

“THE ONLY REASON WHY IT HAPPENED IS SIMPLY BECAUSE WE’RE BLACK
WOMEN!”: THE BLACK PERINATAL HEALTHCARE EXPERIENCE IN CANADA

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Abstract

Background: Black Canadian mothers are more likely to experience an adverse health outcome compared to any other race. Yet, the Black maternal healthcare experience is not adequately documented within a Canadian context. This research study interpreted and analyzed the maternal healthcare experiences of Black women living in the Greater Toronto Area.

Methods: Focus groups and interviews were conducted utilizing Zoom, with eight Black Canadian mothers.

Findings: The mothers agreed that healthcare organizations provided insufficient perinatal provisions, discussed feeling neglected by healthcare providers, the relationship between culture and care, preconceived healthcare biases, expressed their appreciation for supportive healthcare providers, and the stereotype of the ‘strong’ Black woman.

Implications: To provide culturally competent care to Black women, healthcare providers must acknowledge their unconscious biases, health services must be made more public to Black mothers, and the Canadian health policies must be modified to improve the Black Canadian morbidity and mortality rates.

Dedication

This thesis is dedicated to my late father, Akwasi Afranie-Frimpong. Although you are not here in the physical, your love and emphasis on the importance of education prepared me to complete my Masters' degree. Incidentally, he passed away only 18 days into this degree program. Yet, his consistent guidance and support gave me the strength to complete this thesis. Forever grateful for your love and encouragement.

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Chapter 1: Introduction

In 2019, the World Health Organization (WHO) revealed that between the years 1990 and 2008, the maternal mortality rate declined by 40% worldwide, however the rate increased in 23 nations including The United States and Canada (Mijal, 2019). Black pregnant women have higher incidences of morbidity and mortality in relation to other maternal populations (Canty, 2020). American statistics confirm that approximately 41.6/100 000 Black maternal deaths occur throughout the various pregnancy and labour phases (Thompson-Dudiak, 2021). The rise in the Black maternal morbidity and mortality rates have been attributed to racial inequalities, prejudices, and structural racism within Canadian and American healthcare infrastructures (Etowa et al., 2015; Kwate et al., 2003). Historically race-based data has not been collected causing ambiguities surrounding the factors that contribute to the maternal mortality and morbidity rates for Black women (Etowa et al., 2015). To provide care, Canadian physicians use data from the United Kingdom and United States to better understand the existing Black maternal health disparities (McKinnon et al., 2016). Canadian literature has acknowledged the current Black maternal health crisis, yet research documenting the voices of Black Canadian women's maternal health experiences are marginal.

My research aimed to contribute to addressing the dearth of information on the Black maternal healthcare experience in a Canadian context, recognizing that the majority of research on this issue is from the United States and does not address the nuances of Black Canadian women's pregnancy experiences. This research study focused on the maternal healthcare experiences of Black Canadian women living in Canada's Greater Toronto Area. Understanding Black women's maternal experiences and their perceptions of the Canadian healthcare system is vital in improving access to culturally safe care within our community. Ultimately, the goal of

my research study was to enlighten healthcare organizations, healthcare providers, and educators of the inequities Black pregnant women living in Canada withstand, and the measures health organizations and care providers can implement to ensure all women receive equitable care in Canada.

Research Questions

Research recognizes that Black women are more likely to experience adverse health outcomes compared to women from other ethnicities, yet The Black maternal healthcare experience is not well documented within a Canadian context. The purpose of this research study was to explore Black women in Canada's perception of their maternal healthcare experiences within the last 5 years. Initially, I presented two major research questions:

1. What are the perceptions and lived health experiences of women from the Black maternal population in Canada's Greater Toronto Area (GTA) on the antepartum care of pregnancy?
2. What barriers and facilitators do Black Canadian women from the Greater Toronto Area experience when obtaining antenatal care from healthcare organizations and providers?

Originally, my research questions focused on the antenatal phase of Black women's pregnancy experiences. However, the participants recognized that the Canadian healthcare system fails to provide adequate care during all stages of pregnancy as well as the postpartum period. I decided to study the perinatal period because it includes pregnancy and up until a year after giving birth (Simpson, 2013). Therefore, I modified the research questions to reflect this:

1. What are the perinatal healthcare experiences and perceptions of care from Black women living in Canada's Greater Toronto Area (GTA)?

- a. What provisions and resources can the Canadian healthcare system implement to sufficiently support Black women in Canada as they transition into motherhood?

Chapter 2: Literature Review

I sought to identify the implications for the high morbidity and mortality rates within Canada's Black maternal population. Canadian Black maternal health literature is marginal; therefore, this literature review will also include evidence from American research regarding this phenomenon (See Appendix A for a detailed outline of my literature search). This literature review captures the experiences of Black women who were pregnant in North America within the last decade. Acknowledging the stories of Black mothers provides insight on the Black maternal healthcare experiences.

