It’s Not Always Rainbows and Unicorns: The Lived Experience of Severe Maternal Morbidity among Black Women

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It’s Not Always Rainbows and Unicorns:
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Lucinda Canty, PhD, CNM

University of Connecticut, 2020

In the United States, Black women have a long history of poor maternal health outcomes. Black women are three to four times more likely to die from a pregnancy-related complication and twice as likely to experience severe maternal morbidity when compared to White women. A serious gap exists in our knowledge of the reasons for health disparities in maternal health; factors contributing to disparities in maternal health are complex and not clearly understood. The experience of severe maternal morbidity among Black women can assist with identifying the causes of these disparities and assist with the development of interventions to address the issue. The purpose of this study was to better understand the experiences of Black women who experienced severe maternal morbidity during childbirth and postpartum. The principles of van Manen’s interpretive phenomenology (1990) were the methodology used for this study.

The purposeful sample included nine participants who were all female, Black, and who experienced a severe complication during childbirth or postpartum. Essential themes of their experience identified were: 1. I Only Know What I Know; 2. Faced with Uncertainty; 3. How You Cared For me: subtheme 1: Part of someone’s routine; subtheme 2: Felt safe and cared for; 4. Race matters; and 5. Still healing. The themes demonstrate the complexity of severe maternal morbidity among Black women and the influence of the role of health care professionals. This study contributes to the knowledge of the experience of severe maternal morbidity and provides a foundation for future studies that investigate disparities in maternal health.
It’s Not Always Rainbows and Unicorns:
The Lived Experience of Severe Maternal Morbidity among Black Women

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B.S.N., Columbia University, 1991
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Doctor of Philosophy Dissertation

It’s Not Always Rainbows and Unicorns:
The Lived Experience of Severe Maternal Morbidity among Black Women

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The following research would not have been possible without the women who shared their experiences with me. I'm honored that you trusted me with your personal birth experiences. I learned so much from each of you. I will make sure this research is used to support Black women in their childbirth journey and improve maternal health outcomes among all women.

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Chapter One. Overview of Problem

Introduction

This dissertation is a report of a phenomenological study of the experience of Black women who suffered severe maternal morbidity during childbirth or postpartum. This first chapter, It’s Not Always Rainbows and Unicorns, includes the background, significance and purpose of the study.

The background section contains information regarding the prevalence of severe maternal morbidity. In this section, both historical and the current social context of severe maternal morbidity among Black women are highlighted. In the significance section, the need for qualitative studies that examine the experience of Black women during childbirth and postpartum is explored. In the Purpose of the Study section, I discuss why this phenomenological study was conducted and the goals of the study.

Background

Severe maternal morbidity, also referred to as a “near miss” or near fatal complication, is identified when a life-threatening obstetrical complication occurs during pregnancy, childbirth or postpartum. Severe maternal morbidity includes a preventable complication with significant consequences to the women’s health, one that could have resulted in her death (Brown et al., 2011; Kuklina & Goodman, 2018).

Severe maternal morbidities are pregnancy-related complications that have been classified as conditions that result in extended hospitalizations, transfer to an intensive care unit or require blood transfusions (Aziz et al., 2019; Callaghan et al., 2012). Examples of these conditions are cardiomyopathy, cardiac arrest, severe preeclampsia, eclampsia, sepsis, and postpartum hemorrhage (Aziz et al., 2019; Callaghan et al., 2012).
In the United States (U.S.), there has been an increase in severe maternal morbidity during childbirth and postpartum, affecting approximately 0.5% to 2% of births annually (Callaghan et al., 2012; Gray et al., 2012; & Ozimek et al., 2016). Black women disproportionately experience higher rates of severe maternal morbidity compared to White women. Black women are three to four times more likely to die from pregnancy-related causes than White women (Creanga et al., 2017). The maternal mortality ratio (MMR) for Black women from 2011 to 2015 was 48.2 deaths per 100,000 live births, compared with 13 deaths per 100,000 live births in White women (Center for Disease Control and Prevention (CDC), 2019). Also, Black women are twice as likely to experience life-threatening complications during childbirth and postpartum compared to White women (Conrey et al., 2019; Creanga et al., 2014a; Grobman et al., 2015; & Howell et al., 2016; Metcalfe et al., 2018).

Current research into maternal mortality and severe maternal morbidity demonstrate that racial and ethnic health disparities continue to exist (Creanga et al., 2012; Creanga et al., 2017). Studies designed to investigate the causes of these disparities, predominately epidemiologic studies, have identified an association between race, co-morbidities, underutilization of prenatal care, insurance status, geographical location and socioeconomic status, and increased risk for pregnancy-related mortality, and severe pregnancy complications (Creanga et al., 2017; Mahmood et al., 2015; Moaddab et al., 2016; Shahul et al., 2015).

From 1993 to 2012, pregnant Black women had the highest in the prevalence of preexisting chronic diseases, such as, hypertension, diabetes, and asthma compared to pregnant White women; 17.3% of Black women had at least one pre-existing co-morbidity compared to 10.3% of White women (Metcalfe et al., 2018). Black women were more likely to enter pregnancy with at least one chronic condition (Metcalfe et al., 2018). There has been an increase
in pregnancies with comorbidities, with the highest prevalence among Black women (Metcalfe et al., 2018). Higher rates of co-morbidities are thought to explain why Black women are at greater risk for pregnancy-related complications or death (Creanga et al., 2017; Metcalfe et al., 2018; Shahul et al., 2015). These conditions can be prevented and managed through adequate care before, during and after pregnancy, which can minimize these disproportionate risks to Black women.

Tucker and colleagues (2007) investigated the prevalence and mortality rates of each of the five leading causes of maternal mortality for Black and White women. Their findings identified no significant difference in the prevalence of preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum hemorrhage among Black women compared to White women. Despite this, Black women were 2 to 3 times more likely to die than White women experiencing these conditions (Tucker et al., 2007). The reasons why Black women have higher fatality rates have not been clearly identified.

**Historical Context**

Black women have a long history of poor maternal health outcomes in the U.S. The maternal and infant mortality rates for Black women and babies have always been higher than those of Whites. In 1937, the U.S. Children’s Bureau reported the MMR of Black women in comparison to White women from 1933 and 1935, during which approximately 2,400 Black women died annually from pregnancy and childbirth related conditions (Tandy, 1937). The MMR during this time period for Black women was 96.1 per 10,000 live births compared to 54.6 per 10,000 for White women (Tandy, 1937). Black women had significantly higher rates of maternal deaths. Of note, during the 1930s, the Black population represented approximately
9.9% of the U.S. population, demonstrating the sharp differences in maternal mortality ratios (U.S. Census Bureau, 2005).

The leading causes of maternal deaths for Black and White women from 1933 to 1935 were postpartum sepsis, preeclampsia and postpartum hemorrhage (Tandy, 1937). Health disparities in maternal health outcomes were evident at the time as deaths rates for Black women were higher for each condition. Specifically, Black women experienced higher rates of postpartum sepsis (37.2 per 10,000 live births compared to 21.8 per 10,000 for White women), preeclampsia (27.5 per 10,000 live births compared to 11.8 for White women), and postpartum hemorrhage at (8.7 per 10,000 live births compared to 6.1 per 10,000 for White women) (Tandy, 1937).

The U.S. Children’s Bureau acknowledged the gap in maternal health outcomes between Black and White women in maternal deaths, stillbirths and newborn and infant deaths (Tandy, 1939; Tandy, 1940). These differences were acknowledged and recorded due to improvements in documentation, such as birth and death certificates (Tandy, 1937; Tandy 1940). The reasons for poor maternal health outcomes were believed to be caused by inadequate care Black women received during pregnancy, childbirth and postpartum (Tandy, 1937; Tandy 1940). Reports also identified disparities in other variables, such as the health status of the women, lack of prenatal care and lay midwives attending births, as well as births that occurred in the home as opposed to births in the hospital (Lee, 1977; Tandy, 1937; Tandy 1940).

It is important to keep in mind the social context of the time and conditions that affected the health and wellbeing of Black women. In the 1940s, Black Americans made up 10% of the total U.S. population with higher concentrations in the South, where they represented approximately 25% of the population (Embree, 1941). Black Americans encountered racial
segregation and discrimination in employment, housing, health care, and education (Embree, 1941). Racial discrimination was obvious in the Southern states; it also existed in the Northern states (Embree, 1941). Jim Crow Laws were passed in the 1880's, legalizing segregation in Southern states and limiting access to health care services. These social determinates of health contributed to these poor maternal health outcomes among Black women and their babies (Canty, 1994).

Over the years, the maternal death rates decreased in the U.S. for both Black and White women. However, maternal death rates remained 2 to 3 times higher for Black women than the rates for White women. In 1946, the U. S. Public Health Service reported the MMR for Black women at 77.3 per 10,000 compared to 32.0 per 10,000 for White women (Gover, 1946). The Black-White gap in health disparities widened. During this time, death during childbirth was the second leading cause of death for Black women aged 15 to 44, only second to tuberculosis (Gover, 1946).

Although the maternal death rates decreased from 1940 to 1972 among both Black and White women, health disparities between Black and White women continued to persist (Lee, 1977). The risk of death from childbirth remained greater for Black women. Midwife-attended births, home births, and underutilization of prenatal care were factors that were believed to contribute to the difference in maternal deaths between Black and White women (Lee, 1977). Midwives attended approximately 50% of births for Black women compared to 4% of White births (Lee, 1977; Tandy, 1937). Twenty-five percent of Black women began prenatal care in the first and second months of pregnancy; 10% in the third trimester and 5% did not receive any prenatal care (Lee, 1977). No statistical data were provided on the onset of prenatal care for the remaining 60% of Black women.
Midwives were blamed for the racial differences and poor maternal health outcomes among Black women. However, research suggests that midwives were actually beneficial to the communities they served because they improved access to maternity services that were limited due to racism, segregation and lack of financial resources (Barry & Boyle, 1996; Canty, 1994). At that time, midwives did not receive any formal training. They learned their trade as apprentices from their grandmothers, mothers, or other senior midwives in the community. For many Black women, midwives were a safe and reliable option (Barry & Boyle, 1996; Graham-Tightman, 2002). Racism, segregation and poverty prevented Black women from utilizing the services of obstetricians (Robinson, 1984). Most Black women could not afford medical care or hospitalization and depended heavily on midwives for care during childbirth (Thomas, 1942). Several public health programs were developed utilizing public health nurses and nurse-midwives to work in collaboration with midwives to educate women about promoting sanitary conditions, handling emergencies and when to call for assistance (Canty, 1994; Thomas, 1942).

Overtime for Black women there was a shift from the home births to hospital births and from midwife-attended births to physician-attended births (Lee, 1977; Tandy, 1937). State regulations posed challenges to practicing midwives, as state mandated programs and licensure requirements created barriers for them to practice (Graham-Tightman, 2002). In 1950, granny midwives attended 50% of the births by Black women; by 1972, granny midwives only delivered 1% (Lee, 1977). The rates of deliveries attended by physicians slowly increased among Black births. In 1950, physicians delivered 50% of the births by Black women (Lee, 1977). From 1950 to 1966, the percentage of Black women who gave birth in hospitals increased from 60% to 90% (Lee, 1977). Contrary to the belief held by many that these changes helped to reduce the maternal disparities experienced by Black women, the disparities remained (Lee, 1977).
It is essential to be aware of the historical aspects of childbirth among Black women to address severe maternal morbidity. Poor maternal health outcomes among Black women are not a new phenomenon. Although there have been changes in the social context in which Black Americans live in the U.S., Black women continue to have the worst maternal health outcomes compared to all other racial or ethnic groups.

**Current Social Context**

According to the CDC (2019), the maternal mortality ratio (MMR) increased from 7.2 per 100,000 live births in 1987 to 17.2 per 100,000 live births in 2015. The U.S. is the only industrialized country in which there has been an increase in maternal deaths over this time period. Since 1987, the MMR among Black women was consistently 3 to 4 times greater than the MMR among White women (Berg et al., 2003; Berg et al., 2010; Koonin et al., 1997; Creanga et al., 2015; Creanga et al., 2017). From 1987 to 1990, the overall MMR was 9.2 per 100,000 live births (Koonin et al., 1997). The MMR for Black women was 22.9 per 100,000 compared to 6.3 for White women. In 2015, the MMR for Black women increased to 42.8 deaths per 100,000 live births compared to 13.0 deaths per 100,000 live births for White women (Koonin et al., 1997). Poor maternal health outcomes continue to persist into the present day (CDC, 2019).

The leading causes of pregnancy-related deaths from 2011 to 2015 were cardiovascular conditions (15.1%), sepsis (12.4%) hemorrhage (11.2%), cardiomyopathy (10.8%) and hypertensive disorders of pregnancy (6.8%) (CDC, 2019). Approximately 60% of these deaths were preventable (Petersen et al., 2019). Black women have the highest prevalence of severe maternal morbidity, surpassing any other racial or ethnic group (Leonard et al., 2019; Metcalfe et al., 2018). From 2012 to 2015, Black women experienced severe maternal morbidity at a rate of
231.1 per 10,000 births compared to White women at 139.2 per 10,000 and at rates higher than any other racial or ethnic group (Admon et al., 2018).

For every maternal death in the U.S., it is estimated that 100 women will experience severe maternal morbidity (Callaghan et al., 2012). There has been a significant increase in severe maternal morbidity over the last 20 years (CDC, 2017). From 2007 to 2014, there was a 65% increase in the prevalence of severe maternal morbidity with Black women disproportionally affected compared to other racial and ethnic groups (Leonard et al., 2019). The reasons for this significant increase remain under investigation and are believed to be associated with an increase in births to women 40 years and older, obesity, and pre-existing co-morbidities (Leonard et al., 2019).

During childbirth, Black women are more likely than White women to experience disseminated intravascular coagulation, renal disease, respiratory disease, hypertension, and cardiomyopathy (Admond et al., 2018; Gyamfi-Bannerman et al., 2018) – all causes of severe maternal morbidity. Black women are also more likely than White women to experience postpartum hemorrhage and have to have a hysterectomy performed (Gyamfi-Bannerman et al., 2018).

Black women are more likely to be readmitted postpartum with severe maternal morbidity. Common causes for readmission include pulmonary edema, heart failure, eclampsia, acute respiratory distress syndrome, and renal failure (Aziz et al., 2019). Black women had a 126% greater risk for developing pulmonary edema compared to White women (Aziz et al., 2019). They experience more severe symptoms from these conditions compared to their White counterparts and they are more likely to die.

Race has been identified as an indicator placing Black women at increased risk for
pregnancy related morbidity and mortality. After controlling for pre-existing chronic diseases, onset of prenatal care, socioeconomic status, geographic location, insurance status, and type of delivery, Black race is an independent factor that places women at risk for poor maternal outcomes (Aseltine et al., 2015; Gyamfi-Bannerman et al., 2018; Harper et al., 2004; Howland et al., 2018; Leonard et al., 2019; Rosenberg et al., 2006; Tangel et al., 2019). Further research is needed to identify the reasons why race places a Black woman at risk for preventable maternal death.

In 2002, the National Institute of Health released the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley et al., 2003). The report provides a panel of experts’ discussion about how persons of color, especially Black people, are treated differently when they enter the health care system. This report increased awareness that race and ethnicity have an effect on the quality of care one receives and that this treatment contributes to health disparities. The findings in this report underscore questions about the quality of care Black women receive during childbirth and postpartum, and how this might contribute to the rates of severe maternal morbidity and maternal mortality (Smedley et al., 2003).

Serena Williams, a professional tennis player, highlighted severe maternal morbidity among Black women when she shared her childbirth experience in *Vogue Magazine* and on CNN.com (Haskel, 2018; Williams, 2018). She discussed the life-threatening complication she experienced after having a cesarean birth. She described the challenges she experienced when she reported her symptoms to the nurse caring for her. She discussed needing to advocate for herself to receive the necessary diagnostic tests, including a CT Scan, which led to her being diagnosed with a pulmonary embolism. She described her experience starting 24 hours after birth
as “6 days of uncertainty” as she was unsure if she would receive the appropriate medical treatment. She had to be persistent with her health care providers so that she received the necessary treatment (Haskel, 2018). Her experience demonstrated how being in an upper socioeconomic status does not insulate Black woman from experiencing life-threatening complications.

The reasons for health disparities in maternal health are not clearly understood; factors contributing to disparities in maternal health are complex and may involve medical, environmental, genetic, and social-economic factors (Braveman et al., 2015; Bryant et al., 2010). Research is needed to understand how these factors contribute to poor health outcomes. To reduce racial and ethnic health disparities, it is important to understand how race places Black women at risk and why differences in maternal health outcomes between Black and White women continue to persist in the U.S.

The voices of Black women are marginalized or absent in the literature. Examining the lived experience of Black women who have suffered severe maternal morbidity can provide a bridge to understanding maternal mortality. This study contributes to the body of research regarding knowledge of the severe maternal morbidity experience of Black women and provides a framework for future examination. This study informs future research with the ultimate goal of developing interventions to improve maternal health outcomes in this population.

**Significance**

Little is known about the causes of health disparities from the perspective of Black women. Quantitative studies have primarily consisted of analyses of data from analyses of birth certificates, death certificates, vital statistics, and chart reviews. Although these are valuable sources of information to identify the medical causes of maternal morbidity and mortality, little
information identifying the factors that contribute to racial and ethnic health disparities is provided.

Qualitative methodology can be instrumental in obtaining data about the lived experiences of Black women who survived a severe maternal complication. Their experiences of the medical complications, the care they received, and the aftermath of the event provided rich data. Employing qualitative methodology provided an opportunity to examine the personal experience of Black women during childbirth and postpartum which reaped data beyond the statistics and allowed a deeper understanding of the lives of those most affected by poor health outcomes. Understanding the challenges Black women face in their everyday lives is essential, including how past and present experiences with racial discrimination influence their health care.

Using a phenomenological approach to understand the lived experience of severe maternal morbidity during childbirth and postpartum among Black women provided a better understanding of their relationship with health care providers, identified how race has an effect on the perception of care and the need for education and emotional support during pregnancy, childbirth and postpartum.

The women described what it was like to experience a life-threatening complication during childbirth and postpartum. Investigating the experience of severe maternal morbidity provided insight into understanding the role of health care providers caring for Black women during severe maternal morbidity. Also, their perceptions of the health care they received during childbirth and postpartum will contribute to the development of culturally appropriate interventions. This study contributes to the knowledge of the experience of severe maternal morbidity and provides a foundation for future studies that investigate disparities in maternal health.
Call to Research

As a Certified Nurse-Midwife with 25 years of experience in providing reproductive health care to women, I never thought about a woman dying during or after childbirth. Although I provided care to women who experienced severe complications, such as preeclampsia, eclampsia and postpartum hemorrhage, I never thought death was a possibility. I also never considered the long-term effects of experiencing a severe complication on their emotional and mental wellbeing.

When I started my doctoral studies, my focus was on disparities in reproductive health. I knew that racial inequality existed in health care. I wanted to understand by conducting research about the causes to allow me to develop interventions that would address those causes.

Through my coursework, I learned that Black women were more likely to represent newly diagnosed human immunodeficiency virus (HIV), be diagnosed at advanced stages in breast and cervical cancer, disproportionately acquire sexually transmitted infections, and were more likely to have poor prognoses after suffering a fracture from osteoporosis. I was unaware of the disparities that existed in maternal mortality and morbidity.

I became interested in the childbirth experience of women in other counties when I was enrolled in an International Health class. I wanted to understand how culture had an effect on a woman's childbirth experience. I also wanted to learn the challenges women experienced in obtaining the reproductive health care they needed.

When I first explored maternal mortality, I looked at other countries, particularly Sudan and Somalia. I selected these countries because I wanted to understand how conflict affects maternal health care. Although the focus of my coursework was global, it was during a weekly
online discussion that a classmate encouraged me to look into what was happening to women during childbirth in the United States (U.S.).

It was alarming to learn about the number of women who died annually during childbirth in the U.S. and that Black women disproportionately represented the number of maternal deaths. I wondered how a country with all of the resources, technology, and education that the U.S. has could have numbers comparable to countries that lacked these resources and were experiencing political conflict. I never thought that race would play a factor if a woman could survive childbirth. I never thought this would or could happen in the U.S.

I started to learn about maternal mortality and wanted to explore why women were dying during childbirth. I immediately went to the literature to search for existing research into maternal mortality and maternal morbidity. I also wanted to see who was investigating why Black women had worse maternal health outcomes than White women. I wanted to know the issues and how this problem was being addressed by the medical community. Mainly, I wanted to know how nursing research was addressing this problem; what was nursing doing to research and understand this issue? I wanted to know the reasons for the high mortality rates and why Black women were more likely to die.

I started to look at the literature to see what the research stated about these disparities. I did not find any clear explanations. The U.S. has an increase in maternal mortality, while other industrialized countries saw a decrease. Even countries that had limited resources have reductions in maternal mortality. As I started to investigate and learn more about maternal mortality, I learned that in the U.S. the number of women suffering from severe maternal morbidity has increased almost 200% from 1993 to 2014, and more that 50,000 women experienced severe maternal morbidity in 2014 (CDC, 2017). While there is data on contributing
factors, such as, pre-existing conditions, obesity, and late entry into prenatal care, there is nothing that specifically explains why Black women are disproportionately affected. If these women did not have an intervention done, they could have died. I wanted to know who these women were and what they had experienced.

