https://doi-org.libproxy.udayton.edu/10.1007/s10995-021-03282-5

Hassanatu, B., Brown, N., Follette, C., Morgan, J., & Yu, H. (2021, March 1). Black, Indigenous, people of color, and international students: Experiences and resolutions beyond COVID-19. *American Journal of Public Health 111*(3), 384-386.

Hesse-Biber, S. N. (2017). *The practice of qualitative research: Engaging students in the research process*. SAGE.

Huesch M., & Doctor, J. N. (2015). Factors associated with increased cesarean risk amongAfrican American women: Evidence from California, 2010. *American Journal of Public Health, 105*(5), 956-962. doi: 10.2105/AJPH.2014.302381.

Impact4Health. (2021, January 11). *Healthcare systems ignoring 40-years of evidence that unconscious bias impacts quality of care.* Cision PRWeb. https://www.prweb.com/releases/healthcare-systems-ignoring-40-years-of-evidence-that-unconscious-bias-impacts-quality-of-care-828985168.html

Israel B. A., Eng E., Schulz A. J., Parker, E. A. (Eds.). (2005). *Methods in community-based participatory research for health*. San Francisco: Jossey-Bass.

Kawachi, I., Subramanian, S., & Almeida-Filho, N. (2002). A glossary for health inequalities. *Journal of Epidemiology and Community Health, 56*(9), 647–52. doi: 10.1136/jech.56.9.647.

Kenney, N. E. (2013). The invisible woman: The status of and challenges facing black women. *Review of Black Political Economy, 40*(1), 5-10. https://doi.org/10.1007/s12114-012-9137-3.

Mintz, S. (2007). The passage of the Nineteenth Amendment. *Magazine of History, 21*(3), 47-50. doi: 1321444261.

National Institute of Minority Health and Health Disparities. (2018). *Community-Based Participatory Research Program (CBPR).* https://www.nimhd.nih.gov/programs/extramural/community-based-participatory.html

Olson, T., Yue, M.B., Walsh, E., & Lewis, W. (2022). "When Will the University Do Something?" A U.S. case study of familiar structures, unintended consequences, and racism. *Journal of Academic Ethics, 21*, 251–267. https://doi.org/10.1007/s10805-022-09453-5

Payne-Gifford, S., Brueton, R., Hamilton, G., Clark, T., and Chang, Y. (2021). *Advantages and disadvantages of reciprocal peer-to-peer interviewing*. University of Hertfordshire. https://uhra.herts.ac.uk/bitstream/handle/2299/23955/Pages_from_social_research_practice_journal_issue_10_winter_2021.pdf?sequence=1&isAllowed=y

Prather, C., Fuller, T. R., Jeffries, W. L., Marshall, K. J., Howell, A. V., Belyue-Umole, A., & King, W. (2018). Racism, African American women, and their sexual and reproductive health: A review of historical and contemporary evidence and implications for health equity. *Health Equity 2*(1), 249–259. doi: 10.1089/heq.2017.0045.

Purewal, S. K., Au, V., Koita, K., Oh, D. L., Briner, S., Burke Harris, N., & Bucci, M. (2018). Ameliorating the biological impacts of childhood adversity: A review of intervention programs. *Science Direct,81*. doi: 10.1016/j.chiabu.2018.04.014.

Rhodes, R. L. (2021). Racial disparities: The unintended consequence. *Journal of the American Geriatrics Society*, *69*(12), 3416–3418. https://doi.org/10.1111/jgs.17479

Rodriguez-Knutsen, A. (2023, February 8). *Why BIPOC women receive unequal healthcare*. YWCA. https://www.ywcaworks.org/blogs/ywca/BIPOC-unequal-health-care#:~:text=This%20gender%20bias%20is%20particularly,emergencies%20and%20deaths%20every%20year

Roeder, A. (2019). *America is failing its black mothers.* Harvard Public Health.

https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/

Spears, T., & Schmader, W. (2021). Unconscious bias in healthcare. *Physician Leadership Journal, 8*(2), 22–24.