Black Women Speak Up: Experiences of Racism

Health disparities rooted in racism affect the quality-of-care Black patients experience from the healthcare system. Salm Ward et al. (2013) categorizes racism into three levels: internal, institutional, and personally mediated racism. I will use Salm Ward's et al. (2013) racial categorizations to organize this literature review and demonstrate how each form of racism alters minorities' access to essential resources, health outcomes, and their perception of care.

Internalized Racism

Internalized racism occurs when marginalized individuals accept the damaging social views and stereotypes made about their demographic population (Salm Ward et al., 2013). This form of racism is often conveyed when the individual rejects their own ethnic and traditional practices and adopts Westernized cultures and customs (Salm Ward et al., 2013). Salm Ward et al. (2013) recognizes how internalized racism can erode an individual's self-esteem and hinder discussions surrounding racism. Research pertaining to internal racism in relation to Black maternal perinatal care experiences are minimal, therefore this literature review will focus on the impacts of institutional and personally-mediated racism on the Black maternal population.

Institutional Racism

Institutional racism in health care is defined as the core guidelines, standards, and traditions which restrict specific ethnic groups from attaining equitable, equal, and quality care (Howell et al., 2018). This form of racism occurs when minorities experience inconsistencies while obtaining healthcare resources, amenities, and opportunities (Salm Ward et al., 2013). Institutional biases are a result of structural and organizational inequities rooted from slavery and racial segregation (Howell et al., 2018). Canada is viewed as a utopic society; however, remnants of slavery's social, cultural, and political constructs continue to persist and are evident within the healthcare system (Howell et al. 2018; Salm Ward et., 2013). Researchers Etowa et al. (2015), Chambers et al. (2020) and Nuru-Jeter's et al. (2008) studied Black mother's experiences and perceptions of their perinatal care. The maternal participants revealed that institutional prejudices were the negative financial, societal, and cultural biases they experienced throughout their prenatal healthcare visits that other races did not routinely experience. Many of the Black participants' expressed feelings of judgement and despair while seeking prenatal care (Etowa et al., 2015; Chambers et al., 2020; Nuru-Jeter et al., 2008). When racist practices are embedded within health infrastructures it resulted in unjust medical conduct and negative health outcomes (Dominquez, 2011; Howell et al., 2018).

Hidden Resources and Barriers to Seeking Care. Medical professionals advise all women to book their initial prenatal visit within the first trimester of pregnancy because early and regular physician visits ensures a healthy and safe pregnancy and delivery (Dominquez, 2011; Etowa et al., 2015). Research indicates that reluctance in obtaining early and regular prenatal care results in pregnancy and birthing complications (Dominquez, 2011; Etowa et al., 2015; Salm Ward et al., 2012). Canadian and American Black mothers in Etowa et al. (2015),

Chambers et al. (2020), and Salm Ward's et al. (2012) studies indicated that their lack of knowledge regarding prenatal care and isolation from healthcare facilities were a result of the segregation of Black families after the emancipation of slavery. The systematic decision to isolate Black neighbourhoods resulted in these populations having limited access to medical resources and community programs, higher incidences of health complications, and negative perceptions of care towards the healthcare system (Chamber et al., 2020; Nuru-Jeter, 2008; Salm Ward et al., 2012). Black American women from Chambers et al. (2020) and Nuru-Jeter's (2008) studies were aware of the repercussions of segregation on prenatal care initiation. Both research studies acknowledged that discriminatory policies and laws that segregated Black communities away from health resources interfered with Black women's willingness to attain medical attention in a timely manner (Chambers et al., 2020; Nuru-Jeter's, 2008). Black American women from Nuru-Jeter's (2008) study admitted that other impeding factors in early prenatal visits were distance and location of the pregnancy clinics. Black Canadian participants in Etowa's et al. (2015) study expressed that the "good clinics" were too far from their neighbourhoods and almost impossible to get appointments to, thus delaying their prenatal care visits. Aspects of the high mortality and morbidity rates in the Black maternal community can be attributed to minimal and/or delayed prenatal care visits (Nuru-Jeter et al., 2008; Salm Ward et al., 2012).