Several studies that examined maternal morbidity (and mortality) had an incidental finding that Black women were more likely to die or experience a severe complication. These studies were predominately epidemiological studies. No qualitative studies were conducted to investigate Black women who experienced severe maternal morbidity. I wanted to know who are the women behind these statistics. I wanted to give these women a voice and share their experiences to provide valuable information that could offer solutions.

**Purpose**

The purpose of this study was to describe the experience of Black women who suffered severe maternal morbidity during childbirth or postpartum and to explore the meaning of severe maternal morbidity from their perspective. Using a phenomenological approach to understand the lived experience of severe maternal morbidity during childbirth and postpartum among Black women provides a better understanding of reasons that contribute to disparities in maternal health and will inform interventions to reduce disparities.

The experience of Black women with severe maternal morbidity is at the center of this investigation. Van Manen’s interpretive phenomenology provided a methodological approach to encourage women to discuss their experiences and perceptions in the context of maternal morbidity. The research question for this study was: What are the experiences of Black women who suffered severe maternal morbidity during childbirth or postpartum?
The purpose of this study was to better understand the experiences of Black women who experienced severe maternal morbidity during childbirth and postpartum. Medical conditions alone cannot explain why Black women are more likely to die when they experience a pregnancy-related complication. One must examine the type of health care Black women receive when they access care during childbirth and postpartum. The perspectives of Black women could provide insight into how they perceive their care and their health care needs.

**Conclusion**

Chapter one introduced the research study *It is Not Always Rainbows and Unicorn: The Lived Experience of Severe Maternal Morbidity among Black Women*. Chapter two contains a review of the literature on Black women who suffered a serious complication. In chapter three van Manen’s interpretive phenomenology as the method of this study is discussed. The results of this research are presented in chapter four. Chapter five contains the discussion of the findings related to other research, implications for clinical practice and future research, as well as limitations and recommendations for future research.
Chapter Two. Review of Literature

Introduction

In this chapter, I discuss the review of the literature. In the literature search, I searched for research studies that focused on the experience of Black women that suffered severe maternal morbidity. I located research studies regarding racial-ethnic health disparities in severe maternal morbidity, particularly Black-White differences in pregnancy-related complications. The articles in this review focused on the causes of severe maternal morbidity and why Black women are at higher risk for severe maternal morbidity compared to White women.

Procedure

To address the health disparities in maternal morbidity, it is important to understand the childbirth experiences of Black women. Black women have a long history of significant differences in maternal health outcomes compared to White women. Understanding why poor maternal health outcomes among Black women continue to persist in the U.S. involves learning about their experiences during childbirth and what is known about those experiences that may place them at risk.

The Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Sociological Abstracts and PsycInfo databases were searched using these key search terms: African American or Black women, pregnancy, childbirth, maternal mortality, maternal morbidity, pregnancy complications, qualitative and the United States. There were no limitations set for the years of publications. Studies included in this review were conducted in the U.S. and were designed to examine Black/White disparities in severe maternal morbidity and the experience of Black women during childbirth. Excluded were studies conducted outside of the
U.S., and those that did not present isolated results for Black women and that focused on infant mortality or neonatal health outcomes.

**Results**

No qualitative studies were found that focused specifically on the experience of Black women with severe maternal morbidity in the U.S. It was challenging to find relevant articles due to the limited number of qualitative studies published on the experience of Black women during childbirth. Only three qualitative studies were found that examined the experience of Black women during childbirth.

Twenty-five quantitative studies were identified in which researchers examined racial disparities and severe maternal morbidity. These studies are primarily epidemiologic studies reporting data analyses of medical records, International Classification of Diseases, ninth revision (ICD-9)/International Classification of Diseases, tenth revision (ICD-10) codes, discharge summaries and newborn birth certificates. Although these studies provide valuable sources of information in regards to identifying the medical causes of maternal morbidity and documenting that health disparities do exist, there is limited information on the experience of the women who lived it.

Research indicates that Black women experience disproportionately higher rates of severe maternal morbidity compared to other racial or ethnic groups (Admon et al., 2018; Cabacungan, Ngui, & McGinley, 2012; Creanga et al., 2014a; Gyamfi-Bannerman et al., 2018; Howell et al., 2016a; Howland et al., 2019; Leonard et al., 2019). Severe maternal morbidity affects Black women at two times the rate of White women (Conrey, et al., 2019; Creanga et al., 2014a). Admon and colleagues (2018) found that Black women experienced severe maternal morbidity at
a rate of 231.1 per 10,000 births compared to White women at 139.2 per 10,000 and at rates higher than any other racial or ethnic group.

The Centers for Disease Control (CDC) identified 25 delivery-related indicators that designate a condition as severe maternal morbidity based on ICD-9 codes (see Table 1) (Creanga et al., 2014a). These indicators demonstrate the severity of the situation and assist with classification as a “near miss” or life-threatening situation. Leading indicators for severe maternal morbidity are blood transfusion, disseminated intravascular coagulation (DIC), heart failure during surgery or procedure, hysterectomy, cardiac monitoring and ventilation (Creanga et al., 2014a). An example would be a woman who has a postpartum hemorrhage that results in a hysterectomy or requires blood transfusion due to significant blood loss.

Black women had higher rates for 22 of the 25 indicators (see Table 1) as compared to White women and other racial and ethnic groups (Creanga et al., 2014a). Black women had higher rates of blood transfusions, cardiac monitoring, heart failure, DIC, acute respiratory distress syndrome, ventilation, hysterectomies, and acute renal failure (Creanga et al., 2014a). Black women had the highest rates of severe maternal morbidity among both women who received blood transfusions and those who did not (Admon et al., 2018; Creanga et al., 2014a). Black versus White women with severe maternal morbidity who received blood transfusions were at a rate 284.26 per 10,000 compared to 113.93 per 10,000. Black women with severe maternal morbidity who did not receive blood transfusions were 131.67 per 10,000 compared to White women at 48.06 per 10,000.

Black women also continue to be at greater risk for maternal complications during the postpartum period compared to White women (Aseltine et al., 2015; Aziz et al., 2019; Gyamfi-Bannerman et al., 2018). Aseltine and colleagues (2015) found that 30-day readmission rates
were significantly higher after cesarean birth among Black women (28.9 per 1,000 readmissions) compared to White women (12.9 per 1,000). The most common reasons Black women had for readmission within 30 days postpartum of cesarean birth were due to hypertension, infection, postpartum hemorrhage, or surgical wound infections. For vaginal births, Black women also had high readmission rates at 14.6 per 1,000 readmissions compared to White women at 7.5 per 1,000. The most common reasons for readmission after vaginal births were for infection, hypertension and postpartum hemorrhage (Aseltine et al., 2015).

Aziz and colleagues (2019) also found that Black women had an 80.4% greater risk of readmission during the postpartum period and a 27% greater risk of severe maternal morbidity compared to White women during that readmission compared to all other racial and ethnic groups. Black women had higher rates of mild, severe and superimposed preeclampsia compared to other racial and ethnic groups (Aziz et al., 2019). They were also at higher risk to suffer from conditions, such as pulmonary edema and acute heart failure. Readmission rates for these conditions were 8.4% for Black women compared to 3.7% for White women (Aziz et al., 2019). Due to these conditions, Black women were more likely to experience a higher severity of complications during the postpartum period compared to White women.

Black women were significantly more likely to experience severe postpartum hemorrhage compared to White women (Gyamfi-Bannerman et al., 2018). Compared to White women, Black women who experienced postpartum hemorrhage had higher rates of blood transfusions (26.6% versus 20.7%), DIC (8.4% versus 7.1%), and emergency hysterectomies (2.4% versus 1.9%) (Gyamfi-Bannerman et al., 2018). Black women who experienced postpartum hemorrhage had five times higher mortality rates at 121.8 per 100,000 births compared to 24.1 for White women.
Small and colleagues (2012) examined severe maternal morbidity and obstetrical intensive care unit (ICU) admission. Black women represented the largest number of ICU admissions and 87% of these women were admitted postpartum. The leading condition for ICU admissions was cardiovascular disease at 36% with cardiomyopathy as the leading diagnosis. Hemorrhage was the second leading cause at 29%, followed by sepsis (9%), hypertensive disorders (9%), and pulmonary embolus (3%).

Black women with cardiomyopathy were more commonly diagnosed during the postpartum period instead of during the pregnancy compared with White women who were more likely diagnosed during the pregnancy (Goland et al., 2013). Eighty-three percent were diagnosed during postpartum compared to 64% of White women. Black women were often farther advanced in the disease process and 72% presented as New York Heart Association (NYHA) functional class III and IV with severe symptoms compared to 42% of White women (Goland et al., 2013). Black women were more likely to be symptomatic with limited activity and at rest, and have significantly larger left ventricular size. Black women who were diagnosed with cardiomyopathy had a higher prevalence of gestational hypertension compared to White women (61% versus 41%) (Gorland et al., 2013).

**Black Women’s Experience of Childbirth**

Although no studies specifically focused on Black women’s experience with severe maternal morbidity during childbirth, three studies included information about childbirth from the perspective of Black women. Raines & Morgan (2000) conducted an exploratory study using a descriptive, qualitative design to explore the cultural meanings of support, presence, and involvement during childbirth. Using the grounded theory approach informed by Strauss and Corbin (1990), they explored the perceptions and beliefs of 10 Black women and 10 White
women who delivered within the last 72 hours. The findings suggest there are cultural differences between the Black and White women in this study.

Raines and Morgan (2000) identified cultural differences in factors that influence comfort. Black women in the study found the presence of the family members provided comfort and safety during their birth experience. The presence of female family members, particularly mothers and sisters, were identified as important to Black women. White women in the study reported pharmacological interventions such as epidurals and medication provided the primary source of comfort. Both groups felt it was important for the baby’s father to be present.

Raines and Morgan (2000) identified cultural differences in the role of the support people present during birth. While White women wanted the support in the form of coaching during labor, for Black women, the support came in the form of someone just being physically present during labor (Raines & Morgan, 2000). Black women reported they just wanted their support people to be there and did not see their family members as coaches (Raines & Morgan, 2000).

Fries (2010) conducted a qualitative descriptive study using Colaizzi’s phenomenology to examine the experience of Black women who had an unplanned cesarean birth. The sample consisted of seven Black women who gave birth within the last year. Women who experienced an unplanned cesarean birth had mistrust of health care providers, feelings of being rushed into having a cesarean and the fear of the unknown. Fried (2010) also found that the women felt they sacrificed themselves for their babies.

Fries (2010) identified that Black women often sought resources outside of the health care system to prepare for childbirth. Information and advice received from family and friends helped the women prepare during the pregnancy. Also, their own previous birth experience assisted with their preparation for subsequent births (Fries, 2010).
Fries (2010) identified that communication with the health care provider was essential, and the timing of information was important for women. Delivery of information was also a concern for the women. The women discussed receiving incomplete information, not receiving information promptly, or not receiving information at all. Some perceived that the provider withheld information about concerns and informed them late, leaving them with minimal time to make decisions about having a cesarean birth. Poor communication led to a distrust of health care providers.

Abbyad and Robertson (2011) conducted a descriptive qualitative design using focus groups to explore how Black women prepared for childbirth. The sample consisted of 12 Black women who were maternity health care providers. Abbyad and Robertson (2011) found that Black women consider childbirth a natural process. Black women often sought resources outside of the health care system to prepare for childbirth. They received education from close female family and friends, those who had previously experienced birth, like mothers, grandmothers, and sisters (Abbyad, & Robertson, 2011). Similar findings to Fries, their own previous birth experience, also assisted with their preparation for subsequent births (Abbyad & Robertson, 2011).

Abbyad and Robertson (2011) found that Black women want to be part of a health care system that is responsive to their needs, making them feel valued. The women described encounters with health care providers that treated them differently because of their race. The women believed that health care providers were not aware of their own implicit bias. The women in this study wanted to be empowered and prepared for childbirth (Abbyad & Robertson, 2011).

Factors that Place Black Women at Risk for Severe Maternal Morbidity
It is important to understand what places Black women at risk for severe maternal morbidity. Several researchers investigated which factors placed Black women at risk for severe maternal morbidity. Women who were more likely to suffer from severe maternal morbidity had lower socioeconomic status, state medical insurance, late onset of prenatal care or no prenatal care, or had one or more chronic medical conditions, such as hypertension, diabetes or obesity (Aseltine et al., 2015; Braveman et al., 2015; Bruce et al., 2012; Cabacungan, Ngui, & McGinley, 2012; Creanga et al., 2014b; Howell et al., 2016a; Howell et al., 2016b; Margerison, Catov, & Holzman, 2019; Small et al., 2012). Black race and higher maternal age were also indicators for higher risk for severe maternal morbidity (Aseltine et al., 2015; Aziz et al., 2019; Booker et al., 2018; Cabacungan, Ngui, & McGinley, 2012; Creanga et al., 2014a; Gray et al., 2012; Howell et al., 2016a; Howell et al., 2016b; Marshall et al., 2014). The hospital where Black women give birth has also been associated with risk for severe maternal morbidity (Howell et al., 2016a; Howell et al., 2016b).

**Socioeconomic Factors.** Women who resided in low-income neighborhoods had higher rates of maternal morbidity compared to women of higher income neighborhoods (Creanga et al., 2014a; Howell et al., 2016a). There was a higher prevalence of low socioeconomic status (SES) among Black women who experienced severe maternal morbidity compared to White women (Aseltine et al., 2015; Bruce et al., 2012; Cabacungan, Ngui, & McGinley, 2012; Howell et al., 2016a; Margerison, Catov, & Holzman, 2019). Howell and colleagues (2016a) found that 47% of Black women who experienced severe maternal morbidity lived in low-income areas compared to 20.5% of White women.

Disparities in severe maternal morbidity occurred across all socioeconomic levels for Black women (Bruce et al., 2012; Howland et al., 2019). While higher SES has been correlated
with improvements in maternal health outcomes among White women, a higher socioeconomic position did not lower risk for severe maternal morbidity among Black women (Bruce et al., 2012; Braveman et al., 2015). Howland and associates (2019) found that although women living in low-income areas had higher rates of severe maternal morbidity, Black women residing in high-income areas and who had higher educational levels were still disproportionately affected by severe maternal morbidity compared to their White counterparts.

In New York City, Black women experience three times higher rates of severe maternal morbidity compared to White women (Howland et al., 2019). From 2008 to 2012, Black women had a rate of severe maternal morbidity of 386.9 per 10,000 deliveries compared to 126.7 per 10,000 deliveries for White women (Howland et al., 2019). Black women continue to have higher rates of poor maternal health outcomes regardless of income level or educational status. While an increase in educational status had an effect on lowering the rates of severe maternal morbidity among other racial and ethnic groups, Black women continued to have the most significant disparities compared to White women. Black women with a college degree had higher rates of severe maternal morbidity than White women who had not graduated from high school (333 per 10,000 compared to for 131.5 per 10,000) (Howland et al., 2019).

Medicaid insurance has been identified as a positive predictor for severe maternal morbidity (Aziz et al., 2019; Cabacungan, Ngui, & McGinley, 2012; Creanga et al., 2014a; Gyamfi-Bannerman et al., 2018; Small et al., 2012). Black women were more likely to have Medicaid insurance (Aziz et al., 2019; Cabacungan, Ngui, & McGinley, 2012). Aziz and colleagues (2019) found that 62.0% of Black women readmitted for complications during the postpartum period had Medicaid coverage compared to 39.8% of White women. The association between Medicaid coverage and severe maternal morbidity is not clearly established. Medicaid
provides access to care during pregnancy, childbirth, and postpartum. There is no mention of the quality of care that women with public insurance receive before and during birth and postpartum. Further research is needed to understand how Medicaid is a predictor for severe maternal morbidity and to determine if there a link to SES.

Maternal age. Maternal age has been associated with increased risk for severe maternal morbidity (Aseltine et al., 2015; Cabacungan, Ngui, & McGinley, 2012; Gyamfi-Bannerman et al., 2018). Women under the age of 20 had a higher risk for severe maternal morbidity compared to women aged 20 to 24, with a relative risk (RR) ratio of 1.2 (1.1-1.2) (Creanga et al., 2014a). Women aged of 35 to 39 also had higher rates of severe maternal morbidity compared to women age 20 to 24, RR = 1.4 (1.4-1.4) (Creanga et al., 2014a). Women aged 40 to 44 and 45 to 49 had higher rates of severe maternal morbidity compared to women age 21 to 24, RR = 1.8 (1.8-1.9) and RR = 3.1 (2.8-3.5) respectively (Creanga et al., 2014a). Higher rates of severe maternal morbidity were noted with an increase in maternal age, particularly for women over the age of 40 (Aziz et al., 2019; Creanga et al., 2014a; Gray et al., 2012; Gyamfi-Bannerman et al., 2018; Howland et al., 2019).

In births to women aged 40, Black women had the highest risk of severe maternal morbidity compared to White women with a RR = 2.04 (1.98–2.04) (Booker et al., 2018). Higher rates of preeclampsia, cesareans and gestational diabetes have been observed in this age group among all women, regardless of race or ethnic group, the most significant increase was among Black women (Booker et al., 2018). This population is also at increased risk for maternal mortality (Creanga et al., 2017). The reasons for this increase are believed to be a higher prevalence of chronic medical conditions and co-morbidities (Booker et al., 2018). Black women had a higher risk of death than White women with a RR ratio of 4.71 (3.36-6.61) (Booker et al.,
Creanga and colleagues (2017) found that Black women aged 40 and over had a mortality rate three and a half times greater than White women (192 deaths per 100,000 live births compared to 53.9 per 100,000 live births).

**Site of Birth.** The hospital where Black women give birth has been associated with their risk for severe maternal morbidity and may play a role in the quality of care they receive during childbirth. Black women who gave birth at hospitals serving predominately Black women, those with greater than 78% of their births by Black women, had higher risks for severe maternal morbidity than Black women who delivered at hospitals that delivered low numbers of Black women (22% of deliveries). The rates of severe maternal morbidity for Black women in hospitals delivering a high percentage of Black women were 17.3 per 1000 compared to 13.5 per 1000 Black women in hospitals delivering a low percent of Black women (Howell et al., 2016a). Hospitals that served large numbers of Black women during childbirth were more likely to be teaching hospitals, located in urban areas, and located in Southern states (Howell et al., 2016a).

Hospitals that had a higher percentage of births to White women (65% of White births) had lower rates of severe maternal morbidity than White women who delivered at hospitals that served predominately Black women (12.3 per 1000 compared to 19.2 per 1000 respectively) (Howell et al., 2016a). Howell and colleagues (2016a) demonstrated the need to further examine the health care system in understanding racial and ethnic health disparities in maternal health. Hospitals that served large numbers of Black women during childbirth had higher rates of severe maternal morbidity even after controlling for patient factors and hospital characteristics. The findings suggest that further investigation is needed into the quality of care provided at institutions with high rates of severe maternal morbidity.
**Pre-existing Medical Conditions and Comorbidities.** Women with pre-existing chronic medical conditions had an increased risk for severe maternal morbidity (Brown et al., 2011; Creanga et al., 2014a; Ghosh et al., 2014; Gray et al., 2012; Howell et al., 2016a; Metcalfe et al 2018). Women who started their pregnancy with chronic conditions, such as diabetes, heart disease, hypertension, respiratory disease, renal disease, liver disease, obesity and human immunodeficiency virus/ acquired immunodeficiency syndrome were at greater risks for severe maternal morbidity (Creanga et al., 2014a; Howland et al., 2019). Black women had the highest prevalence of every chronic health condition – including hypertension, diabetes, and asthma – compared to White women (Admon et al., 2017; Margerison, Catov, & Holzman, 2019). Women with pre-existing hypertension and obesity were more likely to experience severe preeclampsia and cardiomyopathy (Ghosh et al., 2014; Howland et al., 2019; Metcalfe et al 2018).

Black women were more likely to enter pregnancy with chronic diseases compared to White women (Aseltine et al., 2015; Howell et al., 2016; Leonard et al., 2019; Shahul et al., 2015). Black women were significantly more likely to be either hypertensive (28.5% vs. 15.4%) or prehypertensive (26.4% vs. 23.3%) compared to White women (Margerison, Catov, & Holzman, 2019).

The prevalence of comorbidities among Black women explain the higher rates of severe maternal morbidity (Howell et al., 2016). Obesity has also been associated with increased risk for postpartum complications, such as wound complications and sepsis (Aseltine et al., 2015; Howland et al., 2019; Shahul et al., 2015).

Among women who experienced severe maternal morbidity, there is a higher prevalence of obesity among Black women compared to White women (Harper et al., 2007; Leonard et al., 2019; Marshall et al., 2014; Small et al., 2012). Of women who suffered severe maternal
morbidity, Black women had higher BMIs and were more likely to be obese compared to White women. Black women who were admitted to the ICU for pregnancy-related complications had a mean BMI of 35 compared to a mean BMI of 28 among White women (Small et al., 2012).

There was no difference in rates of preeclampsia or cesarean births between Black and White obese women (Marshall et al., 2014). Women who were obese had higher rates of preeclampsia and cesarean births compared to women with a body mass index (BMI) in the normal range (Marshall et al., 2014).

**Utilization of Prenatal Care.** Prenatal care has a significant influence on maternal health outcomes. Women who start prenatal care early have better health outcomes (Howland et al., 2019). The maternal mortality rate for females who receive no prenatal care is five times greater than that of women who receive prenatal care for any duration (Berg et al., 2010; Harper et al., 2007). Howland and colleagues (2019) identified that women who did not receive any prenatal care had a severe maternal morbidity rate of 574.8 per 10,000 significantly higher than women who started prenatal care during the first, second, or third trimester, 208.2, 296.7, and 251.8 per 10,000 respectively).