Suarez-Balcazar, Y., Buckingham, S., Rusch, D. B., Charvonia, A., Young, R. I., Lewis, R. K., Ford-Paz, R. E., Mehta, T. G., & Perez, C. M. (2023). Reproductive justice for Black, Indigenous, women of color: Uprooting race and colonialism. *American Journal of Community Psychology*. https://doi.org/10.1002/ajcp.12650.

Tsai, Y. (2011). Relationship between organizational culture, leadership behavior and job satisfaction. *BMC Health Serv Res 11*, 98. doi: 10.1186/1472-6963-11-98.

Tucker Edmonds, B., Sharp, S., Walker, V. P. (2023). Mitigating misogynoir: Inclusive professionalism as a health equity strategy. *Clinical Obstettrics & Gynecology, 66*(1):14-21. doi: 10.1097/GRF.0000000000000768.

United States Constitution, Art. IV, §1, cl. 1.

Werner, R. M., Asch, D. A., & Polsky, D. (2005). Racial profiling: The unintended consequencesof coronary artery bypass graft report cards. *Circulation, 111*(10): 1257-1263. https://doi.org/10.1161/01.CIR.0000157729.59754.09

Zewude, R., & Sharma, M. (2021). Critical Race Theory in medicine. *CMAJ: Canadian Medical Association Journal*, *193*(20), E739+. https://libproxy.ecpi.edu:2242/apps/doc/A662305354/AONE?u=lirn55593&sid=bookmark-AONE&xid=b9fce1cb

Zhu, Y. (2019). Can participatory action research empower participants in adult education studies? *The Canadian Journal for the Study of Adult Education*, 63–73.

APPENDIX A:

Fast Track Survey/Interview Questions IRB Application

Account/Department

SoE Dean's Office (220000)

Service

Institutional Review Board (IRB) / Institutional Review Board (IRB) D-2 Fast-Track Survey/Interview Application

Created

Wed 4/12/23 3:24 PM by Andre White

Last Modified

Thu 4/13/23 1:52 PM by Danita Nelson

Are you a student?

Yes

Faculty advisor name

Aaliyah Baker

Project title

Dissertation in Practice

No federal funds will be used in this research.

Agree

No compensation will be offered to participants.

Agree

No subjects under the age of 18 will be used in this research.

Agree

No deception will be used in this research.

Agree

The researcher has permission to conduct their research at the data collection site.

Show Help for The researcher has permission to conduct their research at the data collection site.

Agree

What location(s) will you be conducting research/collecting data?

Zoom

Survey Data and Interview Responses will be secured and kept private using lock-and-key (paper data) or password-protected computer files (digital data) on a computer with limited access.

Agree

Access to the research data will be protected and restricted to the researcher and/or faculty member.

Agree

This type of research does not require the researcher to document informed consent. In lieu, the researcher will use the University-approved Invitation/Information Sheet template (see the IRB website). This sheet will be provided to the subjects prior to data collection.

Show Help for This type of research does not require the researcher to document informed consent. In lieu, the researcher will use the University-approved Invitation/Information Sheet template (see the IRB website). This sheet will be provided to the subjects prior to data collection.

Agree

Provide a brief abstract of your research or project that includes the following sections: Background and Purpose, Participants, and Methods.

Show Help for Provide a brief abstract of your research or project that includes the following sections: Background and Purpose, Participants, and Methods.

The purpose of this qualitative study with a participatory action research design is to explore the lived healthcare experiences of Black women in the state of North Carolina. This study will allow participants to share their perception of and their lived experiences with the health care system in North Carolina. 10 Black women will be interviewed using a peer-to-peer participatory action research interviewing method.

APPENDIX B:

Participant Recruitment Email

Hello!

Thank you so much for reaching out and your willingness to participate in my study!

Let me tell you a little bit about myself and my study! My name is André White Jr., I am 27 years old, originally from Cleveland, Ohio, but I have called North Carolina my home for the last 18 years. I have a Bachelor's degree in Communication Studies with a minor in Clinical Psychology, a Master's Degree in Conflict Studies concentrating on Education, and I am matriculating towards a Doctorate of Education (EdD) focused in Organizational Leadership.

In 2018, I lost my younger brother, Aaron, to an aggressive and fast growing brain tumor that took him from this world in less than 90 days. Living through that experience gave me a newfound passion for advocacy for marginalized people in spaces that have been disadvantageous for us, including, but not limited to, the healthcare space, the workspace, etc.