Another major theme identified by Black American women in Chambers et al. (2020) and Salm Ward et al. (2012) research studies was the lack of and struggle to acquire health resources specific to Black women and children. Many of Etowa's et al. (2015) and Chambers' et al. (2020) participants' expressed difficulties obtaining sufficient information surrounding maternal health and/or knowledge of essential community services like perinatal and infant feeding programs. Other women described insufficient public resources and inequalities in medical

amenities fundamental for a safe and healthy pregnancy (Chamber et al., 2020; Etowa et al., 2015). Participants in Chambers et al. (2020) study spoke about a community program centered around Black infant health that was not publicized, readily available, or discussed by any medical professionals (Chambers et al., 2020). Study participants in the Chambers et al. (2020) and Etowa's et al. (2015) study stated that difficulties in obtaining health resources and programs elicits negative perceptions towards the healthcare system.

Research indicates that many Black mothers believed the marginalization of Black communities has affected how health organizations incorporate Black patients' health needs within various health institutions (Chambers et al., 2020; Etowa et al., 2015). Studies also indicate that institutional racism conceals and restricts health resources and negatively impacts the health outcomes of the Black maternal population in Canada and the United States (Chambers et al., 2020; Nuru-Jeter et al., 2008). To reduce the morbidity and mortality rates in the Black community, healthcare resources must be easily accessible, non-discriminatory, and safe (Arnett et al., 2016).

Personally-Mediated Racism

Personally-mediated racism occurs when an individual has negative assumptions and actions towards another individual's capabilities, intentions, and goals based on their race (Salm Ward et al., 2013). Black women perceive and experience this form of racism as discriminatory and prejudicial as it impacts the level-of-care they receive from healthcare providers (Wynn, 2020).

Stereotypes. Slavery has had a lasting impact on how Black women are viewed within Western society (Thompson-Dudiak, 2021). Historically, Western culture's inhumane treatment of Black women's bodies formed the "Jezebel" stereotype; a woman who is ruled by her 'erotic cravings'

and desires towards men (Wynn, 2020). The Jezebel stereotype has resulted in Black women being viewed as sexual objects, while White women are seen as innocent and virtuous (Thompson-Dudiak, 2021; Wynn, 2020). The sexualized perception of Black women subsequently enabled the “bad mother” reference. Black women are depicted as lazy, constantly manipulating public assistance programs, and intentionally reproducing unwanted children as a source of additional income (Wynn, 2020). Another stereotype of Black women is termed the Angry Black Woman (ABW). The ABW describes an angry woman who is vulgar, brassy, stubborn, and domineering (Wynn, 2020). The Jezebel, Black fertile mother, and ABW stereotype depicts Black women as manipulative and unqualified in logical decision making (Thompson-Dudiak, 2021).

The racialized stereotypes of Black women facilitated control over the Black female reproductive system (Wynn, 2020). Thompson-Dudiak (2021) and Wynn (2020) acknowledged that the disparaging and devaluing descriptions of Black mothers cast Black reproduction as threatening and has negatively influenced the rapport between Black pregnant women and their physicians. Black American women in Benkert and Peters (2005), Chambers et al. (2020) and Salm Ward et al. (2012) studies described explicit experiences of blatant prejudice and stereotypical actions from healthcare providers throughout their pregnancies. The women retold stories of being constantly scolded, ridiculed, and belittled by physicians and nurses.

Participant “A” in Benkert and Peters’ (2005) study described how a White nurse assumed an injury from a fall was caused from sexual activity less than six weeks after the delivery of her infant. After repeatedly informing the nurse about the fall, the participant recalled feeling judged and ignored (Benkert & Peters, 2005). Unfortunately, no further test or assessment was conducted on the participant and her injuries were completely disregarded

(Benkert & Peters, 2005). Many Black American women from Salm Ward's et al. (2012) study had similar experiences of prejudicial behaviours from health professions. Assumptions were constantly made regarding the women's medical insurance, marital status, and/or use of drugs when accessing healthcare amenities (Salm Ward et al., 2012). Participant "B" in Salm Ward's et al. (2012) study informed her healthcare provider that she did not like going to her prenatal visits. The provider automatically asked, "Are you doing crack?" (p.1756). Black women agreed that these forms of prejudicial comments were common amongst healthcare providers (Benkert & Peters, 2005; Salm Ward et al., 2012; Wynn, 2020).

Stereotypes regarding Black women are discriminatory and affects the care individuals receive. Whether comments from healthcare providers are intentionally or unintentionally racist, this form of discrimination ultimately jeopardizes the health of Black pregnant women and their unborn child(ren) by creating a barrier to perinatal care (Benkert & Peters, 2005; Chambers et al., 2020; Salm Ward et al., 2012).

Feeling Stereotyped. Lui et al. (2019), Mijal (2019), Ormsby (2018) and Parasides et al. (2015) explored the lived health experiences of the Black maternal population in America. Each study investigated the reason Black women were more likely to experience health complications and/or death during pregnancy. Reoccurring themes of neglect were identified amongst many of the Black maternal participants (Mijal, 2019; Ormsby, 2018). It was revealed that the women's health needs were often disregarded, and they were mistreated by their healthcare provider(s) (Khemani, 2020; Ormsby, 2019).