Black women were more likely to start prenatal care in the second and third trimester of pregnancy compared to White women (Creanga et al., 2015). Harper and colleagues (2007) found that of women who experienced severe maternal morbidity, Black women were more likely to start prenatal care later than White women, the mean gestational age for the onset of prenatal care was 13 weeks compared to 9.8 weeks for White women. Black women were more likely to enroll in prenatal care later in the pregnancy or not receive any prenatal care at all as compared to White women (11.3% versus 3.6%) (Marshall et al., 2014). Black women were more likely to receive fewer prenatal visits compared to White women (10.3% vs 2.1%) (Painter
et al., 2018). Black women had higher rates of late entry into prenatal care and attended less than the recommended number of prenatal visits at 22.0% and 50.3%, respectively compared to White women at 12.2% and 42%, respectively (Bengiamin et al., 2010).

**Cesarean Births.** Cesarean births have been associated with severe maternal morbidity, due to the risk for potential postoperative complications. When compared to White women, Black women had higher rates of cesarean births, 33.2% compared to 29.2% (Leonard et al., 2019). Min and colleagues (2015) investigated the racial differences in risk factors for primary cesarean births, Black women had a cesarean birth rate of 24.7% compared to 22.2% for White women. Black women had a higher risk for having a primary cesarean birth compared to White women, RR, 1.32 (1.20 -1.44) (Min et al., 2015).

There has been an increase in cesarean births among Black women who are 40 years and older, increasing from 36.4% in 1998 to 55.6% in 2014 (Booker et al., 2018). During this time period, Black women had higher rates of cesareans compared to all other racial groups combined, 50.2% versus 44.8% (Booker et al., 2018). Black women age 40 or older had a higher risk for cesarean birth than White women, RR 1.72 (1.43 - 2.08) (Min et al., 2015).

A higher incidence of cesarean births was present among Black women who experienced severe maternal morbidity versus White women (36% compared to 32.7%) (Admon et al., 2018). Shahul and colleagues (2015) found that among women with preeclampsia, Black women had higher rates of cesarean births compared to White women, 57.20% compared to 26.28%.

**Black Race.** Research findings suggest that Black race is a factor that increases risk for severe maternal morbidity. Research findings demonstrate that race remained a significant predictor of severe maternal morbidity even after controlling for maternal age, underutilization of prenatal care, comorbidities, socioeconomic status, and insurance status (Aseltine et al., 2015;
Creanga et al., 2014a; Howell et al., 2016a; Howell et al., 2016b; Howland et al., 2019; Leonard et al., 2019). After controlling for these factors, Black women had two times higher rates of severe maternal morbidity compared to White women among women who received blood transfusions and those who did not, RR = 2.1 (2.0-2.2) and RR = 2.4 (2.3-2.5), respectfully (Creanga et al., 2014a).

Howland and colleagues (2019) found that race was a consistent factor placing Black women at a significantly higher risk for severe maternal morbidity compared to White women. After controlling for sociodemographics, Black women still had significantly higher rates of severe maternal morbidity compared to other racial and ethnic groups, adjusted odds ratio (AOR) of 1.84 (CI 1.72–1.97) (Howland et al., 2019). Booker and colleagues found that among women who are 40 years and older, Black women had a 104% higher risk for severe maternal morbidity than white women, RR 2.04 (1.98–2.04). After controlling for sociodemographics the risk for Black women remained elevated with an 81% increased for severe maternal morbidity, adjusted RR 1.81 (1.76–1.87) (Booker et al., 2018).

Several researchers’ findings demonstrate that Black women are at higher risk for severe maternal morbidity; however, there is no clear explanation of why their race places them at risk. Racism is believed to be a contributing factor to the increased rates of severe maternal morbidity among Black women. However, there is no consensus on how racism plays a role. Weathering is one concept that is believed to explain why Black women are at increased risk for poor maternal health outcomes compared to White women.

Geronimus (1996) introduced the conceptual framework, weathering, to explain the effects of chronic stress related to social inequalities due to racism and the influence on the health status of Black women. Weathering is an accelerated aging process that causes early
deterioration in health caused by chronic exposure to stress from racism and coping mechanisms (Geronimus, 1996; Geronimus, 2001). Weathering posits that this deterioration leads to the development of chronic conditions that Black women develop at an earlier age than White women. Weathering is theorized to place Black women at increased risk for morbidity and mortality, contributing poor infant health outcomes, such as low birth weight (LBW), preterm births, and infant mortality (Geronimus, 1996; Geronimus, 2001).

In the *Levels-Of-Racism: A Theoretic Framework and a Gardener's Tale*, Jones (2000) described the three levels of racism that exist in our society: structural, personally mediated, and internalized and theorized how they contribute to health disparities. Nuru and colleagues (2009) found that Black women experience these forms of racism throughout their lives, starting during childhood (Nuru-Jeter et al., 2009). It is believed that these experiences have long-term and profound effects on their physical and mental wellbeing (Nuru-Jeter et al., 2009). Regardless of socioeconomic level, Black women reported experiencing racism in a variety of settings (Nuru-Jeter et al., 2009).

Racism experienced by Black women can result in stress and anxiety, which has been associated with poor neonatal outcomes, such as premature births and low birth weight infants (Catov et al., 2016; Christian et al., 2013; Nuru-Jeter et al., 2009). Researchers who examined maternal health outcomes related to race with a focus on neonatal outcomes posit that chronic stress related to racism over a lifetime increases risks for preterm labor and birth, small for gestational age, low birth weight infants and infant mortality (Catov et al., 2016; Christian et al., 2013; Jackson et al., 2001).

The studies are limited and focus on women having low birth weight and premature infants, not on the health of the women or whether chronic stress plays a role in increasing the
risk for severe maternal morbidity. The focus of these studies has been on infant outcomes and do not concentrate on maternal health outcomes. There is a gap in the literature that investigates the impact of racism on severe maternal morbidity. There is no consensus on how to operationalize racism and determine how racism influences poor maternal health outcomes. There is a desperate need for research on the role of race and poor maternal health outcomes to develop our understanding of the role of racial health disparities in severe maternal morbidity.

**Conclusion**

Little is known about the experiences of Black women who experienced severe maternal morbidity during childbirth or postpartum as few researchers examine severe maternal morbidity from the woman’s perspective. Although research results clearly demonstrate that Black women are at increased risk of pregnancy-related morbidity, sociodemographics and medical conditions alone do not explain why Black women disproportionately represent pregnancy-related mortality and morbidity. Black race remained a significant predictor for severe maternal morbidity after controlling for these factors.

There is a gap in the research literature presenting the perspective of Black women who experienced severe maternal morbidity during childbirth or postpartum. Data are not available regarding the women’s perceptions of their care or their experience of severe maternal morbidity. Qualitative studies can provide a voice to Black women through their description of the event and a deeper understanding of the experience than what is obtained through quantitative methods. The purpose of this study was to describe the lived experience of Black women who suffered severe maternal morbidity during childbirth or postpartum.

Chapter two included results from my review of the literature related to the severe maternal morbidity. This review included published quantitative research into racial disparities in
severe maternal morbidity, and I identified a dearth of qualitative work evaluating these experiences from the perspective of the Black women who endured them. In chapter three, I will discuss the research method, van Manen’s interpretive phenomenology, which was utilized for this research.
Chapter Three. Study Methods

Introduction

In this chapter, I discuss the research method utilized in the study. The research question, research purpose, description of the research design (van Manen’s interpretive phenomenology), sample, protocols to protect research participants, setting, procedure/general steps, and the researcher’s resources and skills are also addressed.

Research Question

The research question for this study was: What were the experiences of Black women who suffered severe maternal morbidity during childbirth or postpartum?

Research Purpose

The purpose of this study was to explore, describe and understand the meaning of experiencing and surviving a life-threatening complication during childbirth or postpartum and to explore the meaning of severe maternal morbidity from their perspective. This understanding could lead to improvement in the care provided to women who experience severe maternal morbidity. This study will also provide the foundation for future research into this important issue, as well as racial and ethnic health disparities in maternal health.

Research Method

In this section, I will provide an overview of the different approaches to phenomenology to lay the foundation for van Manen’s interpretive phenomenology, the research method used to guide this study. Van Manen’s methodology was chosen to understanding the nature of the lived experience and guided my investigation into the phenomena of severe maternal morbidity among Black women. Van Manen’s interpretive phenomenology is the most appropriate methodology to discover aspects that are essential to the phenomenon of severe maternal morbidity (van Manen,
Research has demonstrated that health disparity in maternal health is a complex issue requiring further investigation from those who live the experience. Following the overview of approached, I will discuss van Manen’s Interpretive Phenomenology.

Phenomenological Approaches: Overview

Phenomenology posits to find the essence of something, you must return to the lived experience as all experiences have meaning (van Manen, 1990). The roots of phenomenology stem from German philosophers Husserl and Heidegger.

Edmund Husserl was a German philosopher and former mathematician who developed descriptive phenomenology. Husserl introduced the concept of the lived experience and regarded all experiences as a source of knowledge (van Manen, 1990). Husserl (1970) believed that traditional sciences did not fully explore the human existence and recognized the need to evaluate how we conduct research in the human sciences. Phenomenology describes the essence of the lived experience. Phenomenology as a philosophy and a research method provides an understanding of who we are as we exist in the lifeworld.

Husserl (1964) believed in phenomenological reduction, also referred to as bracketing. Husserl believed that researchers “carefully exclude all valuable positions, all questions of reason or unreason of their human subject matter and its cultural configurations” (Husserl, 1970, p.6). Bracketing requires the researcher to suspend their biases, assumptions, and pre-understanding to allow one to see the pure essence of the phenomenon (Husserl, 1964). This method allows the research findings to represent the experiences of the participants with the preconceive ideas of the researcher.

Phenomenology becomes hermeneutical when the method is taken to be interpretive and not descriptive. The elemental tenet of hermeneutic phenomenology is that our most fundamental
and basic experience of the world is already full of meaning (van Manen, 2014). Martin Heidegger, a German philosopher, made significant contributions to the development of hermeneutic phenomenology. Heidegger’s (1996) philosophy posited the framework that interpretation was needed to understand what it means to be human and to exist in the world. His approach emphasizes the rich description to be found in everyday living and the interpretive basis of all understanding (Heidegger, 1996). Heidegger’s philosophy is a way of people reflecting on their experiences, uncovering what is hidden and bringing it to light. This discovery allows one to find meaning and make sense of their existence in the world.

Heidegger (1996) used the term “Dasein,” being-in-the-world, to refer to the way human beings exist in the world. Dasein represents what it is to be and how we live in the world. Heidegger notes, “Dasein always understands itself in terms of its existence— in terms of a possibility of itself; to be itself or not itself” (Heidegger, 1996, p.12). He was concerned with explaining the fundamental nature of being-in-the-world and what encompasses it (van Manen, 1990).

Heidegger (1996) believed Dasein to be not a physical object that could be named, rather a representation of a particular view of how someone exists in the world. When the question is asked, “What is Being?” in hermeneutic phenomenology, it does not involve looking for an entity that can be easily recognized and distinguished. Instead, it examines the existence of the lived experience and finds meaning in that experience. Dasein is not something that can be easily categorized. Heidegger (1996) further described Dasein as being hidden from itself or taken for granted in everyday life.

Heidegger (1996) rejects the notion that one can achieve pure objectivity. He believed that it was impossible for researchers to understand the experience if they bracket and suspend
their preconceived notions. Heidegger believed the researcher’s background and pre-understandings could not be easily discounted (Heidegger, 1996). There is no way to separate yourself from being-in-the-world. It is our culture, experience, knowledge, perspectives that allow us to exist in the world. Assumptions are an essential part of how we exist in the world and determine our ability to understand people in their life experiences. In hermeneutics, prior knowledge guides investigation into the phenomenon. An examination into presuppositions allows us to have a better understanding of the inquiry. This examination is not to generate new knowledge; instead, it helps us recognize what we already know about the phenomenon (van Manen, 1990).

Hermeneutic phenomenology suggests that the lived experience is an interpretive process and is not concerned with objectivity and bracketing (van Manen, 1990). The focus is on the subjective experience of individuals as they attempt to find meaning in their experience. Their stories provide an understanding of the phenomenon under investigation. Researchers conducting hermeneutic phenomenological research must adapt themselves towards the ontological nature of the phenomenon (van Manen, 1990). The researcher needs to recognize you do not need to see something for it to exist.

Hermeneutic phenomenology is the art of understanding and interpreting both verbal and nonverbal expressions. The relationship between the researcher and the participants is a crucial part of hermeneutic phenomenology. The aim is to understand the lived experience through dialogue, verbal and non-verbal, allowing participants to conceptualize and determine their meaning. It is essential to recognize that those who lived the experience are knowledgeable about their being and experiences (Heidegger, 1996). When conducting a hermeneutic investigation,
the researcher describes, seeks to understand and interprets the participants’ experience (van Manen, 1990).

According to Heidegger (1996), the hermeneutic circle is the process used to understand and interpret the experience. In this approach in which interpretation through understanding is achieved is through the circular process of movement between the parts and the whole while continuously reexamining the data. One's understanding of the text as a whole is discovered by analyzing the individual parts and one's understanding of each part by analyzing the whole. Through the use of this process, the researcher attempts to reveal the true meaning of the experience. This process involves looking at the data from various perspectives.

**Van Manen’s Interpretive Phenomenology**

Van Manen’s interpretive phenomenology (1990) is an approach to research rooted in hermeneutic phenomenology and provides guidelines to investigate the lived experience. Van Manen (1990) recognizes the difference between descriptive phenomenology and hermeneutics and stated that phenomenology is a “pure description of the lived experience” and hermeneutics is “an interpretation of experience via some text or some symbolic form” (p.25).

According to van Manen (1990), hermeneutic phenomenology recognizes that everyday experiences have meaning. It is an appropriate methodology to describe, understand and interpret the lived experience of severe maternal morbidity. Van Manen’s interpretive phenomenology (1990) was the chosen methodology because it allows the focus to be on Black women in the context of their existence. Van Manen’s approach allows the participants to make sense of their experience. The participants in this study described their understanding of the complication and reflected on the meaning of their experience of severe maternal morbidity. This approach
provided a deeper understanding of the experience of severe maternal morbidity for Black women.

According to van Manen (1990) language is an essential aspect of phenomenology. Van Manen explains that the participants' experiences could be misinterpreted if language is not an expression of their culture. Their words have meaning. Language allows individuals to remember and reflect on their experiences. The dialogue between the researcher and the participants enhances our understanding of their experience.

Writing in phenomenology involves more than just writing results, writing is a reflective process that involves “our whole sensual and sentient embodied being” (van Manen, 2014, p. 20). The researcher interprets the text to explore the lived experience. Meanings embedded in the text are explained and deepen understanding of the phenomena (van Manen, 1990). Van Manen (1990) uses the written text to understand and bring meaning to the experience.

Van Manen’s (1990) interpretive phenomenology involves the interplay of six research activities to explore the lived experience: 1). Turning to the phenomenon of interest; 2). Investigating the experience as we live it; 3). Hermeneutic phenomenology reflection; 4). Hermeneutic phenomenology writing; 5). Maintaining a strong and oriented relation; and, 6). Balancing the research context by considering parts and whole (van Manen, 1990, p. 30-31).

These steps are discussed further in the data collection and data analysis section.

Sample

Black women who experienced severe maternal morbidity during childbirth or postpartum were invited to participate in this study. Conditions that classified as severe maternal morbidity consisted of the leading causes of pregnancy-related deaths for Black women, which are cardiomyopathy, cardiovascular disease, hypertensive disorders of pregnancy
In the context of this study, the terminology of “Black woman” encompasses women of African, African American, and Sub-Saharan African descent. They may have been born in the U.S., the Caribbean, Central America or South America. They are women who reside and gave birth in the U.S.

The inclusion criteria for the sample were as follows: women who self-identified as Black/African American, were over 18 years of age, gave birth in the United States, gave birth within the last 20 years and experienced one of the following complications: pregnancy-induced hypertension, sepsis, obstetrical hemorrhage, cardiovascular disease, cardiomyopathy or postpartum hemorrhage. There has been a significant increase in severe maternal morbidity within the last 20 years. Women who delivered within the past 20 years could provide valuable information. Exclusion criteria included: women who did not self-identify as Black/African American, were under 18 years of age, delivered outside of the U.S., gave birth over 20 years ago and had multiple gestations.

Recruitment consisted of advertising over social media, word of mouth, and the snowballing technique. An advertisement (Appendix A) was posted on Facebook – my Facebook page and four additional Facebook pages. No personal information was exchanged over Facebook. Potential participants were provided with a phone number and email address to contact to receive additional information about the study. Anyone who responded to the advertisement was screened to determine if they met the inclusion criteria. If they qualified to participate in the study, I discussed my background and the purpose of the study. An interview
was scheduled at a time and location selected by the participant. Informed consent was obtained before starting the interview.

Additional recruitment was through word of mouth and the snowballing technique. Snowballing techniques involved asking the participants to identify other women they may know who experienced severe maternal morbidity and inviting these other women to participate in the study (Wilson & Washington, 2007). Recruitment ended after the ninth interview because data saturation was reached. According to Polit and Beck (2017), the normal range for the sample size in a phenomenological study is 7 to 10 participants.

The purposive sample consisted of nine Black women who experienced severe maternal morbidity during childbirth or the postpartum period. The participants self-identified as Black or African American. The sample of women ranged in age from 28 – 53 years (M = 37, SD = 7.41). There were 13 experiences of severe maternal morbidity among the nine participants occurring between 8 months to 18 years ago (M = 7.15). Five (5) participants had one (1) experience of severe maternal morbidity and four (4) participants had 2 experiences of severe maternal morbidity.

The highest level of education completed among the participants was as follows: four (n = 4) had a high school diploma with some college experience, two (n = 2) had bachelor degrees, one (n = 1) had a master’s degree, and two (n = 2) doctorate degrees. Five (n=5) of the participants were married, and four (n = 4) were single. The participants’ incomes ranged from $29,000 to $300,000, with a median income of $76,375.

All of the women started prenatal care in the first trimester. Three (n = 3) of the women had pre-existing conditions: two (n = 2) had chronic hypertension, and one (n = 1) had
hypothyroidism. All three women were under the care of their primary care provider for their pre-existing conditions.

All of the pregnancies resulted in a live birth, six (6) were preterm births, and seven (7) were full-term. There were three (3) vaginal births and ten (10) cesarean births. Eight births were complicated by preeclampsia, five (5) by postpartum hemorrhage, one (1) was complicated by antepartum hemorrhage, one (1) by eclampsia, and one (1) by sepsis. Five (5) births were complicated by postpartum hemorrhage, four (4) required blood transfusions and two (2) resulted in emergency hysterectomy.

Protocols to Protect Research Participants

Internal Review Board

The University of Connecticut’s IRB approved this study on February 2, 2019.

Human Protection/Ethical Considerations

Women who expressed interest in the study were screened to determine eligibility and provided with a description of the study. Informed consent was obtained from women who met the inclusion criteria (see Appendices B and C). I transcribed all audiotapes. Participants were informed that their information would be kept confidential. All data acquired was securely stored in password protected devices and locked in file storage. Transcripts, field notes, and audio recordings did not contain any identifying information.

Setting

Participants were involved in face to face, one-to-one, in-depth conversational interviews with the researcher. There were two interviews completed with each participant. The first interview was the initial interview, during which the instances of severe maternal morbidity were discussed in depth. The second interview was to verify and interpret the findings. The interviews
were conducted in a location chosen by the participants. The first interviews lasted approximately 45 minutes to 75 minutes. The second interview lasted approximately 25 minutes to 30 minutes.

Procedure/General Steps

In this study, I asked Black women to describe their experience during childbirth and postpartum, and when they experienced severe maternal morbidity. I focused on their experience of severe maternal morbidity. Their descriptions provided a deeper understanding of the complexities of experiencing a life-threatening complication.

Turning to the Nature of the Lived Experience

The first research activity involved turning to the phenomenon of interest to the researcher (van Manen, 1990). According to van Manen, the “lived experience is the starting point and the end point of phenomenological research” (van Manen, 1990, p. 36). The process involves orienting to the phenomenon of interest, formulating the research question and explicating assumptions and preunderstandings (van Manen, 1990).

The phenomenon of interest for this study was the experience and significance of severe maternal morbidity among Black women. The purpose of their study was to explore, describe and understand the meaning of experiencing and surviving a life-threatening complication during childbirth and postpartum. The research question for this study was: What are the experiences of Black women who suffered severe maternal morbidity during childbirth or postpartum?

According to van Manen (1990), the researcher’s pre-understandings and assumptions of the phenomenon are explained and reflected upon. “If we simply try to forget or ignore what we already ‘know’, we might find that the presupposition persistently creep back into our reflections” (van Manen, 1990, p. 47). Thus, I used a journal to document field notes that
consisted of actions I took throughout the data collection and data analysis process. In-depth field notes included reflections and observations with participants.

**Preunderstandings.** I am a Black woman who identifies as an African American woman and a nurse-midwife with several years of experience. Since this study focused on Black women, I needed to reflect on my experience and understanding of the phenomenon. I did not experience a life-threatening complication when I gave birth to my son, however, I did have gestational diabetes and gave birth by cesarean due to fetal distress. I had an uncomplicated postpartum period, but I did feel the physical effects of having had major surgery. When I reflected back on my childbirth experience, I realized that I did not consider that notwithstanding my educational background and career, as a Black woman I too was at a higher risk for complications or death. I never considered there was a possibility that I could become a part of those statistics of Black women and poor maternal health outcomes.