My Dissertation in Practice (DIP) is an in depth study I have been working on for the last two and a half years. It is a phenomenological qualitative study focusing on the lived experiences of Black women in North Carolina's healthcare system as it relates to their pregnancy. I am seeking to investigate and critique the pervasive and insidious system barriers that plague our communities. Through this study, I am looking to add to the existing body of work and research that exists already.

For this study, as a participant, you'd be interviewed in a peer-to-peer method over zoom. What this means is you and another participant would be given a set of interview questions and answer them in the form of conversation with one another. These interviews will be very informal. You are encouraged to share as much or as little as you wish. The discussion would be moderated by a female identifying member of my nonprofit organization and not myself. Since I am a male and the subject matter of these discussions is personal, your comfort level is at the forefront of my priorities, so I will not be moderating.

Your privacy is paramount. The interviews will be recorded but you can be assured that your identity will be safe and an alias will be used in place of your name in the written study.

Attached to this email is a privacy consent form as well a list of the interview questions that you will be asked to speak on. We would like to conduct interviews during the week of Monday, May 29th - Sunday June 4th.

If you are willing to participate in this study please respond to this email with the signed consent form, your availability for 5/29-6/4, and any questions, comments, or concerns that you may have. I can be reached at this email ---- whitea47@udayton.edu

I truly and genuinely appreciate your interest in this study. Thank you!

APPENDIX C:

Invitation to Participate in Study

Research Project Title: **The Underground Railroad: Critical Race Theory, Oppression, and the Fight for Equitable Treatment in the North Carolina Health System**

You have been asked to participate in a research project conducted by André White Jr. from the University of Dayton, in the Department of Education Administration, School of Health and Human Sciences.

The purpose of this qualitative study with a participatory action research design is to explore the lived healthcare experiences of Black women in the state of North Carolina. This study will allow participants to share their perception of and their lived experiences with the health care system in North Carolina.

You should read the information below, and ask questions about anything you do not understand, before deciding whether or not to participate.

- Your participation in this research is voluntary. You have the right not to answer any question and to stop participating at any time for any reason. Answering the questions will take about 90 minutes.
- You will not be compensated for your participation.
- All of the information you tell us will be confidential.
- If this is a recorded interview, only the researcher and faculty advisor will have access to the recording, and it will kept in a secure place.
- If this is a written or online survey, only the researcher and faculty advisor will have access to your responses. If you are participating in an online survey: We will not collect

identifying information, but we cannot guarantee the security of the computer you use or the security of data transfer between that computer and our data collection point. We urge you to consider this carefully when responding to these questions.

- I understand that I am ONLY eligible to participate if I am over the age of 18.

Please contact the following investigators with any questions or concerns:

André White Jr, whitea47@udayton.edu / Phone Number: 980-288-2161

Dr. Aaliyah Baker, abaker1@udayton.edu

If you feel you have been treated unfairly, or you have questions regarding your rights as a research participant, please email IRB@udayton.edu or call (937) 229-3515.

Researcher _____ Participant _____

APPENDIX D:

Interview Questions

1. How did you feel about your prenatal care experience leading up to the birth of your child?
2. Did you feel like your concerns and questions were addressed adequately by your healthcare provider during your pregnancy? Please Elaborate.
3. How did you choose the hospital where you delivered your child? Was it a difficult decision?
4. Can you describe your experience during labor and delivery? Did you feel like you were treated respectfully and with dignity?
5. Were you given pain relief options during labor? If so, were you given enough information to make an informed decision about which options to choose?
6. Did you feel like your healthcare provider communicated clearly with you throughout your labor and delivery? Were they responsive to your needs?
7. Were you given the opportunity to have a support person or doula present during your labor and delivery? If so, how did they contribute to your experience?
8. Were you satisfied with the level of support you received from the nursing staff during your hospital stay? Did you feel like they were attentive to your needs?
9. Did you experience any complications or unexpected events during your hospital stay? How were these handled by the healthcare team?
10. Looking back on your hospital experience, is there anything you wish had been done differently?

11. Do you feel there was any correlation between your hospital experiences and your identity as a Black woman?

12. Do you believe that your healthcare providers were adequately prepared?