I do believe that my experience was atypical and my role as a nurse-midwife had a significant effect on the care that I received. This belief was not only because of my profession, but because of the relationship that I was able to establish with my obstetrician. It was a relationship built on mutual trust, respect and good communication. My obstetrician also knew that I was a nurse-midwife. It doesn’t escape me that perhaps part of the reason why my care was so exceptional was because of my medical background. I also gave birth at a hospital where I worked with nursing students during their clinical rotation, so I was familiar with the nursing staff and other health care professionals. I know this would not have prevented a complication from occurring, but it helped me to feel safe during my surgery and postpartum recovery.

Although I did not experience a life-threatening complication during my delivery, I am aware that there were potential risks associated with having a cesarean. Prior to conducting this
study, my understanding of the experience of having severe maternal morbidity was limited because I did not have a personal experience that placed me in a life-threatening situation. Also, research reports on the experience of Black women during childbirth or who suffered from severe maternal morbidity were limited in the literature.

When I searched the literature for research about maternal mortality, I found strong evidence that Black women are more likely to die or experience a life-threatening complication, but there was no clear explanation as to why, only that race was a significant factor. I understood that race played a role but did not know how it placed women at risk. I did not have any beliefs about why Black women experienced worse maternal health outcomes. I used van Manen’s interpretive phenomenology because I did not want to bracket who I was as a Black woman or a maternal health care provider. I knew my experience would guide me as a researcher to understand the women’s perspectives.

**Assumptions.** My primary assumption was about whether the women would be willing to talk to me about their experience with severe maternal morbidity. In the Black community there is a belief that women do not want to talk about any issue related to reproductive health. Thus, I assumed that some women might find it difficult to talk about their experience due to feeling vulnerable or lack of trust in the medical establishment. However, I believed that being a Black woman and a mother, I could provide an environment where women would feel safe. Also, after I explained the purpose of my research, I knew the women would be willing to talk to me.

The other assumptions I had were:

1. The participants might feel vulnerable talking about their experiences.
2. There would be common challenges and experiences among the participants regardless of socioeconomic status or educational level.
3. The participants would be able to articulate how race, class, and gender had an impact on their experience.

4. The participants who lived through the experiences were considered experts and could provide valuable knowledge.

5. The participants would feel liberated in talking about their experience.

I did not have any assumptions about their experiences with severe maternal morbidity because of my limited knowledge with this phenomenon.

**Investigating Experience as We Live It**

According to van Manen, the research activity “investigating experience as we live it” involves becoming submerged in the phenomenon (van Manen, 1990, p. 53). This exploratory phase involved gathering data to develop a deeper understanding of the nature of the lived experience. There are several approaches used to collecting data of the lived experience, such as interviewing, observing, and obtaining written sources of the personal experience (1990).

Conversational interviews were conducted with Black women about their experience of suffering severe maternal morbidity during childbirth or postpartum. The dialogue between the researcher and the participant is an essential part of learning about the meaning of the experience. The participants described their understanding of the event and reflected on the meaning of their experience (van Manen, 1990). The purpose of the interviews was to gain insight into their experiences (van Manen, 1990). The interviews focused on their understanding and participants were asked to provide as much detail as possible. The interviews were audiotaped and I transcribed them verbatim.

A demographic information sheet (see Appendix D) was completed by every participant. Information requested included: age, race/ethnicity, marital status, education level, employment
status, insurance status, and annual income. Information about the pregnancy and childbirth was also obtained, including pregnancy history, gestational age at the onset of prenatal care, gestational age at delivery, mode of delivery, and type of complication experienced during delivery or the postpartum period. The women provided information for each pregnancy.

I informed each participant that the purpose of the interviews was to understand what it is like to have a severe complication during childbirth or postpartum. It was essential to develop questions to assist with understanding the women’s experience of severe maternal morbidity and promote dialogue with the women (van Manen, 1990). The interview began with the question: Can you tell me about your experience of having a complication during childbirth or postpartum? Can you tell me what it was like to experience the complication? Please describe all your thoughts, feelings and perceptions that you can remember. The participants were asked to describe specific situations related to the event. Interpretation began during the first interview and continued to develop with the subsequent interviews (van Manen, 1990). Themes identified during the interviews assisted with discussions in the second interviews with the same participants and in subsequent interviews with other participants (van Manen, 1990).

Van Manen (1990) suggests that there are many means of data gathering for the analysis of lived experience of individuals when gathering their reflective recollections. Given this, I inquired about any journals or other forms of written expressions that the participants may have to describe their experience. None of the participants had any journals or writings about their experience of severe maternal morbidity.

I also investigated other creative and artistic sources, such as film, documentaries, literature, art, and poetry that address the phenomenon of maternal morbidity in the Black community. I searched Internet movie data bases, such as blackclassicmovies.com and

I was unable to identify creative or artistic sources that captured the meaning of severe maternal morbidity. I created paintings based on the interviews (Figures 1 – 5). These artistic sources are further discussed in Chapter four and were used to enhance the understanding of the phenomenon and provide another dimension of investigation of the phenomenon.

**Hermeneutic Phenomenological Reflection**

Hermeneutic phenomenological reflection is the third research activity and involves understanding the essential meaning of the phenomenon. The researcher reflects on “the essential themes which characterize the phenomenon” (van Manen, 1990, p. 30). The essence of the experience is discovered through reflection.

Hermeneutic phenomenological reflection began during the first interview. The meaning of a phenomenon is complex as it is multi-dimensional and multi-layered (van Manen, 1990). This process involved reading and re-reading the data from each interview and the field notes. The process was repeated several times as it requires using different ways to think about the data (van Manen, 1990).

Reflecting on lived experience requires reflectively analyzing the thematic aspects of the experience (van Manen, 1990). Themes are structures of the experience and provide understanding of the phenomenon. Van Manen has three approaches to isolating statements during phenomenological reflection 1. the holistic or sententious approach; 2. the selective or highlighting approach; and 3. the detailed or line-by-line approach (van Manen, 1990, p.92 – 93).

For this study, I used the selective or highlighting approach (see Table 2) to uncover “thematic aspects of the phenomenon it describes” (van Manen, 1990, p. 92). I read and reread
the transcripts several times and identified statements and phrases that were essential or revealing to the experience of severe maternal morbidity (van Manen, 1990). Through this process, themes began to emerge and commonalities across the participants were identified (van Manen, 1990).

The themes identified were categorized using van Manen’s four lifeworld existentials (Figure 6): 1. lived body or corporeality which provides descriptions of the participants’ body relative to their experience; 2. lived human relation or relationality is the relatedness expressed between the patients, their families and health care providers; 3. lived space or spatiality describes the environment; and 4. lived time or temporality is the passage of time in relation to the experience of what was happening (van Manen 1990). These lifeworld existentials are “the lived world as experienced in everyday situations and relations” (van Manen, 1990), p. 101). The lifeworld existentials are not viewed in isolation as they are interconnected.

Van Manen (1990) discussed the importance of differentiating between incidental and essential themes, which requires determining what is common to the experience and what is essential to the experience. According to van Manen, “Essential meanings are historical and culturally determined or shaped” (p. 106). The phenomenon could not exist without the essential themes (van Manen, 1990).

For each participant, data collected during the interviews were analyzed and essential themes summarized (see Table 3). Then comparisons were made across all the participants’ experiences of severe maternal morbidity. Essential themes with the same meaning were grouped together (van Manen, 1990). The findings consisted of a collection of the women’s meanings of their lived experiences of severe maternal morbidity. I returned to all participants after the themes were identified to interpret the findings and confirm the validity of the interpretations.
**Hermeneutical Phenomenologic Writing**

Hermeneutic phenomenologic writing is an essential part of the analysis process, which involved writing and rewriting to describe the phenomenon (van Manen, 1990). Van Manen considers hermeneutic phenomenologic writing an artistic process. The written text helps the reader develop a deeper understanding of the phenomenon (van Manen, 1990). This process uncovers the true meaning of the phenomenon and brings something to light which was previously hidden (van Manen, 1990).

Writing in phenomenology involves more than just writing results, writing is a reflective process that involves “our whole sensual and sentient embodied being” (van Manen, 2014, p. 20). The researcher interprets the text to explore the lived experience. Meanings embedded in the text are explained and deepens understanding of the phenomena (van Manen, 1990).

Language is an important aspect of phenomenology as language allows participants to describe their experience as they reflect on their experience (van Manen, 1990). This process was challenging as it was important for me to be sensitive to the language of the women who experienced severe maternal morbidity. Since I wanted to learn about their experience, I needed to “listen to the language spoken by the things in their lifeworlds, to what things mean in this world” (van Manen, 1990, p.112).

**Maintaining a Strong and Oriented Relation**

Van Manen’s fifth research activity is to maintain a strong and oriented relation to the phenomenon under investigation. The goal is to have the most accurate interpretation of the phenomenon and to understand the lived experience of the participants (van Manen, 1990).

Lincoln and Guba (1985) determined four criteria for trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability. I used several techniques
throughout this study to address trustworthiness. Credibility indicates the authenticity of the study, meaning the data accurately reflect the phenomena under study (Lincoln and Guba, 1985).

Credibility was achieved by engaging in a reflexive dialogue throughout the analysis (Beck, 1993). An audit trail was maintained throughout the study. Field notes were taken before and after each interview, as well as throughout the analysis. The field notes included details about the interviews; questions and impressions were also noted. I had discussions with my dissertation committee to reflect on the research process. Emerging themes were discussed and confirmed with my major advisor, who independently analyzed the transcripts of the interviews. To ensure the credibility of the data, I returned to the participants to validate the findings.

Transferability refers to the generalizability of the research findings (Lincoln & Guba, 1985). Factors such as diversity among the participants in the study can increase the likelihood that results found can be transferred or generalized to other settings of contexts. Transferability was increased due to the diverse sample of Black women participants based on age, educational level, socioeconomic status, marital status, and geographical location.

Confirmability is concerned with the concept of objectivity in the research process and dependability refers to the degree of consistency of the findings if the research is repeated (Lincoln & Guba, 1985). Communication with the major advisor to review the research process assisted with objectivity and consistency. I maintained an audit trail and my research advisor reviewed the transcripts to increased objectivity and consistency. Further, to eliminate biases in the research findings, I developed a reflexive journal to document the research process.

Balancing the Research Context by Considering Parts and Whole
Van Manen’s (1990) final research activity is “balancing the research context by considering parts and whole” is the final research activity that van Manen (p. 33). Themes emerge from the individual interviews and are then connected and linked to one another.

Themes were identified for each transcribed interview and a summary was written for each participant. Each transcript was examined in the context of the other participant interviews. The final step involves looking for patterns across themes to conceptualize the “whole” lived experience of the phenomena. The phenomenon for this study was the lived experience of severe maternal morbidity (van Manen, 1990).

Comparisons were then made across the participants’ experiences. Structures of the experience of severe maternal morbidity that were common in each account were identified. The findings were presented across all interviews as a whole by five overarching essential themes revealed from the unique essential themes in the 9 interviews. Together they presented the participants’ lived experience of severe maternal morbidity.

**Researcher’s Resources and Skills**

I am currently a Ph.D. candidate at the University of Connecticut School of Nursing. My education provided me with the skills to investigate health issues and identify gaps in research. I have studied qualitative, quantitative and mixed research methodologies. Each course contributed to strengthening my program of research and furthering my understanding of the complexities of health disparities. I am a certified nurse-midwife with over 24 years of experience in providing health care to women. I understand the challenges that health care professionals experience in providing care to women within a complex health care system.

As an Assistant Professor of Nursing at the University of Saint Joseph, I serve as the faculty advisor for students’ independent honors research projects. I am currently collaborating
with a colleague on incorporating cultural awareness and sensitivity into undergraduate and graduate nursing education. We recently completed a qualitative study to investigate an innovative way to use Leininger’s Sunrise Model to teach family nurse practitioner students how to become culturally aware of the populations they serve (Mokel & Canty, 2018).

For my master’s thesis at Yale University, I conducted historical research about the first nurse-midwifery school for African American nurses. I presented my findings at the American College of Nurse Midwives Annual Meeting. My work was published in Contributions in Historical Research: The Graduates of the Tuskegee School of Nurse-Midwifery, in Celebrating the Contributions of Academic Midwifery: A Symposium on the Occasion of the retirement from the faculty of the Yale University School of Nursing (YSN), of Professor Helen Varney Burst. My research increased awareness about the contributions of African Americans made to nursing.

**Timetable**

When the IRB at the University of Connecticut approved this protocol on February 9, 2019, I immediately posted the advisement on Facebook. Recruitment began February 2019 and continued to April 2019. From February to March, I conducted nine interviews. Data analysis started after the first interview. I transcribed all of the interviews. The transcribed interviews were read and reread several times and essential themes were identified for each participant, then themes were combined for all participants. All the participants reviewed and validated the themes. My major advisor also read all of the transcribed interviews to validate my identified themes.

**Summary**

Van Manen’s Interpretive Phenomenology was the method used for this study. In this chapter, I discussed the procedures used to investigate the phenomenon of severe maternal
morbidity among Black women. The sample consisted of nine women who experienced severe
maternal morbidity. In the next chapter I discuss the findings of the study.
Chapter Four. Results

Introduction

In Chapter Four, I present and discuss the findings of my study, the purpose of which was to explore the experience of Black women who experienced severe maternal morbidity during childbirth or postpartum. Nine women shared their stories to provide insight into this phenomenon. Each participant shared between one and two experiences that occurred during childbirth or postpartum, five (5) participants had one experience and four (4) participants had two experiences (for a total of 13 experiences), occurring between 8 months to 18 years ago. Van Manen’s four lifeworld existentials informed data analysis: the lived body (corporeality), the lived space (spatiality), the lived time (temporality) and the lived human relationships (relationality) (Figure 6). Five essential themes were generated by this analysis that describe in depth the experience of severe maternal morbidity among Black women. The themes were reviewed and validated by all of the participants. I used artistic sources to enhance the understanding of the experience of severe maternal morbidity. The artwork created was based on the essential themes that emerged from the experience of the participants.

Findings of the Inquiry

Van Manen’s (1990), hermeneutic phenomenological exploration provided the lens through which to explore the data and discover the essences of the participants' lived experience of severe maternal morbidity. This approach provided a holistic way to reflect, understand and gain knowledge from their experiences. Data analysis informed by van Manen’s four lifeworld existentials, the lived body (corporeality), the lived space (spatiality), the lived time (temporality) and the lived human relationships (relationality), revealed the following five essential themes:
1. I Only Know What I Know
2. Faced with Uncertainty
3. How You Cared for Me/Connected
   Subtheme 1: Part of Someone’s Routine
   Subtheme 2: Felt Safe and Well Cared For
4. Race Matters
5. Still Healing

The five themes represent the participants’ experience of severe maternal morbidity. The themes describe how their level of knowledge affected their experience with the complication, the uncertainty of their situation and their survival, their interaction with health care professionals, how race influenced their perception of their experience when they entered the health care system, and the long-term physical and emotional effects of the experience.

**Theme 1: I Only Know What I Know**

The theme “I Only Know What I Know” was recognized when exploring the experiences of severe maternal morbidity through their lived body. According to van Manen (1990), this lifeworld existential reflects how we present to the world through our bodies and consists of the woman’s physical presence and how she is situated in and experiences her world. Knowledge helps us interact and experience the world. Knowledge also influences how we feel, communicate and interact with others. This knowledge played a significant role in their experiences of severe maternal morbidity.

The women experienced severe maternal morbidity through their bodies and knowledge was an essential dimension in their personal perception of their complication. The women described how their level of knowledge influenced how they responded to the complication.
before, during or after the event occurred. Knowledge influenced how they responded to the physical symptoms and how they responded when they entered the health care system. The participants experienced their complications during birth and postpartum; their level of knowledge affected their perception of how they viewed the complication. According to van Manen (1990), we learn about ourselves through our bodies, through our physical and bodily presence. When the women reflected on their experience of severe maternal morbidity, they realized their level of knowledge had an influence on how they responded physically and mentally.

The participants reported different levels of knowledge about their diagnoses. Five (5) participants (56%) had never heard about their complication or fully understood their condition. Five (5) participants (56%) reported some knowledge about their diagnoses, but were unaware of the seriousness of their complication or that it could be life threatening. One (1) participant reported that she learned about her complication from her mother, however, she had misconceptions about the physical symptoms. Knowledge deficits left them vulnerable and unprepared, as they did not know they were at risk or they did not know it was possible that it could happen to them.

Some participants were blindsided by their complications. They considered themselves healthy before becoming pregnant and started prenatal care in the first trimester. Their perception was that everything was going fine. When the women developed warning signs and symptoms the women thought they were normal signs or symptoms related to pregnancy; if the signs and symptoms occurred after they gave birth, they associated them with normal postpartum healing. They did not recognize that they were having symptoms of a serious and possibly life-threatening problem.
Participant 2 did not realize she was having symptoms of cardiomyopathy as she did not receive the diagnosis until she was 12 months postpartum. She associated her fatigue with normal postpartum recovery, breastfeeding, and caring for an infant. She started to have difficulty breathing and went to the emergency room to be evaluated. She stated, “They came in for the echo, and I'm not thinking like anything major's wrong because I was always healthy. I've never had any problems. I never had any surgery.” When the provider told her that her ejection fraction was at 10%, and that normal was 55 to 60%, she realized the severity of her disease. She stated, “That whole year, I have been going into failure… I didn't even realize I was having all the symptoms of something being wrong with my heart … because we're not educated to really know those types of things.”

Several participants were unaware of the risk factors for their complication or that they were at risk. The participants described themselves as being in “good health,” “never had any health problems.” Even those who were diagnosed with hypertension or hypothyroidism did not have any complications related to their medical diagnosis because they were controlled on medications. They explained being unaware of the potential complications that could occur. Participant 9 was told that her blood pressure was at stroke level and was diagnosed with preeclampsia. She stated:

I don’t really know what that is. I’ve heard of it and I know it has to do with your blood pressure, but again up until that very day I have never had a blood pressure that sustained the high numbers that it did.

Some participants reported not being informed of warning signs of possible complications. This is partly why they perceived that their pregnancy was progressing normally, and when they started to experience symptoms they perceived their symptoms as normal.
symptoms of pregnancy or postpartum. This lack of knowledge placed some of the women in dangerous situations.

Participant 3 did not realize that she was experiencing symptoms of preeclampsia. She woke up with a severe headache that lasted for 3 days. She continued to do her daily activities, like driving her daughter to school and running errands. She thought the headache would go away after a good night’s sleep. It was not until after interacting with a friend who urged her to call her provider that participant 3 notified anyone about her symptoms. She was instructed to go by ambulance to the hospital for evaluation. Still not aware of the seriousness of her condition, she instead told her friend to drive her to the emergency room (ER). On the way to the hospital, she had a seizure. She was then taken by ambulance to the hospital; she had two more seizures and was unconscious when she arrived.

Participant 3 had some knowledge of preeclampsia but never heard of eclampsia. When reflecting on her experience, she stated, “I heard about preeclampsia…I thought that was just swelling in your ankles. Not that. So, I don't think people are educated enough.”

When Participant 7 was reflecting on her experience, she realized her lack of knowledge placed her in a dangerous situation. Approximately 2 weeks after having a cesarean birth, she developed a headache and her legs and feet began to swell. Initially, she dismissed the symptoms, she related it to recently having a cesarean birth. Her blood pressure readings were: 176/107, 175/112, 170/112, and 182/117. She called the hospital immediately and informed the emergency room provider instructed her that she could come in to be evaluated. “So I drove myself. In hindsight, I should’ve never, but because he was so nonchalant, you know, I’m thinking of like, well, maybe am I over exaggerating? They readmitted and diagnosed me with postpartum preeclampsia.”
There was a range in the participants’ knowledge about the seriousness of their condition. Many did not realize their condition was life-threatening. Some participants had heard about their condition before their pregnancy, but still did not realize the seriousness until they were diagnosed, in the hospital, and receiving treatment. Participant 8 developed a headache, swelling of the face, nausea, and swollen legs nine days after giving birth. She checked her blood pressure and it was 190/110. She stated her providers prepared her for warning signs to look for when she was initially discharged, so she returned immediately to the hospital for evaluation. She was diagnosed with postpartum preeclampsia. She stated, “My liver enzymes were elevated, I was diagnosed with postpartum preeclampsia, which I didn’t even know was a thing… I didn't think that it was life or death…. that it impacted your kidneys and liver and your other organs.”

There were some participants who never really understood what happened because they did not receive information from their health care providers. In the aftermath, they were still left wondering what happened. Although they had a sense of the seriousness of their complication, they received little or no education about what happened or the treatment during the complication. Some participants still, even years after they experienced the complication, are unclear about what occurred. Their situation was never fully explained to them in detail. They still desired information about their diagnosis, what happened to them or the treatments they received.

Participant 3 was brought to the bathroom by her nurse 5 hours after a normal vaginal birth of a 9 pounds 2 ounces baby. Suddenly she felt something pouring out of her that she had no control over. “I just hear like the sound, like somebody's pouring a gallon of milk in the toilet, it was just pouring out.” She realized it was blood and called the nurse immediately for help. While the medical team was trying to control the bleeding, she became unconscious and woke up
the next morning. She stated, “They just said, oh, ‘you lost a lot of blood due to hemorrhaging’ and not really explaining what hemorrhaging is… not explaining the seriousness of it.”

She did not have a clear understanding of postpartum hemorrhage and what was happening to her body to cause her to hemorrhage. During her hospitalization, nothing further was explained to her. Other than receiving blood transfusions, she does not know what the doctors and nurses did to her after she fell unconscious. She learned from her mother how serious her condition was and that she could have died.

Some participants understood that they required emergency intervention and what could have caused their complication. However, they wanted to know why specific treatment options were chosen for them. Some were left wondering if there was anything else that could have been done.

Participant 5 had a cesarean due to an arrest of dilation. Her daughter was delivered without any difficulty, and she felt her cesarean was uncomplicated. She noticed they were in the operating room for an extended period. They were still working on closing her incision. She questioned the health care providers about why they were still in the operating room. She stated,

No one would say anything. Then eventually, someone said, “You are still having a lot of bleeding, we are going to have to put you to sleep.” No one quite clearly told me why you're having some bleeding or we're probably going to have to do surgery and take out your uterus.

Since they were unable to stop the bleeding, an emergency hysterectomy was performed. Participant 5 was unaware of the possible risk for hemorrhage due to having a cesarean. She even attended an educational program for first-time mothers. She stated, “You come to these classes, and you get points for showing up. More like an education that the hospital offered…. 
we did not cover complications or anything. It was more of a general overview…. we never talked about C-sections.” She feels that she did not receive the education during the pregnancy to prepare her for complications that could happen during childbirth.

**Theme 2: Faced with Uncertainty**

According to van Manen (1990) the lived space represents more than the physical space, it includes the emotional space or the felt space. The lived space describes the subjective experience of space and describes the way we interpret a particular environment during the experience (van Manen, 1990). The theme “Faced with Uncertainty” represents how the woman felt in this emotional space during their experience of severe maternal morbidity. In this study, the women described how they experienced several emotions when they were hospitalized, diagnosed with their condition and receiving treatment. The women reported how they felt when they realized the severity of the complication and the possibility they may not survive.

Six of the participants (67%) thought about their mortality for the first time when they experience the severe maternal morbidity. The possibility of death was something they never expected to be associated with their childbirth experience. When they were preparing for childbirth, they were more focused on the pain associated with labor, they never considered the possibility of dying. Although it became their reality, the women realized this was a situation that may or may not have a positive outcome. They felt there was nothing they could do except wait to see what happened.

The participants described feeling emotional turmoil as they realized the seriousness of their condition and that although they were receiving treatment it still did not mean their condition would improve. Participant 2 was unclear what was going to happen to her after she was diagnosed with postpartum cardiomyopathy. She described her experience:
I was going into failure. “We're going to help you prolong your life.” So that was just like a life shattering statement when the doctor said that to me …. nobody talks about life expectancy …. I was like, oh Lord, I'm about to die and my baby and my husband, what am I going to do?

For most of the women, their complication happened quickly. Most women described not having time to process what was happening. They did not feel like they were in control and were unsure how their complications were going to affect them. A participant (6) who was diagnosed with placenta previa and accrete, arrived at the hospital with heavy bleeding. She was told that she was going to be taken in immediately for an emergency cesarean. She began to worry. She stated, “Am I going to make it? Is my baby going to make it?” She woke up a day and a half later in the Intensive Care Unit (ICU). She stated, “The baby almost killed me. I was on life support. I can hear my sister talking, but I couldn't kind of like put it together….. is this like a dream? Is this heaven, am I dead, am I alive?”

The physical space was their location in the hospital and the emotional space was the feelings of uncertainty that developed when they realized their birth experience was not going as expected. The women felt as though they had little control over the situation. Although they knew that procedures and treatments were done to save their lives, they did not have time to consider what this would mean for their future. Participant 5 needed an emergency hysterectomy and was being placed under general anesthesia. All she could think about was if she was going to survive. She stated,

What if I do not wake up from my anesthesia. I just had a baby; she’s not going to have a mother. I was having a full-on panic attack. I remember them giving me sedation via the little mask or whatever it was. That’s what I remember at that point.
In this emotional space, the women described feelings of fear, anxiety and helplessness as they realized something was seriously wrong and were unsure if their situation would improve. They knew their condition could impact their baby and worried about their wellbeing as well. Participant 1, who was diagnosed with sepsis stated, “I was hot, my body was literally hot. You can feel the heat radiating off of me and it just kept getting worse and worse as the day went. That’s what got me scared.”

This uncertainty caused some of the women to question decisions they made during childbirth. Participant 4 developed preeclampsia during delivery. She was offered a cesarean, but she wanted to have a vaginal birth. It took time, but she was able to delivery vaginally. She wondered if her decision had a negative impact on her and the baby. She described how she felt when her daughter was born. She stated:

I knew that my blood pressure was high, but, you know, at that point I just started to get really worried about her and wondering if she was okay …. she hadn't cried and she wasn't breathing…. I was just really scared about, you know, if she was, if she was going to be all right and if she was even alive at that point.

Some women’s conditions became critical so they were physically unable to hold or care for their baby immediately after birth. Participant 9, did not see her daughter when she was born. She stated, “Never heard her cry. She did go to NICU [Neonatal Intensive Care Unit]. I remember I wasn't able to see her until the next day or so, 24 hours later, because I had been given magnesium.” The process of waiting was difficult, because they were unsure of their prognosis and worried whether or not they would have an opportunity to see their baby.

The women thought about their families and the baby they just gave birth to, when they realized there was a possibility that they could die. They thought about their baby growing up
without a mother. If they did not survive, what was going to happen to their baby. This realization caused the women to be in a dark space that put a cloud over their childbirth or postpartum experience.

The women had to find a way to cope through their experience of severe maternal morbidity. Their family members, particularly husbands, partners, and mothers were often identified as their primary support. They advocated for them when it was needed and took care of their emotional and physical needs. They needed that love and support when they found themselves in this space of uncertainty. Spirituality and religious beliefs also provided comfort to them.

All of the babies were born without complications, except for one that was born at 31 weeks and required admission to the NICU. The babies had good Apgar scores, were breathing on their own, had healthy birth weights and did not require medical interventions. The women described how knowing that their babies were okay helped them when they found themselves in this emotional space of uncertainty.

Although the women were in the hospital receiving treatment, they did not always feel safe or secure that their condition may not improve. The women described feeling like they were still at risk for dying because they may not have responded to treatment immediately. The women also reported that although they were stable medically after the event, they still worried that something may go wrong with their condition. Participant 8 worried because her blood pressure was high and would not go down. She stated,

They were giving me blood pressure medicines in almost every form. They were giving me potassium…. I was getting everything…. So I was like what’s going to happen and I
was very scared. I was very nervous, but I was just trying to, you know, be positive and be calm…. So I just, just prayed a lot and thankfully we're okay.

The artwork “Uncertainty” (Figure 2) represents the dark place where these women found themselves during their experience of severe maternal morbidity. They were faced with unexpected challenges and felt afraid, alone, anxious and helpless. In this emotional space, the women realized they might not survive their complication and considered their own mortality for the first time.

**Theme 3: How You Cared for Me**

According to van Manen (1990), the lived relations is the communication and relationships experienced with others through the spaces and interactions we share. The theme “How You Cared for Me” represents the interpersonal space the participants shared with health care providers during the complication. During the event the women interacted with health care providers who played an essential role in their experience. In the context of this study, the health care providers were any professional member of the health care team, which included nurses, nurse-midwives and obstetricians who provided care during childbirth or the postpartum period.

“How You Cared for Me” represents the relationship the women had with their health care providers when they experienced severe maternal morbidity. The women described their interactions with those responsible for delivering care they received during their hospitalization, when they were going through the birth process or the postpartum period. These interactions were essential to their experience with a life-threatening complication.

The women described their experiences with nurses, nurse-midwives and obstetricians during and after the complication. The women described several aspects of their interactions and discovered that their relationship with health care providers had significant influence on how
they perceived their experience of severe maternal morbidity. Although women were provided with lifesaving procedures and treatments, some women were left feeling like they received exceptional care while others felt as though their health care providers did not care about their physical health and emotional well-being.

Three (3) participants (33%) perceived their experience with health care provider as negative. They did not have any positive experiences with any health care providers they encountered. Three (3) participants (33%) reported their entire experience was positive. They did not experience any negative interactions and had no complaints about the care they received. Three (3) participants (33%) reported having both negative and positive interactions with health care providers during their experience.

The following subthemes represent the positive and negative experiences the women in this study described and the factors that had an influence on how they perceived their care during the complication and the relationship with health care providers. The subtheme 1, A Part of Someone’s Routine represents the women who did not connect with their health care providers and viewed their interactions as negative. The subtheme 2, Felt Safe and Cared for represents the women who had positive relationships with their health care providers and felt a connection to them.

Subtheme 1: A Part of Someone’s Routine

The subtheme “Part of someone’s routine” represents how some participants felt about their experience with health care providers who provided care to them during or after their severe maternal morbidity complication. The women described not feeling connected to the nurses, nurse-midwives or the obstetricians. The women perceived that their health care providers focused on vital signs, providing pain medications, answering call bells and providing lab results.
The women described not feeling like they received individualized care. They felt their care did not reflect that they experienced a life-threatening complication.

The women described feeling like they were part of someone’s routine, because the provider focused on the complication and did not go beyond the technical aspects of care. The women understood that due to the severity of their condition there were medical treatments and procedures that they needed. However, they did not feel a connection to those who provided the care. Participant 5 described her experience:

Outside of the regular medical routines and things, obviously after hemorrhaging you need to check a CBC [complete blood count]. And they would say your blood count looks better or lower. Not anything outside of your standard medical routine. You draw a CBC and you tell the person the results. A task-oriented kind of thing. Not on a personal level. … I think they made sure I was okay health wise and by saying that I mean they make sure I had my morning CBC done and you know we talked a lot about pain control.

Some women reported they did not feel supported in the care they received. There was no compassion and, at times, they felt the interaction was demeaning and disrespectful. They did not have good communication with their health care providers. They felt they were not the priority in the care provided. Some women perceived that they were not even seen on a human level. Participant 7 who had preeclampsia and needed an emergency cesarean because the fetus showed signs of distress, states her health care providers just came into the room and started preparing her for an emergency cesarean. Participant 7 described the communication with her provider during the interaction. She stated,

The doctor at the time did not discuss with me the fact that I needed to have an emergency C-section. She spoke to my mother who was in the hallway, as she was going
back in, she says, “you know, she has been laboring for a couple of days.” She said, “…. baby's in distress and we need to do a C-section.” So her entrance into the room was with nurses, who were quickly gathering things. They threw scrubs at my husband and told him to hurry up, that he needed to get dressed because they were going to do a C-section.

The women described feeling that there was no human connection in the aftermath. Some participants perceived that their health care providers’ lack of compassion minimized the seriousness of the complication. After experiencing a life-threatening complication, the women felt it was important for family to be aware and present to provide support. Many felt this was not acknowledged or respected by the health care providers. Participant 3 was alone in her room when she began to bleed heavily. She became unconscious while the medical team was working on her to stop the bleeding. She woke up the next morning with the nurse by her bedside. She described her interaction with the nurse who cared for her during the night. She stated,

It was the next morning and she's just like “I'm so happy you made it. Um, you had us scared for a little bit. You lost a lot of blood, but we gave you the transfusions and now you're coming back around,” …. And I was like, “did anybody call my mom? She was like, “No, you have to call your mom as soon as you can.”

Since the women experienced a traumatic event, they thought their health care providers were going to provide support and emotional guidance. Many felt like they were on their own to deal with the aftermath. Some women experienced life-saving procedures that would have long-term consequences to their health and well-being. They expected health care providers to talk to them and provide anticipatory guidance. They described feeling disappointment when they realized they would not receive this type of support from the health care providers who shared this experience with them. Participant 5 described the lack of support she received. She was
young and had a hysterectomy. Not only was she trying to understand what happened, she also thought about her future and wanted to know what was next for her. She stated,

I wanted to go home at that point. There wasn't no indication for me to stay but I was ready to go home. I was done with them. When you are in a traumatic situation, you don't feel supported. I would rather be at my house and be completely surrounded by people that can support me. Just to sit here and be part of someone’s routine. It was traumatic, no one wanted to talk about it. No one wanted to have a conversation with me about it, so I just wanted to go.

The women described that although they received care that saved their lives, they did not feel a human connection with their health care providers. The women experienced a life-threatening complication, leading them to feel vulnerable and afraid. The women felt their health care providers had no desire to have a personal connection with them. This was perceived because of the lack of communication, dismissiveness or not recognizing them as an individual. Participant 7 did not feel her provider was interested in developing a relationship with her. She stated, “You kind of need that person who has that compassion and understanding…. wanting to relate to you, in some shape, form or fashion and make you feel comfortable, so I actually switched to another physician within that same practice.”

The women described not feeling valued by the health care provider during the experience of severe maternal morbidity. The women acknowledged that there were two patients. The mother and the baby, but the baby was the priority. Although they went through an experience that affected them both physically and emotionally. They felt their needs were not addressed because the focus was on the baby. Participant 7 described her care with health care
providers. She stated, “I felt like, you know, the care is routine. You come and you have the baby. We do our part. You do your part, you go home.”

Some women described situations when wanting to do something different than the “routine” was an inconvenience for some health care professionals. When they spoke up with their concerns, they felt like they were causing problems or making the situation more difficult. Participant 4, who had preeclampsia and wanted to have a vaginal birth, discussed the experience she had with her nurse during her delivery. She stated,

I asked to speak to the doctor because I started getting frustrated because the nurse that I had was saying things to me like, “well, you should just go ahead and do the C-section.” And she was just really adamant about me getting a C-section and I really wanted to try to avoid that because I know that that comes with another host of complications.

Some of the women did not feel that the care they received addressed their mental and emotional needs. Some of the women viewed their experience as traumatic and expected health care providers to provide support and guidance. Their experience had an effect on their mental and emotional wellbeing. Some women were traumatized by their experience and wanted to not only have their physical needs addressed, they wanted a mental health assessment. Participant 5 had a hysterectomy due to postpartum hemorrhage. She was a young woman who learned that she had had her first and only child. Although her experience was traumatic and would have a long-lasting effect on her for the rest of her life, she felt her care only focused on her physical needs. She never received a mental health assessment. She stated:

No offerings of counseling afterwards. No mental health evaluations. How are you doing? How are you feeling? Do you understand what happened? Do you understand why we had to do it? No, I was never asked any of those questions. Never ever.
Subtheme 2: Felt Safe and Well Cared For

The subtheme “Felt Safe and Well Cared For” represents the lived human relationship. It represents the interpersonal space the participants shared with health care professionals. This theme embodied the experience of the women who had a connection with their health care providers. In this theme, the interactions with obstetricians and nurses left the women feeling safe and well cared for.

The women described their relationship with health care providers during their experience of severe maternal morbidity. The women felt that their providers took the time to explain things, and showed concern and compassion. Many felt their providers were knowledgeable and monitored them closely. This led to the participants establishing a trusting relationship with their providers. Participant 1 stated “The nurses were good…. I didn't have a bad experience. It was a great first experience, interactions went very well. I think everything was explained to us. It was my first child, and I wasn’t sure what to expect.”

The women believed that their health care providers made them feel comfortable and they genuinely cared about their wellbeing. Their providers provided extra support and showed compassion. The women were provided with opportunities to express concerns or ask questions. The women described feeling like they were part of a team in their care, even felt their family member were included in the care. Participant 8, who experienced postpartum hemorrhage and preeclampsia, felt her health care providers monitored her closely and wanted to be informed of any concerns she had. She stated, “My doctor actually told me, she said, ‘any problem is a big problem. I don't care how small you think it is. You need to tell me…. it may be something serious.’”
The women described having a relationship built on trust with their health care provider. The women felt this relationship developed because their providers viewed the woman as an individual and took the time to learn about them and their concerns. Their providers listened to them and were not dismissive. They felt respected and were taken seriously by their health care providers. The women felt that when the obstetrician or nurse took the time to communicate with them about their concerns, it made them feel respected.

Some of the women knew their health care providers for years and developed a relationship built on mutual trust and respect. Over time they felt their providers got to know who they are and were able to provide individualized care because their providers knew them well as a person and focused their attention on their individual needs. This relationship with severe maternal morbidity contributed to the women having a positive experience with health care providers. Participant 9, who experienced preeclampsia, described her experience. She stated:

I loved my provider. I had Dr. [name]. Also, if she wasn't there, like she's doing a delivery at my appointment or something, I would see Dr. [name], she was amazing too… I still have her. I've only been there for my whole GYN history. For 23 years I had the same providers.

The women described feeling like their relationship went beyond the patient-provider relationship. The women perceived that since their provider knew them and their families, they were viewed on a human level. Participant (6) had a relationship with her obstetrician for over 25 years. She considered him a part of the family. During her complication he advocated for her and she feels his actions saved her life. She stated:
My doctor said…. there was one doctor that was kind of like almost gave up on me, you know, because legally you're only supposed to have so many pints of blood. My doctor, he knew me. He knew me personally. He went to the lengths that any doctor could possibly go. He helped me when I had my first son … So, he knew my family. He was not only my doctor, he was my friend. So, he went to war to save me, you know….. I'm glad he did … because I could have died. (Participant 6).

The women felt their health care providers made certain their concerns and needs were addressed. Participant 4 had preeclampsia and wanted to avoid having a cesarean birth. Her obstetrician already knew her plans and wanted to support her decision for a vaginal delivery. She felt safe and trusted her obstetrician to advocate and make the right decisions for her. She stated:

I had a really good, strong relationship with my OB/GYN, so I just kind of trusted her… to make good decisions for me. You know, because I knew that she knew me well…. I felt that she kind of made the experience better for me.

Many health care professionals went beyond just taking care of the women’s physical needs and addressed their emotional needs by being supportive. The women reported being able to communicate with them and felt they were listened to in the process. Participant (8) felt the nurses went beyond just providing routine care. Her nurses did not just focus on vital signs, passing out medication and reporting laboratory test results. They wanted her to feel safe and not put herself in a situation where she could fall or harm herself. She stated:

The nurses were great. I mean to the point where they would like rub my feet… I don't like to ask for help. So, I would try to do things on my own. And I had this one nurse, she just told me, “listen, I understand, you know, this is a weird position to be in where you're
used to being able to do everything for yourself but you physically can’t…. I don't want you to hurt yourself. Just hit the button and I'll come and I'll help you.”

Participant 4 described how her obstetrician and nurse were an essential part of having a vaginal birth, instead of a cesarean. She was being pressured by her primary nurse, who wanted her to have a cesarean and not waste time trying for a vaginal birth. She described how having a different nurse changed her experience from negative to positive. She stated:

The nurse actually seemed upset when the doctor said, “okay, well let's do this.” I think it was almost like she didn't want to do that. So fortunately, shortly after that their shift change happened and I had a new nurse who was excellent and I felt a lot more attentive to me, and what I wanted and helping me reach my goal and getting my baby here. I really believe that her coming on when she did was crucial to me not ending up with a C-section because I felt that she really worked hard. … She helped me, you know, stay calm and not stress out, which I'm sure helped the situation.

These women felt their health care providers were involved in their care and closely monitored their health status. They trusted the decisions their providers made about the management of their care. The women described how personal involvement improved their health outcomes. Participant 8 was 5 hours postpartum. She was in the room by herself when her health status changed quickly. She stated,

And I just started feeling like a warm sensation, like from my head to my feet. And then that's all I remember for two days. So, what I later found out is my uterus didn’t contract back after the C-section and I hemorrhaged. Yes. And then I coded. So, if the nurses had not been on top of it and been in the room as often, as regular as they were, then it might've been a different outcome.
The artwork “Safe and Well Cared For” (Figure 3) represents how participants perceived their interactions with health care professionals. The participants knew their situation was complicated, but they believed their health care providers cared about their physical and emotional wellbeing. The participants trusted and believed in their health care providers.

**Theme 4: Race Matters**

The theme “Race Matters” represents the lived body. According to van Manen (1990), the lived body represents the physical or bodily presence and includes how a person presents and is perceived by the external world. The lived body reveals something about who we are and influences how we respond to the world in which we live. We share who we are through our lived body. Race influenced how the women presented themselves physically, how they responded to their health care providers and how their health care providers responded to them.

In this study, the lived body considers how race influenced the participants’ perception of their experience of severe maternal morbidity. Race is an integral part of who Black women are and how they are perceived by society. Some of the women in this study described how their skin color played a role in how they were treated when they entered the health care system. The women discussed how being Black influenced their relationship with health care providers and possibly the care that they received.

Some participants viewed their negative interactions with the health care system as subtle forms of racism. There were times where participants perceived their health care providers were demeaning and disrespectful and felt that was because they were Black. Five participants discussed how race mattered when they received care during and after the complication.

Some participants felt that being Black would limit access to medical procedures. They felt their prognosis would not have been good if they required further medical intervention.
Participant (2), who was diagnosed with cardiomyopathy, stated that her condition significantly improved after her diagnosis and subsequent medical treatment. Her ejection fraction increased from 10% to 45% in 3 months and is currently at 55 – 60%. She no longer needed a heart transplant and was grateful. She stated,

I knew a heart transplant would not have happened for me. I felt like that because I am Black. I would not have been a priority. All I kept thinking was, Lord, if I need a transplant, who was going to give this Black lady a transplant. Because I understand that there are disparities against us in health care. … I always understand that as a Black woman, you're not taken seriously.

The participants described experiencing several racial stereotypes during their care. They felt that it was perceived that they were unmarried, on state insurance, or exaggerating their symptoms to receive attention. One participant stated,

Oh, you're married. Okay. Oh, you have insurance. Look at that. We were not expecting all of that. It's weird because a lot of the time it's so funny how they love to call you Miss and you have to correct them…I know my insurance played a big role in the way that they treated me…. I wasn't the typical, you know, single mother on Husky.

Some participants perceived that being a Black woman, her health care providers perceived that they were only interested in learning about free government programs. Some wondered if they received limited information about the risk because it was perceived they did not care or understand. Participant 3 wonders if her providers perceived that she did not have the ability to understand the information or that she did not care what was happening to her. She stated,
All they do is push nutrition on you and they see your skin color and push all these programs, WIC [women, infant, and children] food stamps and that's like they pushed all those things to you. Tell me about the risk, tell me if this happens then this will happen.

Some women experienced racial bias from the obstetricians, nurse-midwives and nurses. They believed their provider’s perception was that their concerns were exaggerated. One participant felt that in every encounter with health care providers her race had an influence on how she was treated. She felt her concerns were minimized and dismissed. They were made to feel like she was exaggerating her symptoms. Participant 7 described an experience she had when she went to the hospital because she was leaking fluid. She stated:

I was feeling like I was like leaking fluid, it didn't feel like it was normal discharge. So, I went to the labor and delivery triage just to kind of get checked out…They kind of said, oh, you know, it's just normal fluid. The way in which she reacted, it was like, you know, ‘you're just being dramatic, you're fine.’ And she was like, ‘you know, it's just normal fluid. You didn't need to come here for that. You're fine.’

Participant 7 began leaking fluid a few weeks later and delayed getting care because she started to question herself as a result of the first experience. When she did return to the hospital, she found out she was actually leaking amniotic fluid. She stated “That was kind of was a theme of all of my triage experiences, I was made to feel like, okay, maybe I'm over exaggerating.”

Participant 2 went to the Emergency Room (ER) for evaluation after two nights of having chest pain and difficulty breathing. She was told by the ER provider that she was having “some angina” but “it will pass.” She felt that the emergency room physician was dismissive. She was dressed and was getting ready to leave when another physician came into her room. She stated,
“he told me, ‘I looked at your XRAY. We're going to have to admit you right now.’” She was diagnosed with postpartum cardiomyopathy and was admitted to the ICU.

The question was raised that if someone has a high socioeconomic status, does that influence the type of care they receive. Participant 8 believes she received exceptional care during her childbirths but wonders if her positive experience with health care providers was due to her high socioeconomic status. She resides in an affluent area. She stated:

Well, you know, my husband is a retired professional athlete, so you know, it's a certain demographic here than it is with my family in [town]. So, I’m wondering if that has something to do with that….. Like here are we receiving better care because it's a different socioeconomic status? I don't know. I am curious to know.

Another participant felt that race affected the care that she received and the outcome. Participant 5 felt her experience was also influenced by race and the geographical area where she resided and received care. She stated:

However, I live in [town] area, I delivered at a hospital in the inner city that serves young Black, African American women in a hospital that was predominately a White operated institution. Unfortunately, from practicing in [Town] there is a stigma, there is not a lot of things offered for Black people. We are not interested. We do not care. I feel like that stigma came true.

The artwork “Race Matters” (Figure 4) reflects how the external world perceives Black women during the experience of severe maternal morbidity. Some of the women in this study felt that their race had an influence on their experience of severe maternal morbidity. The women described how they were viewed by health care professionals when they enter the health care system. It is evident to them that race does matter in our society; the women described how it
manifested in the way they were viewed by those who provided care to them during their complication. This artwork represents that race matters in the experience of severe maternal morbidity.

Theme 5: Still Healing

According to van Manen (1990), the lived time is not just about the past, present or the future, it represents our subjective understanding of time. The theme “Still Healing” represents the ways in which the women experienced time during the complication to the present day. The women described their lives since the experience of severe maternal morbidity. They discussed their recovery since birth of their child, which extended beyond the routine 6-week postpartum period. As they described their physical and mental recovery, they had stories of loss, growth, resilience, and survival. The women reflected on how they found meaning through their experiences and described how it is moving them forward in their lives.

All of the women (100%) reported that their complications affected both their mental and emotional wellbeing. Five (5) participants (56%) described their experience as traumatic. Three (3) participants (33%) were diagnosed with postpartum depression, postpartum anxiety or both disorders. All of the participants (100%) reported that they recovered physically without complications. Lived time proved to be a significant aspect in the women’s lived experiences, especially in regards to their physical and mental recovery. The experiences of severe maternal morbidity happened 8 months to 18 years ago and still have an impact on their lives today. The women described how they are still recovering mentally after suffering severe maternal morbidity.

Some participants discussed the event as if it happened yesterday. It was evident in their voice, facial expressions and body language that their experience was still fresh in their minds.
and their experience of severe maternal morbidity was something they wanted to talk about. Participant 6 became emotional when she described her experience. It has been 18 years since she experienced the complication. She stated, “Yeah, the baby almost killed me. …. I almost bled to death. I think had I had about five bags of blood…. (she began to cry) I can't believe I’m getting emotional.”

The women described feeling traumatized by their experience of severe maternal morbidity. The women experienced different sources of trauma. Trauma was caused by recognizing the severity of their condition. Trauma from how things happened quickly, and that they did not have time to process what was happening. Others described the birth itself as traumatic. Some even described their interactions with health care providers as traumatic. Although the women described different sources of trauma, they all said that affected them emotionally and mentally. They are still recovering from the trauma they experienced.

The time from being diagnosed with the severe maternal morbidity to the birth of their baby happened quickly for some women. Since it was unexpected, they did not have time to prepare mentally. Some women went for a routine prenatal appointment and were told that they had to deliver the baby the same day. The women reported not having enough time to process what was happening to them. All they knew was that if the baby was not delivered, their situation could place both of them in danger. Participant 8 who had two experiences of preeclampsia, stated, “I think I’m still traumatized from it. You know, because I know it happened so quickly. We were totally unprepared.”

Another source of trauma was the treatment from the obstetricians, nurse-midwives or nurses who provided care during and after the complication. Some participants described feeling like their needs and wellbeing were not the priority. They recognized that the wellbeing of the
baby is important, but felt that there were two patients who both needed care. The participants believed that they were viewed by the health care provider as a source of stress.

Participant (7) described when she was rushed in for an emergency cesarean and was not properly anesthetized. As the obstetricians started to cut her she felt all the pain. When she communicated that to them, they continued to proceed with the surgery. She was told “the baby has to come out.” She stated, “It was very horrific. I literally, I think screamed, cried and yelled during that entire procedure.” Participant (7) describes her experience when she first returned home after delivery. She stated,

I wasn't able to fully process that experience the first couple of weeks home were pretty difficult. Um, lots of crying spells, which I think to some degree are a kind of, you know, normal adjustment and you're sleep deprived here, learning how to breastfeed this new person. And you're, you know, trying to recover from the pain of a C-section. So, I think some of that was to be expected, but I do think that a degree of that was also because of the trauma that I experienced.

Most of the women felt that their experience was traumatic due to how their baby was delivered or what happened shortly after the birth. Participant 3 stated she was traumatized by both of her births, the experience of the postpartum hemorrhage (because she didn’t realize how close she came to dying) and having eclampsia with her second. According to her, the second was more traumatic because of the way her son was delivered, by cesarean in the emergency room. Participant 3 still feels negatively about her experiences and how she perceives childbearing. She stated “It makes me look at having kids a whole other way. I noticed that when people are talking about having kids, I think it's the worst thing in the world.” She felt so negatively about her birth experiences that she has undergone a tubal ligation.
The women described feeling a sense of loss during their experience. Some women were disappointed that they did not have the childbirth experience that they planned. The loss of not having a vaginal delivery. Participant 1 did not experience labor, because she had sepsis, the baby was delivered quickly. She did not experience labor or a vaginal birth. She stated:

And I just kind of felt, I'm not going to say cheated, but I felt my child birthing experience was cheated. I didn’t have contractions. I didn't go through the labor pain…I still have a little bit of issues with that and just feeling like, you know, my first child, I didn't get to have that natural experience.

The participants who experience severe maternal morbidity or during delivery described losing something at the birth. A part of themselves. Not being able to have a vaginal birth, instructed to not become pregnant again. Some women were told not to have another pregnancy because they could experience another life-threatening complication and may not survive. Some women decided on their own that they did not want to have more children and decided to have a tubal ligation. For some women the decision was made for them because they had to have an emergency hysterectomy to save their lives.

One participant vividly remembers the moment her daughter was born. Looking at the clock when her daughter was born by cesarean. She had a postpartum hemorrhage that resulted in an emergency hysterectomy. That moment affected her for the rest of her life. She realized she would have only one child. She was traumatized by her experience. Physically she healed without complications, but mentally she is still healing. She stated,

I had a one-week post-op. And like my 6-week post-op. I didn't have any extra visits to the hospital or anything like that, so I feel like recovery course was expected. Mentally, well that is still to be decided. … Mentally, I feel that I am in a better space, more on an
acceptance level for the first couple of years, and I want to say still now, there is an avoidance built into it.

The way we feel can influence how we experience time and moments. These lived experiences have affected their feelings about future pregnancies. Some women reported they are still coping with the fact that they did survive. They are aware that they situation could have ended differently. Participant (7) stated, “So that's still an ongoing battle, but at least I'm here. At least I'm here because looking back, I didn't have to be.”

Some women were diagnosed with mental health disorders. Although they are not sure if their experienced with severe maternal morbidity caused their diagnosis, they definitely felt that it affected the way that they felt after the birth. Participant 4 experienced preeclampsia for both of her pregnancies. After her second birth, she noticed that something was wrong in the way she felt. She reported no complications healing from the cesareans, her incisions healed fine. While she healed fine physically, she did not feel mentally well. She described her postpartum experience after her second pregnancy. She stated,

I would say maybe when she was about a month old was when I really started to notice that I felt really, um, really tired and I felt really, I don't really know how to explain it, but I just felt like I couldn't handle it. Like I felt like I couldn't handle having two kids. I felt like I wasn't a good mother…. I was able to take care of them, but I really wasn't able to take care of myself. So, I got to a point where, you know, I was kind of lying in bed a lot…not taking care of myself the way I should be, so I wasn't really eating…. I really wasn't able to function well and I would get really anxious about just about anything and everything. And so, once I started seeing a therapist and they were able to give me medication. And I would say within a couple of weeks of taking the medication, I started
to feel better. I started to feel like myself again, and I started to be able to handle things better and handle myself more…. when she was about six months old.

Some women described how their experience with severe maternal morbidity caused them to develop anxiety. In the aftermath, they discussed how they had this fear that something was going to happen to them or their baby. The women discussed how if they felt any physical symptom they were calling their health care provider or visiting the emergency room. Participant 9 described her experience after the birth of her daughter at 31 weeks. She stated:

I was so miserable and I had such anxiety. It was starting to take over my life. When I had my postpartum follow up with Dr. [Name] and she suggested I talk to a doctor at [hospital]. She was super nice and she did diagnose me with postpartum anxiety. ….. I still think I have a little bit of anxiety.

All the women described how their family and friends were critical to their physical and mental recovery. The women discussed their healing process and how support from their husbands, partners and their families played an essential role in helping them to care for themselves and their babies.

The participants reflected on who they were at the time of their experience of severe maternal morbidity and who they became in the aftermath; they often reflected on how they are different since they experienced the complication. They reflected on who they were at the time of the complication and who they are now. The participants found meaning in their experiences.

What happened in the past had an influence on what is occurring in their lives today. One participant became a women’s health care practitioner and her experience influences how she provides care to her women patients. She understands the need to emotionally support women as
they go through pregnancy and childbirth. Two participants are continuing their education, one is currently in nursing school and the other participant is obtaining a degree in mental health.

One participant made a work area change so that she can work with women during labor and delivery; she wants to address social justice issues in maternal child health. She stated,

I think it kind of sparked a passion. I would say. Oh, I think my kind of frustrations with the system and just the personal experiences of, um, you know, my provider interactions. And it made me want to make sure that doesn't happen to anyone else…… I literally spent my time while I was on maternity leave, just researching and like all of the articles started to come out around that time of how high the maternal death rate was, particularly with African American women.

All of the participants reported they found talking about their experience therapeutic and wanted to share their story to help other women who experienced serious complications during childbirth and postpartum. The participants also wanted to participate in research because it was a lived experience for them and they wanted to see the trajectory change in how medical providers address maternal morbidity among Black women. Participant 5 stated,

I literally say having a baby is the time that you put your health at the highest risk ever. It is not always rainbows and unicorns there are so many things that can happen…. If I can share my story and the stuff I went through and what was not there. If it can help another person, then that is good enough for me.

The artwork “Still Healing” (Figure 5) represents where participants are now as it relates to their experience of severe maternal morbidity. All the participants are not the same person they were before the birth of their baby. Some described being traumatized from their
experience. Physically they healed, mentally they are still healing. The women found meaning in their experience that manifested in several different ways, contributing to their healing process.

The artwork “Not Always Rainbows and Unicorn” (Figure 5) represents the Black woman’s experience of severe maternal morbidity. The participants described the complexities of their experience when they entered the health care system for childbirth and are faced with a life-threatening complication.

**Conclusion**

Nine women shared their stories of experiencing severe maternal morbidity during childbirth and postpartum. Van Manen's four lifeworld existentials guided the data analysis and helped me to examine their experience holistically. Five essential themes reveal the essence of the phenomenon of severe maternal morbidity among Black women. In chapter five, I will discuss the research findings.
Chapter Five. Discussion, Application, and Conclusions

Introduction

Chapter Five contains a discussion of the research findings on the experience of severe maternal mortality among Black women. The clinical practice and health policy implications of the study are examined. The limitations of this study, suggestions for future nursing research and contributions are also discussed.

It’s Not Always Rainbows and Unicorns

A participant’s quote, “It is not always rainbows and unicorns, there are so many things that can happen” describes the essence of the experience of severe maternal morbidity by the Black women who suffered from it. There is a generally accepted social construct that presents childbirth as an exciting and normal, healthy event that culminates with the birth of a beautiful baby. The postpartum period encompasses the time the family bonds to that baby and the mother recovers within 6 weeks. An experience that one remembers and reflects on with happiness and joyfulness. The findings in this study highlight how the experience of childbirth and the postpartum can be overshadowed by unexpected life-threatening complications.

The purpose of this study was to describe the experience of Black women who suffered severe maternal morbidity during childbirth and postpartum and to explore the meaning of their experience. The women in this study experienced the leading causes of pregnancy-related deaths, which are cardiomyopathy, cardiovascular disease, hypertensive disorders of pregnancy (preeclampsia/eclampsia), antepartum and postpartum hemorrhage, and sepsis. And, despite experiencing these complications, they survived to tell their story. The findings from this study demonstrate the complexity of the issue of severe maternal morbidity among Black women and the important implications for clinical practice and future research.
Van Manen’s Interpretive phenomenology, the methodology for this study, provided an approach to understand and explore the meaning of severe maternal morbidity through the participants’ voices (van Manen, 1990). Phenomenology guided this investigation of the human experience of severe maternal morbidity from the perspective of Black women. This study provides a deeper understanding of what it was like to survive a life-threatening obstetrical complication. Five themes emerged from using van Manen’s (1990) four lifeworld existentials (Figure 6) to capture the lived experience among Black women who experienced severe maternal morbidity during their childbirth and postpartum. Theme 1: I Only Know What I Know; Theme 2: Faced with Uncertainty; Theme 3: How You Cared for Me: Subtheme 1: Part of Someone’s Routine; Subtheme 2: Felt Safe and Well Cared For; Theme 4: Race Matters; and Theme 5: Still Healing.

All of the women in this study started prenatal care during the first trimester and attended all of their prenatal appointments. Some women were enrolled in prenatal educational programs for nutritional counseling, childbirth preparation, and newborn care. These findings demonstrate that the Black women in this study knew the importance of prenatal care and sought prenatal care as soon as they realized they were pregnant. This is in contrast to studies that stated Black women were more likely to start prenatal care later in pregnancy or received no prenatal care at all (Harper et al., 2007; Marshall et al., 2014; Painter et al., 2018). Howland and colleagues (2019) found an association between onset of prenatal care and rate of severe maternal morbidity. There was an increase in the rate of severe maternal morbidity as the women started prenatal care later in the pregnancy (Howland et al., 2019).

Research suggest that Black women have difficulty accessing prenatal care due to financial barriers, cultural influences, or lack of trust in the system (Oparah et al., 2017; Yoder &
The women in this study did not experience difficulty in accessing prenatal care as they all were insured with State Medicaid or private health insurance. They knew the options available for care and selected providers they trusted and believed that they would receive quality care during their pregnancies and childbirths. The women did not express any concerns about the prenatal care that they received. They did not express any distrust in the care that was provided during pregnancy. However, establishing prenatal care early did not prevent them from developing life-threatening complications.

The majority of women in this study (67%) were without pre-existing medical conditions when they became pregnant. The women who did have medical conditions had established care with primary care providers before they became pregnant. They were not experiencing any complications from their medical conditions and reported that their conditions were controlled. Their obstetrical providers were aware of their medical conditions and monitored them closely during their pregnancies. The findings of this study suggest that women without chronic medical conditions are still at risk for developing life-threatening complications.

**Knowledge of Complication**

The women had varying degrees of knowledge regarding the complications that could occur during childbirth and postpartum. What they knew and understood prior to childbirth about severe maternal morbidity had an influence on how they perceived their situation and how they existed in the world at the time of the complication and how they acted upon or explained away their symptoms. There was a range from no knowledge of the complication to having some knowledge. Some women had heard of their complication, but had misunderstandings about the symptoms and the severity of their condition.
Knowledge deficits place women in vulnerable situations. Some women delayed seeking medical treatment because they believed their symptoms were normal and associated with childbirth or postpartum recovery. Some women placed themselves in dangerous situations, for example, driving a car while experiencing symptoms of severe preeclampsia. The women placed themselves in situations that could have resulted in serious injury, which could have easily been avoided with proper education. The findings show how the level of knowledge has an influence on how women responded to the physical symptoms they were experiencing and how they interacted within the health care system.

The women (29%) who were knowledgeable about the possible complications were able to identify warning signs and sought treatment right away. They received information from their health care providers about the warning signs of complications. These women also reported that their health care providers kept them well-informed throughout the management of their care.

The information that women received during and after the complication had a significant effect on their experience of severe maternal morbidity. The nurses and other health care providers were relied on to educate the women about the complication, treatment options and procedures performed. Some women left their experience without a clear understanding of what happened during the complication and believed that information about their care was being withheld. These findings are similar to Fries (2010) who found that the women who did not receive adequate information, expressed disappointment in their care and lack of trust in their health care providers.

Experience with Health Care Providers

Health care providers had a substantial influence on the experience of severe maternal morbidity and played an integral role in how women perceived their complication and the care
they received. The women in this study described both negative and positive interactions with health care professionals. Health care providers could either be a source of stress and conflict or source of support and compassion.

Some women felt there was nothing special in the care they received. They felt the care focused on the physical aspect of their condition and their medical diagnoses and did not focus on all their individual needs. They described feeling that they were not in a supportive environment and wanted to be discharged so that they could be home surrounded by people who loved them.

Some of the women described not having good communication with their health care provider. Some women reported asking their health care providers questions and not receiving direct questions. They felt they did not receive a full explanation about what happened to them during the management of the complication. They believed their health care providers did not want to talk to them about how they managed their care. This lack of communication left them feeling unsupported. Dahlem and colleagues (2015) found that effective communication is associated with increased trust in health care providers, decrease in perceived discrimination and increase in patient satisfaction.

Some women in this study wanted individualized care and a personal connection with their health care providers. The women looked to health care providers for support and guidance. Women wanted them to reach out to them and check-in to see how they were coping in the aftermath. The women, who did not have a personal connection with their health care provider, did not reflect positively with the care they received. These findings are consistent with studies that suggest that women want to be acknowledged and respected by their health care providers (Lori et al., 2011; Tucker Edmond et al., 2015).
Women in this study that felt safe and well cared for had a strong relationship with their health care providers. The women reported being able to communicate with their obstetricians and had their symptoms, diagnosis, and management explained. They were given instructions on self-care and warning signs to look for with instructions to contact them immediately. The women reported their providers were caring, attentive to their physical and mental health needs, and provided good support. The women described trusting their health care providers. Some women believed that if their providers were not as attentive as they were, they would not have survived their complication.

**Race Matters**

There is a higher prevalence of severe maternal morbidity among Black women when compared to other racial and ethnic groups. In this study, race played a significant role in the experience of severe maternal morbidity. Women in this study were educated, had access to prenatal care, started prenatal care in the first trimester, most did not have any pre-existing medical conditions, and those who did have pre-existing medical conditions had their conditions well controlled and were under the medical care of their primary care providers; they still experienced severe maternal morbidity. These finding are consistent with previous studies that have shown that race is a significant indicator for severe maternal morbidity after controlling for other factors, such as age, onset of prenatal care, type of delivery, co-morbidities, socioeconomic status, and geographic location (Gyamfi-Bannerman et al., 2018; Howland et al., 2018; Leonard et al., 2019; Tangel et al., 2019). Studies have also shown that understanding the role of race and how Black women are at higher risk for developing severe maternal morbidity is not clearly understood (Aseltine et al., 2015; Bruce et al., 2012; Creanga et al., 2014a; Gray et al., 2012; Howland et al., 2019; Howell et al., 2016a; Leonard et al., 2019).
Some of the women in this study perceived that race was a significant factor in how women were treated when they entered the health care system. These women discussed how being Black influenced their relationship with health care providers and possibly the care that they received. When they expressed their concerns about symptoms they were experiencing, the women reported not feeling valued and being dismissed. Some felt that because they were a Black woman, they were not taken seriously and made to feel like they exaggerated their symptoms. The women viewed these interactions with health care providers as subtle forms of racism.

Some of the women in this study believed that race played a factor in the education they received from health care providers. The education the women received during pregnancy focused on social programs, newborn care, and breastfeeding. Some of the women felt they were not provided with education about complications because it was perceived that they do not care or were not interested. Some of the women felt that their race prevented them from receiving all the treatment options available to them.

Mental Health and Wellbeing

All of the women felt their experience of severe maternal morbidity affected them physically and mentally. Although they physically healed from the complication, they are still healing mentally, even years after the event occurred. Their experience had long-term effects on them. The women reported being traumatized by their experiences and found themselves experiencing more than postpartum blues. Some women were later diagnosed with postpartum depression or anxiety, and they believe this was as a result of their experience.

In *Birth Trauma: In the Eye of The Beholder* Beck (2004) described birth trauma as “traumatic experiences that may occur during any phase of childbearing (p. 32).” The women in
this study described different sources of trauma throughout their childbirth and postpartum experiences. They experienced trauma when they were diagnosed with their complication, when they understood the severity, and the realization that they might die. Their encounters with health care providers were also perceived as traumatic as some women experienced psychological distress from their interactions. Medical procedures during and after the complications were also perceived as traumatic, even though they were performed to save their lives, such as having a third-degree laceration reopen due to uterine compression or an emergency hysterectomy to control postpartum hemorrhage. The women in this study experienced trauma after having an unexpected health crisis to which, similar to Beck’s study, they were still recovering from mentally (Beck, 2004).

When women realized there was a possibility that they might not survive, this had a profound effect on them. The women described feelings of fear, anxiety and helplessness when they realized the seriousness of their condition. Similar studies discussed the emotional response when women learned of their diagnosis and prognosis for the first time. Dekker and colleagues (2016) described how women felt several emotions when diagnosed with peripartum cardiomyopathy and receiving a negative prognosis. They reported feeling overwhelmed, fear, and shock and as well as ‘a sense of doom’ and ‘emotional torture’ as they realized the seriousness of their diagnosis (p. 470). Souza and colleagues (2009) examined the experience of women in Brazil who were admitted to the intensive care unit (ICU) for severe maternal complications during childbirth. These women reported experiencing feelings of hopelessness when they heard their diagnosis and realized they may not survive.

The women in this study were in a dark emotional space when they realized the severity of their condition. They thought about their own mortality and questioned what would happen to
their babies if left without a mother. The experience of a near death event is traumatic, worrying about the baby added another layer of emotional stress. When the women reflected on their severe maternal morbidity experience they felt as though no one else could understand what they were going through. Some were able to share their experience with loved ones, others did not have that outlet.

After experiencing a life-threatening complication during childbirth or postpartum, some women were unprepared and were not sure about what to expect in the aftermath. Women reported not receiving a mental health assessment or follow-up mental health evaluation after being discharged home. Women wanted health care providers to acknowledge that they experienced a life-threatening complication and understand the mental impact it had on them. Even if they were fine physically and the baby was doing well, they wanted some guidance on what to expect during their postpartum recovery or if their complication could affect their next pregnancy.

The women wanted health care providers to address their physical and mental health needs. The women expressed how after the birth of the baby or once they were medically stable, their relationship with the health care providers ended. Some women still had questions and wanted to have access to emotional support from the health care system. They wanted someone to assess their mental wellbeing and just say, “You went through a life-threatening experience, how are you feeling?” Some women received this, while others did not. Some women needed additional support and did not know who to contact during the postpartum period if they had questions or just wanted support.

The women in this study had strong family support systems. The women relied heavily on their spouses, significant others, families, and friends to give them the support they needed
during their recovery. Several women reported feeling traumatized by their experience. They said their loved ones were there to provide physical and emotional support and helped them care for the baby. Souza and colleagues (2009) also found that the women’s families were a significant part of their healing process in the aftermath of severe maternal morbidity.

All of the participants found talking about their experience therapeutic and wanted to share their story to help other women who experienced serious complications during childbirth and postpartum. These finding are similar to Dekker and colleagues (2016) study of women diagnosed with cardiomyopathy who wanted to share their experience to help other women. The women in this study appreciated having a space where they were able to talk about their childbirth experience. They did not want other women to have to go through what they did. If other women did experience severe maternal morbidity, the participants wanted them to realize they were not alone. The participants wanted their experiences to contribute to research to help understand why women, particularly Black women, were experiencing life-threatening complications during childbirth.

The women in this study described the complexities of their experience of severe maternal morbidity. Although they are still healing, they found meaning in their experience. The women described how their experience motivated them and changed their outlook on life. Some of the participants are continuing their education, one in nursing, and the other in psychology. A women’s health care practitioner changed how she provides care to her patients by not only focusing on the physical aspects of care, also offering mental health support. Another made a career change so that she can work closely with mothers and babies and work toward improving maternal-child health outcomes.

**Clinical Practice Implications**
Culturally Appropriate Care

Nurses and other health care providers, particularly those that serve high proportions of Black women during childbirth, need to be aware that Black women have the worst maternal health outcomes compared to other racial and ethnic groups. A Black woman could appear to be low-risk because she established prenatal care early or is without pre-existing conditions, but she is still at risk for serious complications during childbirth and postpartum.

Although racial and ethnic health disparities are not clearly understood, a dialogue with Black women could provide insight into challenges they face and institutional practices that place them at risk. The women in this study felt like their health care providers did not want to get to know them on a personal level. Black women wanted to talk to their health care providers about their concerns and desired an environment where they can feel safe doing so (Karbeah et al., 2019). This dialogue is critical in addressing factors that place them at risk and may improve the quality of care Black women receive during childbirth and postpartum (Jain & Moroz, 2017).

Some of the women in this study recognized how racism can impact their relationship with health care providers. When the women had negative interactions with their health care provider, they felt they were being treated differently because of their race. Nurses also need to take into consideration how they present themselves and interact with Black women (Altman et al., 2019; Pérez-Stable & El-Toukhy, 2018). Bias and judgmental attitudes have an influence on how Black women experience care during the complication. Women in this study felt that health care providers made assumptions of who they are based on their race. Therefore, nurses need to recognize the influence of racism on care and consider that their own personal biases influence their interactions with women during childbirth and postpartum (Murrell et al., 1996).
Therapeutic Relationship

Health care providers play a significant role in a women’s experience of severe maternal morbidity. The women in this study described positive and negative interpersonal experiences with nurses, nurse-midwives and obstetricians. The women in this study wanted a personal connection with those involved in their care and were disappointed when that did not happen. Lori and colleagues (2011) suggest that Black women want health care professionals to acknowledge them and understand their needs. Health care providers need to be aware of the importance of the therapeutic relationship and recognize that their interactions can have a long-term effect on the women who experience severe maternal morbidity.

The women in this study who established a trusting relationship with their health care providers had a positive outlook on their experience. These women felt their health care providers closely monitored them throughout the complication and were attentive to their physical and emotional needs. They felt supported and informed of the status of their conditions and any treatments or procedures performed. The women trusted their health care providers to make the best decisions for them in the management of their care.

The women who reported negative experiences with their health care providers perceived that their providers had no interest in getting to know them on a personal level. They did not feel a personal connection to them. These women felt their health care providers focused on the routine of providing only physical aspects of routine care and did not address or acknowledge their emotional or mental health needs. These women also felt there was implicit bias as it relates to their race, insurance status or economic status.

According to Cuevas and colleagues (2016) a breakdown in communication results in distrust, lack of respect and perceived discrimination which can create barriers to women
establishing a therapeutic relationship. During childbirth, events can occur out of control of the health care provider, life-threatening conditions can develop very quickly. Women recognize that complications can occur, but communication with health care providers helps to alleviate their fears and anxiety (Souza et al., 2009).

The timing of discussion is important to the women when they experience severe maternal morbidity. Women want to be informed throughout the complication and have their questions answered in a respectful manner (Wheatley et al., 2008). They want their health care providers to inform them when they initially have concerns about their condition. Previous studies suggest that women wanted communication with their health care providers to explain what was happening and respond appropriately to questions (Attanasio & Kozhimannil, 2015; Lori et al., 2011; Tucker Edmonds et al., Wheatley et al., 2008).

**Patient Education**

Knowledge was essential to the experience of severe maternal morbidity. For the Black women in this study, I found that it was critical for them to be informed about potential complications that can occur during childbirth and postpartum. Level of knowledge played a significant role in how the women responded when they experience physical symptoms of the complication. The women in this study expressed the desire to receive more information and wanted their health care providers to be a source of accurate health information. They wanted to know the possible complications, the warning signs and when to notify their health care providers.

While the women believed that information was necessary for them to make decisions regarding their health, they also believed that it was important for them to be informed during the complication. The women in this study wanted to understand measures taken to save their lives
and be provided with opportunities to ask questions and clarify. Adequate health education helped the women in this study feel safe and well cared for, and they also felt trust in their health care providers.

The women felt it was not their responsibility to search for information. They believed the health care providers should provide the information and make sure the women understood what was happening to them. For the women who did not receive adequate information, they expressed disappointment in their care and lack of trust in their health care providers.

Nurses and health care providers have the information that women need to feel empowered during their experience of severe maternal morbidity. Health care providers have the power to decide what information can be shared or disclosed. Women feel that health care providers should keep them informed of what is happening or what their feelings are about the situation. According to Jain & Moroz (2017) the women feel empowered when they received adequate information that allowed them to be active in their care. When women are well informed they feel valued and respected by their health care providers (Altman et al., 2019).

After women experience severe maternal morbidity, women need to have an opportunity to discuss what happened during the complication. Women should not be left wondering what happened during the complication. Fries (2010) suggest that labor and delivery nurses meet with the women postpartum to discuss their birth and provide information on the complication. The nurses can answer any questions that the woman may have and address misconceptions about the care they received. No woman should leave the hospital not understanding their medical diagnosis.

Some women in this study reported not being informed of potential complications that could occur in the postpartum period. They associated the warning signs with normal postpartum
recovery. This lack of information caused a delay in seeking medical treatment. The need for education and anticipatory guidance continues into the postpartum period as Black women are at risk and can still experience severe maternal morbidity. Women need information that helps prepare them to care for themselves and identify warning signs of serious complications. Women need to be aware that they are still at risk for developing complications such as cardiomyopathy, postpartum preeclampsia, postpartum hemorrhage and sepsis (Aseltine et al., 2015; Aziz et al., 2019; Gyamfi-Bannerman et al., 2018 Goland et al., 2013; Small et al., 2012).

**Mental Health Evaluation and Support**

When women experience a serious complication during childbirth or postpartum it has a profound effect on their mental wellbeing. Each participant was affected differently by their experience with severe maternal morbidity, but all of the participants reported the effect on their mental wellbeing. The women described experiencing trauma and the effect it continues to have on them. The women reported still healing from their experience, even several years after their experience occurred.

Women who experience severe maternal morbidity during childbirth or postpartum need to be aware of the mental effects their experience could have on them. They should be informed of the risk for depression, anxiety and post-traumatic stress disorder. Therefore, they need to be aware of the psychosocial and medical services that are available to them during the postpartum period, this involves more than the 1-week post-operative visit and the 6-week postpartum visit. Anticipatory guidance could prepare women for a possible effect on their mental and emotional wellbeing and provide them with mental health services as they recover from their childbirth experience.
According to Hauff et al. (2017) pregnant Black women who experience a life-threatening event are at risk for developing post-traumatic stress disorder (PTSD) during the postpartum period. Black women are more likely to present with signs and symptoms of PTSD and are less likely to be properly diagnosed (Seng et al., 2011). Women who experience life-threatening complications during childbirth have unique challenges that require more just the routine care.

Women found themselves looking to their health care providers for emotional support. Some women received this support, while others did not. Women reported they wanted their health care providers to acknowledge the trauma experienced and the need for emotional support. All women who experience severe maternal morbidity need to have a mental health assessment in the aftermath. Health care providers working with this population need to be aware of the trauma the women experience and know how to properly assess for depression, anxiety and PTSD. Women who need additional mental health support could be identified and referred for ongoing emotional support.

Health care providers caring for women who experienced severe maternal morbidity in the aftermath need to be aware of the sources of trauma that these women have experienced and understand how to approach them when providing care. In this phenomenological study, women described their authentic experience of suffering a life-threatening complication and the trauma experienced when they received their diagnosis, during medical procedures, and from their encounters with health care providers. The fundamental approach to addressing trauma in this population is to be sensitive to each person’s source of trauma. This approach has a close relationship to the framework of trauma-informed care (Barnes & Andrews, 2019; Fleishman et al., 2019). Health care providers need to be aware of the history of trauma that patients may have
and remain sensitive and responsive to their individual needs (Barnes & Andrews, 2019; Fleishman et al., 2019). What the findings of this study add to the trauma-informed care literature is the dimension of culture, race and that how health care providers treat patients, even inadvertently, can be a source of trauma.

**Limitations**

Limitations of this study are discussed in this section. There are three major limitations identified: there were no participants who gave birth in Southern states, no participants who were uninsured, and women who did not survive severe maternal morbidity.

There were limitations in the geographical location of the participants. There were no participants who gave birth in the Southern states. Higher concentrations of Black people live in the South. The southern states such as Georgia, Louisiana, Texas, where Black women have disproportionately higher rates of maternal deaths compared to White women (Moaddab et al., 2016). These states have higher numbers of Black women giving birth in the U.S. There are higher numbers of Black women living in poverty and limited access to maternal health services (Moaddab et al., 2016). Women living in rural areas of Georgia live hours away from hospitals that provide obstetrical care, which poses a challenge when women are in labor, this is concerning if they are experiencing complications (Platner et al., 2016). Women who experienced severe maternal morbidity in these states could contribute to the findings in this study.

All the women in this study had insurance and were able to access prenatal care easily. Women who are uninsured or self-pay experience higher rates of severe maternal morbidity compared to women who have private or state Medicaid insurance (Conrey et al., 2019). Uninsured women may experience different challenges when accessing prenatal care and
services during childbirth. Further research is needed to investigate the experience of severe maternal morbidity among uninsured women.

Another limitation is not being able to interview the women who did not survive the obstetrical complication they experienced. It is obvious that this could never happen; however, it is important to acknowledge the women who suffered from severe maternal morbidity and did not survive. The limitation is not being able to hear their experiences because they could have contributed valuable information to this study.

**Suggestions for Future Research**

There is a need for further qualitative studies into the childbirth experiences of Black women. Reports of the experiences of Black women during childbirth are limited in the literature. When addressing health disparities in maternal health outcomes, it is essential to understand what factors place Black women at higher risk for severe maternal complications and pregnancy-related deaths. Studies are needed to investigate how Black women prepare for childbirth and their knowledge of severe maternal morbidity. Knowledge development is necessary to understand the cultural factors that they bring into their childbirth and postpartum and how culture influences their perception of the care provided.

Studies are needed to understand the challenges Black women experience when they enter the health care system for childbirth. Further exploration is needed into the interactions between Black women and the nurses, nurse-midwives, and obstetricians that provide care during birth and postpartum, particularly during severe maternal morbidity. Knowing the perceptions of Black women about these interactions can identify factors that strengthen or breakdown the relationships with their health care providers. Understanding Black women's
perception of the care received during and after birth could provide valuable information in the development of culturally appropriate interventions.

Health care providers played a significant role in the experience of severe maternal morbidity among Black women. Further investigation into the patient-provider relationship and interactions from the perspective of nurses, nurse-midwives, and obstetricians can also provide valuable information. This exploration from the perspective of health care providers can provide insight into the clinical aspects of care as well as how race may play a role in placing Black women at increased risk for severe maternal morbidity compared to other racial and ethnic groups.

Studies are needed to examine the role of implicit bias in encounters with health care professionals during childbirth, not only from the women’s perspective but also from the providers’ perspective. Interventions are needed to improve communication and develop therapeutic relationships between Black women and health care providers.

Research studies have shown that Black women have higher rates of severe maternal morbidity. The next step is developing interventions to improve maternal health outcomes among this population. Studies that further investigate specific conditions, such as preeclampsia, eclampsia, cardiomyopathy, sepsis, and postpartum hemorrhage, are needed as studies have shown that Black women have higher mortality rates for these conditions (Tucker et al., 2007). Studies are needed to identify the physical, genetic, social, mental, and environmental factors that place Black women at risk (Braveman et al., 2015; Bryant et al., 2010). Qualitative studies can provide the knowledge needed to develop interventions that address the specific needs of Black women.
Further research studies are needed to investigate the mental wellbeing of Black women who experience severe maternal morbidity. Women in this study disclosed the effects their experience had on their mental and emotional wellbeing and that they continue to heal mentally even years after the experience. Further exploration is needed to investigate the prevalence of trauma experienced among Black women, the effects of trauma, and the short-term and long-term consequences. Understanding how women cope in the aftermath of a life-threatening complication can assist with the development of culturally appropriate ways to evaluate and support Black women. For example, trauma-informed care is one type of approach used to work with individuals who experienced intimate partner violence or sexual abuse (Reeves, 2015). Currently, the literature on trauma-informed care does not explore race or racism, which is a more subtle form of traumatizing experiences, such as those found in this study.

More Black women need to be involved in nursing research as participants and researchers. Black women need to be active participants in research studies. Crucial data can be obtained from their experiences during pregnancy, childbirth, and during the postpartum period. Their perceptions of what placed them at risk or what occurred could offer rich data that can be used to improve maternal health outcomes. It is important to recognize that Black women have the knowledge and expertise to address health issues that impact them.

Lack of knowledge also prevented the women from advocating for themselves or asking the questions that could help them understand what was happening to them. Some of the women reported receiving education on nutrition, breastfeeding, and how to care for the baby, but little or no information on the possible risks or complications that can occur during pregnancy, childbirth, or postpartum.
Doulas could be the mechanism needed to decrease poor maternal health outcomes among Black women by offering education and support to women during pregnancy, childbirth, and postpartum. Women who utilize doulas are less likely to experience a complication during birth, have a cesarean birth or have a low birth weight baby (LBW), and have increased rates of initiating breastfeeding (Gruber et al., 2013). The women in this study wanted to have someone they could feel comfortable talking to about what they were experiencing in the aftermath. Also, a woman who has a doula is more likely to receive the education that she needs to feel empowered and advocate for herself (Guerra-Reyes, & Hamilton, 2017; Gruber et al., 2013).

There is a community of Black doulas that provide culturally appropriate care to women of color, particularly Black women. The services they provide incorporate traditional African practices that focus on childbirth and postpartum (Guerra-Reyes, & Hamilton, 2017). Some doula practices work in collaboration with midwifery services, and other provide specifically doula care. Black doulas are aware of the historical challenges Black women experience in the health care system and provide culturally appropriate care that focuses on the woman and her individual needs (Guerra-Reyes, & Hamilton, 2017).

Further research is needed to investigate doulas as an intervention to address racial and ethnic disparities in severe maternal morbidity. Doulas can be used to decrease disparities in maternal health outcomes by increasing access to underserved populations. (Strauss et al., 2015). Utilizing doulas can increase support to Black women during childbirth and postpartum.

**Health Policy Implications**

Health care organizations need to be aware of institutional policies and practices that place Black women at risk during childbirth and postpartum (Scott et al., 2019). Although the reasons that place Black women at higher risk compared to other racial and ethnic groups are not
clearly understood, institutional practices can focus on providing culturally appropriate care and improving the quality care provided to Black women (Murrell et al., 1996; Oparah et al., 2017).

It is evident that nurses, nurse-midwives, and obstetricians play a significant role in the experience of severe maternal morbidity among Black women, therefore, it is imperative to develop interventions to strengthen the relationships with these health care providers. When Black women enter the health care system for childbirth, they must feel safe and trust that their providers are providing them quality care that is without racial bias. Recommendations to improve the interactions with anyone they encounter during their care must include cultural awareness and sensitivity training as well as implicit bias education (Murrell et al., 1996; Pérez-Stable & El-Toukhy, 2018). Providers also need education to improve communication skills with the patients they serve, particularly when working with culturally diverse populations (Pérez-Stable & El-Toukhy, 2018).

Health care organizations can have provisions in place to hold health care providers accountable for the care they provide to women during childbirth (Oparah et al., 2017). After their childbirth experience, women can complete patient satisfaction surveys. These surveys are critical in providing the women an avenue to discuss their interactions with health care providers and feelings about the care they received (Oparah et al., 2017). Feedback from these surveys can lead to quality improvement initiatives by identifying what works well and areas needing improvement.

Doulas could provide continuous education and support during pregnancy, childbirth, and postpartum and be the bridge that connects women to the health care system. Services need to be expanded so that all women have access to doula care (Kozhimannil & Hardeman, 2016a; Kozhimannil et al., 2016b). Black women need to have access if they want doula services
regardless of their insurance status. Financial restraints should not be a barrier to doula access (Strauss et al., 2015). Reimbursement for doula services by private insurance, Medicaid, and Medicaid managed care organizations would significantly increase access to doulas (Strauss et al., 2015). Increasing access to full-spectrum doula services by expanding insurance coverage for all women, especially for those who are at increased risk for severe maternal morbidity (Kozhimannil & Hardeman, 2016a; Strauss et al., 2015).

Nursing organizations, such as the American Academy of Nursing, the American College of Nurse-Midwives (ACNM), the American Nurses Association (ANA), and the Association of Women’s Health and Neonatal Nurses (AWHONN) have acknowledged the need to address the poor maternal health outcomes among Black women (Amankwaa et al., 2018). The American College of Nurse-Midwives (ACNM) has acknowledged that racism in the profession has contributed to racial and ethnic health disparities in maternal health (ACNM, 2018; Likis, 2018). The American Academy of Nursing is calling on policymakers to develop and implement policies to improve maternal health outcomes among Black women (Amankwaa et al., 2018; ACNM, 2018; Likis, 2018). These organizations have committed to take an active role in addressing racial disparities in maternal health (Amankwaa et al., 2018).

Nursing organizations can work in collaboration with community organizations that address reproductive rights and inequalities in maternal health care, particularly among Black women, organizations such as Black Mommas Matter Alliance (Black Mommas Matter Alliance, 2018). Not only does this organization work within the Black community, but they also provide the bridge to Black Scholars who are already investigating and addressing the health care needs of pregnant Black women. Nursing organizations can support research initiatives addressing maternal health in Black women and assist with the dissemination of research findings.
Contributions to Nursing Science

This study demonstrates the value of qualitative research in addressing racial and ethnic health disparities. There is a need for qualitative studies that examine the experiences of Black women during childbirth and postpartum. To address racial disparities in maternal health, it is important first to understand the experiences of severe maternal morbidity among Black women. Examining medical records, discharge summaries, and birth certificates and death certificates is not enough to explain the racial and ethnic health disparities in maternal mortality and severe maternal morbidity. Van Manen’s interpretive phenomenology provided a holistic approach to examine the experience of severe maternal morbidity among Black women.

This methodology helped me to identify several factors that I would not have been able to see if I were analyzing quantitative statistical data. This approach provided a deeper understanding of the essential themes related to the experience of severe maternal morbidity from the perspective of Black women. The role of health care providers, the women’s knowledge of the complication, emotional space, mental health and wellbeing, how the women are still recovering mentally, and the influence of race are all essential to the experience of severe maternal morbidity.

I was able to see the long-term effect of severe maternal morbidity on their mental health. It is evident that women are still coping with their childbirth experience. In addition, I was able to identify how women perceive the effect their race had on the care they received and how implicit bias plays out in this experience.

I was able to identify the importance of the level of knowledge and education about the possible complications that can occur during childbirth and postpartum. Knowledge is important given that Black women must be partners in their care and advocate for themselves. Providing
knowledge and education about possible complications can place Black women in a stronger position to care for themselves when they experience signs and symptoms of a life-threatening condition. It is important to understand how the level of knowledge or education provided can place a woman in life-threatening situations. All Black women need education about the potential complications that can occur during childbirth and postpartum, even those that appear low-risk.

The relationship with health care providers is a critical component of the experience of severe maternal morbidity among Black women. The interaction with health care professionals affects how women feel during the care they received and can affect their emotional wellbeing. Women who had positive interactions with health care professionals felt safe and well cared for. Conversely, women who had negative experience felt like there was no compassion in their care, and that they were part of someone’s routine and had to seek emotional support on their own.

The emotional space that women found themselves in when they realized the seriousness of their condition and realized that they might not survive is important to note. There is an emotional and mental effect among Black women who experience severe maternal morbidity during childbirth and postpartum. The need for ongoing support, beyond the routine 6-week postpartum appointment, is essential. There are associated risks for depression, anxiety, and PTSD.

There is a gap in research that focuses on the experience of Black women during childbirth and severe maternal morbidity. This study gave voice to the Black women who participated. The perspective of Black women is often missing from current literature about Black women’s experience in childbirth. The women provided valuable information that will
assist with the development of culturally appropriate interventions as well as lay the foundation for further research into the experience of Black women during childbirth.

**Conclusion**

Severe maternal morbidity affects families, communities, and society. In the U.S., this is a concern for all women. Black women experience worst maternal health outcomes and are more likely to die compared to other racial and ethnic groups. Disparities in maternal health outcomes of Black women is an issue that has persisted in our society and is still not well understood. There is a gap in the literature on the experience of Black women who experienced severe maternal morbidity during childbirth and postpartum.

This study sought to identify and give perspective to the unique challenges that Black women experience during severe maternal morbidity. Black women need education about the possible complications that can occur during childbirth and postpartum so that they can be partners in their care and advocate for themselves. Their interactions with health care professionals had an affect on how women felt during the care they received and can affect their emotional wellbeing. Although the women physically healed from the complication, they are still recovering mentally. This study shows that Black women who experience severe maternal morbidity need emotional as well as physical support.

Education is a critical step in understanding the systems that are currently in place that continue to oppress marginalized communities and place them at risk for poor health outcomes (Karbeah et al., 2019). The voices of Black women have to be amplified to address disparities in maternal mortality and severe maternal morbidity. It is important to understand what they need to provide them with a safe childbirth experience. Advocating for Black women to have access to the resources needed for childbirth and postpartum includes access to diverse types of care that
are available (Guerra-Reyes and Hamilton, 2017). It is essential to provide relevant information and education to Black women, so they are aware of the options available for them during childbirth in order for them to make informed decisions regarding their birth plans.

Nursing research can play a role in developing knowledge that can contribute to identifying and addressing the factors that contribute to health disparities in maternal health outcomes. Nurses must be at the forefront of addressing health disparities in maternal health. Nurses can be instrumental in developing strategies to improve maternal health outcomes for all women. The inclusion of Black nursing scholars into research initiatives that are developing solutions to severe maternal morbidity in the Black women population is especially important as they can provide a unique perspective.

From their experience, nurses and other health care providers can become aware of factors that place Black women at risk for poor health outcomes and factors that may improve maternal health outcomes. Health care during childbirth and postpartum is an important aspect that influences health outcomes. Understanding Black women’s perceptions of that care is an essential next step in understanding disparities in maternal mortality and morbidity. The voices of Black women need to be represented in research that addresses health disparities to incorporate cultural factors that may influence care. The findings will inform the development of clinical interventions and health policies to improve maternal health outcomes among Black women.
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### Table 1

*Severe maternal morbidity indicators by race.*

<table>
<thead>
<tr>
<th>Severe maternal morbidity indicator</th>
<th>White Women (n = 1,485,280)</th>
<th>Black Women (n = 434,431)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion</td>
<td>78.94 ±0.73</td>
<td>187.03 ±2.06</td>
</tr>
<tr>
<td>Disseminated intravascular coagulation (DIC)</td>
<td>12.81 ±0.29</td>
<td>21.96 ±0.71</td>
</tr>
<tr>
<td>Heart failure during procedure or surgery</td>
<td>8.93 ±0.25</td>
<td>23.87 ±0.74</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>7.64 ±0.23</td>
<td>13.12 ±0.55</td>
</tr>
<tr>
<td>Cardio monitoring</td>
<td>1.42 ±0.10</td>
<td>29.28 ±0.82</td>
</tr>
<tr>
<td>Ventilation</td>
<td>5.44 ±0.19</td>
<td>15.54 ±0.60</td>
</tr>
<tr>
<td>Operations on heart and pericardium</td>
<td>7.11 ±0.20</td>
<td>9.55 ±0.47</td>
</tr>
<tr>
<td>Adult respiratory distress syndrome</td>
<td>5.82 ±0.20</td>
<td>13.44 ±0.56</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>3.63 ±0.16</td>
<td>10.36 ±0.49</td>
</tr>
<tr>
<td>Acute renal failure</td>
<td>4.07 ± 0.17</td>
<td>11.65 ±0.52</td>
</tr>
<tr>
<td>Shock</td>
<td>2.71 ± 0.14</td>
<td>4.83 ±0.33</td>
</tr>
<tr>
<td>Sepsis</td>
<td>2.56 ±0.13</td>
<td>5.96 ±0.37</td>
</tr>
<tr>
<td>Puerperal cerebrovascular disorders</td>
<td>1.90 ± 0.11</td>
<td>3.59 ±0.29</td>
</tr>
<tr>
<td>Pulmonary edema</td>
<td>1.32 ±0.09</td>
<td>2.60 ±0.25</td>
</tr>
<tr>
<td>Thrombotic embolism</td>
<td>1.29 ±0.10</td>
<td>3.38 ±0.28</td>
</tr>
<tr>
<td>Severe anesthesia complications</td>
<td>0.82 ±0.07</td>
<td>1.96 ±0.21</td>
</tr>
<tr>
<td>Conversion of cardiac rhythm</td>
<td>0.81 ±0.07</td>
<td>1.82 ±0.21</td>
</tr>
<tr>
<td>Sickle cell anemia with crisis</td>
<td>N/A</td>
<td>6.91 ±0.40</td>
</tr>
<tr>
<td>Cardiac arrest/ventricular fibrillation</td>
<td>0.57 ±0.06</td>
<td>1.50 ±0.19</td>
</tr>
<tr>
<td>Internal injuries of thorax, abdomen, and pelvis</td>
<td>0.39 ±0.05</td>
<td>0.92 ±0.15</td>
</tr>
<tr>
<td>Amniotic fluid embolism</td>
<td>0.28 ±0.04</td>
<td>0.65 ±0.12</td>
</tr>
<tr>
<td>Temporary tracheostomy</td>
<td>0.26 ± 0.04</td>
<td>0.69 ±0.13</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>0.20 ± 0.04</td>
<td>0.46 ±0.10</td>
</tr>
<tr>
<td>Aneurysm</td>
<td>0.10 ± 0.03</td>
<td>N/A</td>
</tr>
<tr>
<td>Intracranial injuries</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Note.** Rates (± standard errors) of severe maternal morbidities during delivery hospitalizations per 10,000 delivery hospitalizations by race/ethnicity.

**Table 2**

*Examples of the selective or highlighting approach to isolating statements.*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Selected Data</th>
<th>Existential Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Only Know What I Know</td>
<td>I didn’t even realize I was having all the symptoms of a heart, something being wrong with your heart because we’re not educated to really know those types of things. Participant 2. And what I’m telling you, I had no idea that was even a thing. I was like what do you mean by postpartum preeclampsia, you know. No one even coined that term to me. Participant 7. I just thought, you know, preeclampsia is when your blood pressure’s elevated and you gain water weight. That’s kind of what I thought it was. I didn’t think that it was life or death. You know, that is impacted your kidneys and liver and your other organs. Participant 8</td>
<td>Lived body</td>
</tr>
<tr>
<td>Faced with Uncertainty</td>
<td>I was hot, my body was literally hot. You can feel the heat radiating off of me and it just kept getting worse and worse as the day went. That’s what got me scared. Participant 1 They were telling me that my heart was so bad, if in the next three months if it didn’t approve, then I might need a transplant. Participant 2 What if I do not wake up from my anesthesia. I just had a baby, she’s not going to have a mother. Participant 5.</td>
<td>Lived space</td>
</tr>
<tr>
<td>How You Cared for Me</td>
<td>They answered call bells and they came and made sure I was eating and stuff. Participant 3 I felt like, you know, the care is routine. You come and you have the baby? We do our part. You do your part, you go home. It wasn’t very personal. Participant 7. Not anything outside of your standard medical routine. You draw a CBC and you tell the person the results. A task-oriented kind of thing. Not on a personal level. Participant 5</td>
<td>Lived human relation</td>
</tr>
<tr>
<td>Felt safe and well cared for</td>
<td>I’ve been blessed to have doctors who have taken me seriously. Participant 2</td>
<td>Lived human relation</td>
</tr>
</tbody>
</table>
I had a really good, strong relationship with my OB/GYN, so I just kind of trusted her, you know, to make good decisions for me. Participant 4

He was not only my doctor, he was my friend. So, he went to war to save me, you know. Participant 6.

My doctor told me ‘Any problem is a big problem. I don’t care how small you think it is. You need to tell me.’ Participant 8

I loved my provider. I still have her. I’ve only been there for my whole GYN history. For 23 years I had the same provider.” Participant 9

Race Matters

I knew a heart transplant would not have happened for me. I felt like that because I am Black. I would not have been a priority.” Participant 2

All they do is push nutrition on you and they see your skin color and push all these programs, WIC and food stamps. Participant 3

There is a stigma, there is not a lot of things offered for Black people. We are not interested. We do not care. I feel like that stigma came true. Participant 5.

Still Healing

It was traumatic and you know, it takes a toll on and it takes a toll on you mentally too because you’re just like, what’s going to happen to me? It’s going to happen to my baby? Participant 2

I really wasn’t able to function well and I would get really anxious about just about anything and everything. Participant 4

Mentally, I feel that I am in a better space, more on an acceptance level for the first couple of years, and I want to say still now, there is an avoidance built into it. Participant 5.

I think I’m still traumatized from it. You know, because I, I know it happens so quickly. We were totally unprepared. Participant 8

I was so miserable and I had such anxiety. It was starting to take over my life. Participant 9
Table 3

*Example of the essential themes from one interview*

- Unaware was having symptoms of a serious complication
- Blindsided by the diagnosis
- Uncertainty about her future
- Considered her mortality
- Felt dismissed
- Positive relationship with health care provider
- Learned to advocate for herself.
- Impact on mental wellbeing: Strong family support: husband and family
- Black women are not a priority
Figure 1. Uncertainty
Figure 2. Safe and Well Cared For
Figure 3. Black Woman Pregnant
Figure 4. Still Healing
Figure 5. Not Always Rainbows and Unicorn
Figure 6. Essential themes and van Manen’s lifeworld existentials
Appendix A Facebook advertisement

University of Connecticut
Participants Wanted for a Research Study
The Experience of Severe maternal morbidity among Black Women.

**Have you experienced a serious complication during childbirth or postpartum?**
Black women are more than 3 to 4 times as likely to die of pregnancy-related causes and twice as likely to suffer a severe complication during childbirth compare to White women. My name is Lucinda Canty, a graduate student, and I am conducting research to learn about the experiences of Black women who had severe maternal morbidity (a severe complication) during childbirth or postpartum. **Please help me investigate this serious health matter.**

If you are Black, over 18 years of age, gave birth within the last 20 years in the United States and experienced a severe complication during childbirth or postpartum, then you may qualify for this research study. Examples of severe maternal morbidity include heart failure, hypertension (high blood pressure), seizures, hemorrhage (excessive vaginal bleeding), and sepsis (the body’s life-threatening response to infection). I want to interview you about your experience. To learn more about this research, contact Lucinda Canty at (860)874-8851 or Lucinda.canty@uconn.edu.

This research is conducted under the direction of Dr. Ivy Alexander at the University of Connecticut School of Nursing.
Appendix B Consent Form for Participation in Study

Consent Form for Participation in a Research Study

Principal Investigator: Ivy Alexander, PhD, APRN, ANP-BC, FAANP, FAAN
Student Researcher: Lucinda Canty, MSN, CNM
Study Title: The Experience of Severe maternal morbidity among Black Women.

Overview of the Research
You are being asked to provide consent to participate in a research study. Participation is voluntary. You can say yes or no. If you say yes now you can still change your mind later. Some key points to consider are summarized in this overview, but you should consider all of the information in this document carefully before making your decision. This research is being done to understand the experiences of severe maternal morbidity (severe medical complication during childbirth or postpartum) among Black women. Examples of severe maternal morbidity include heart failure, hypertension (high blood pressure), seizures, hemorrhage (excessive vaginal bleeding), and sepsis (the body’s life-threatening response to infection). You will be asked to be interviewed about your experience of severe maternal morbidity. We believe there are minimal risks associated with this research study. Risks are described in more detail later in this form. There may also be benefits from participation. This research may also result in information that leads to improved care to women who experience severe maternal morbidity. A more detailed description of this research follows.

Introduction
You are invited to participate in a research study to examine the experiences of women who suffered a severe complication during childbirth or the postpartum.

Why is this study being done?
I am a graduate student in nursing at the University of Connecticut, and am conducting this research for my dissertation work. The purpose of this study is to describe the experience of Black women who suffered severe maternal morbidity during childbirth and postpartum.

What are the study procedures? What will I be asked to do?
If you agree to take part in this study, you will be asked to participate in two interviews (approximately 45 – 60 minutes) about your experiences with severe complication during childbirth and postpartum. The interview will be audio taped. The interview will be scheduled at a time and place that is convenient for you.

What are the risks or inconveniences of the study?
We believe there are minimal risks associated with this research study. You will be asked to discuss your experience with suffering a severe complication during childbirth and
postpartum. Reflecting on these events may cause you to experience emotional distress. To minimize this risk, if you do not want to answer a question or you feel uncomfortable, you are free to skip a question or stop the interview for any reason. The only inconvenience is the amount of time each interview takes, about 45-60 minutes.

What are the benefits of the study?

You may not directly benefit from this research; however, we hope that your participation in this study may help to improve care for Black women during childbirth and postpartum.

Will I receive payment for participation? Are there costs to participate?

There are no costs and you will not be paid to be in this study.

How will my personal information be protected?

The following procedures will be used to protect the confidentiality of your data. The researchers will keep all study records (including codes to your data) locked in a secure location. Research records will be labeled with a code. The code will be derived from a number (e.g. sequential 2-digit code) that reflects how many people have enrolled in the study. A master key that links names and codes will be destroyed once this research study is completed. All electronic files (e.g. database, spreadsheet, etc.) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. Data that will be shared with others will be coded as described above to help protect your identity. If a transcriptionist is used to transcribe audio recordings, he/she will be instructed to keep the information confidential and will not be given names of any participants. No identifying names will be used in the transcript. At the conclusion of this study, the researchers may publish their findings. Information will be presented in summary format. Quotations will be generally representative of overall data and identified with a made-up name. You will not be identified in any publications or presentations. We will do our best to protect the confidentiality of the information we gather from you but we cannot guarantee 100% confidentiality.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus only on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to make sure that the rights and welfare of research participants are being protected.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. You do not have to answer any question that you do not want to answer. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate.

Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this study or if you have a research-related problem, you may contact the principal investigator, (Dr. Ivy Alexander (860) 486-0600) or the student researcher (Lucinda Canty (860) 874-8851). If you have any questions concerning
your rights as a research participant, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

**Documentation of Consent:**
I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature also indicates that I have received a copy of this consent form.

<table>
<thead>
<tr>
<th>Participant Signature:</th>
<th>Print Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Person Obtaining Consent</th>
<th>Print Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>
Appendix C Audio Consent Form

Protocol # H18-229  Principal Investigator: Ivy Alexander, PhD, APRN, ANP-BC, FAANP, FAAN
Protocol Title: The Lived Experience of Severe maternal morbidity among Black Women.

As part of this research study the University of Connecticut and those acting pursuant to its authority (“UCONN”) may record your voice on a particular medium (“recordings”) including but not limited to audio, digital, and electronic mediums during your participation in this research study. Please indicate what uses of these recordings you are willing to permit, by putting your initials next to the uses you agree to and signing the form at the end. The choice is completely up to you. We will only use recordings in the ways that you agree to. In any recording, you will not be identified by name. The recordings with not be used for commercial purposes.

1.________    The recordings can be studied by the research team for use in the research project
2.________    The recordings can be used for scientific publications
3.________    The recordings can be used for scientific conferences or meetings
4.________    The recordings can be used for reports/presentations to any research funding agencies

I understand that all such recordings, in whatever medium, shall remain the property of UCONN. My name will not be used in any publication. I agree that I will not be compensated for the use of the recordings.

I have read the above descriptions and give my consent for the use of the recordings as indicated by my initials above. (Youth under 18 years of age must have a parent/legal guardian signature.)

(Name, please print)

(Signature of Subject)                     (Date : MM/DD/YY)

(Parent/Guardian Signature, if participant is a minor)                     (Date : MM/DD/YY)

(Signature of Person Obtaining Consent)                     (Date : MM/DD/YY)
Appendix D Demographic Information

**Demographic Information**

Age:

Race/ethnicity:

Marital status:

Education level:

Employment status:

Insurance status:

Annual income:

**Maternal Health History**

How many pregnancies?

How many children?

How far along was the pregnancy (weeks) when you started prenatal care?

How far along was the pregnancy (weeks) when you delivered?

Type of Delivery:  ____ Vaginal  _____ Cesarean

Complication experienced during delivery or the postpartum period:
Appendix E

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Jan 21, 2020

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Licensed Content Publisher Elsevier
Licensed Content Publication American Journal of Obstetrics and Gynecology
Licensed Content Title Racial and ethnic disparities in severe maternal morbidity:
a multistate analysis, 2008-2010
Licensed Content Author Andrea A. Creanga, Brian T. Bateman, Elena V. Kuklina, William M. Callaghan
Licensed Content Date May 1, 2014
Licensed Content Volume 210
Licensed Content Issue 5
Licensed Content Pages 8
Start Page 435.e1
End Page 435.e8
Type of Use reuse in a thesis/dissertation
Portion figures/tables/illustrations
Number of figures/tables/illustrations 1
Format both print and electronic
Are you the author of this Elsevier article? No
Will you be translating? No
Title It's Not Always Rainbows and Unicorns: The lived experience of severe maternal morbidity among Black women
Institution name University of Connecticut
Expected presentation date Feb 2020
Portions TABLE 2 Rates (± standard errors) of severe maternal morbidities during delivery hospitalizations per 10,000 delivery hospitalizations by race/ethnicity