A Black woman from Khemani's (2020) study discussed her experiences of being a Black pregnant woman within the American healthcare system. She informed her obstetrician (OB) of her high-risk twin pregnancy, yet the physician accused her of being a hypochondriac

and refused additional treatment for her and the fetuses (Khemani, 2020). The participant delivered her twins at only 28-weeks' gestation and expressed how little her well-being was ensured throughout the labour and postpartum periods (Khemani, 2020). The OB's reluctance to prioritize the participants' health concerns resulted in life-long complications for her and her twins (Khemani, 2020).

Each research study presented multiple stories of Black women expressing their health concerns to healthcare providers. Their fears were constantly ignored and treated with minimal significance by medical professionals. Black women described the ignorance, neglect, and mistreatment by healthcare professionals and organizations, which they believed to be the direct cause for their pregnancy loss and labour complications (Khemani, 2020; Lui et al., 2019; Mijal, 2019). Research has affirmed that Black women across the United States and Canada are constantly disregarded and neglected by healthcare providers throughout their pregnancy (Mijal, 2019; Ormsby, 2018). Experiences of ill-treatment and negligence are commonly reported. Neglectful behaviours from the healthcare system contribute to adverse health outcomes within the Black maternal population (Khemani, 2020).

Eliminating structural racism includes acknowledging its deteriorating systemic components and ensuring the appropriate modifications exist to guarantee positive health outcomes for the Black maternal population in Canada (Ormsby, 2018). Throughout the literature, Black women defined structural racism as an organization of oppression that facilitates harmful social views of Black women and limits health and community resources, resulting in insufficient medical care and community infrastructures (Etowa et al., 2015; Chambers et al., 2021; Mijal, 2019; Nuru-Jeter et al., 2008). The intent of my literature review is to provide awareness of the inequities Black women endure throughout the perinatal phase. With the

information attained from this research study healthcare providers may be more cognizant of Black woman's unique experiences of pregnancy (Canty, 2020). Acknowledging the discriminatory healthcare experiences of the Black maternal population is imperative in recognizing the impacts of structural racism on the Black Canadian maternal mortality and morbidity rates (Etowa et al., 2015; Khemani, 2020).

Chapter 3: Theoretical Framework

Background Knowledge: Defining Race, Ethnicity, and Structural Racism

Race and ethnicity are complex terminologies. Although both terms are used interchangeably, their origin and meanings differ (Agyemang et al., 2005). Race describes an individual's biology and is based on regional phenotypic characteristics (i.e., skin pigment, facial feature, and hair type) (Agyemang et al., 2005; Feldman et al., 2003). Ethnicity is a cultural phenomenon grounded in religion, viewpoints, and customs (Agyemang et al., 2005; Feldman et al., 2003). Race and ethnicity as social constructs are valuable within the medical context because they may offer insights about social environments and lifestyle routines (Feldman et al., 2003). Recognizing the racial and ethical components of an individual's health can assist healthcare providers in identifying potential racial discrimination and health disparities (Feldman et al., 2003).

Race based terminologies specific to African populations are important in understanding regional and intercontinental similarities (Agyemang et al., 2005). The terms Black, African, African Caribbean/Afro-Caribbean, and African American are often used interchangeably in research (Feldman et al., 2003). However, each group of individuals partake in different customs and traditions (Agyeman et al., 2005; Walker, 2013). For the purposes of this thesis the term 'Black' will be used to define Black women with African ancestral roots who identify as descendants of Africa regardless of their place of birth (Agyemang et al., 2005; Walker 2013). My decision to use the term Black allows for the inclusion of participants from various African and Caribbean countries. Although the term 'Black' will be used throughout this thesis, I used the terms Black/African/Caribbean/Black Canadian in the field to ensure the inclusion of women

from African/Caribbean's diverse cultural backgrounds who do not identify as Black but are African, Caribbean or both.

Structural racism is described as the public policies and judicial practices that precipitate racial disparities (Lui et al., 2019). Structural racism occurs when the development, sustainability, and process of the healthcare system favors a particular racial group, resulting in inadequate allocations of resources and economic opportunities (Chambers et al., 2020). Research confirms that prejudicial practices negatively affect the healthcare experiences of minorities by altering interactions between the healthcare provider(s) and the patient, forming barriers and restrictions when accessing resources, and inhibiting minorities from attaining essential care (Kwate et al., 2003; Lui et al., 2019; Paradies et al., 2015). There is an assumption that the source of the high Black maternal mortality rates in the United States and Canada are rooted in difficulties obtaining healthy foods, reliable transportation, and accessing decent schools and jobs (Thompson-Dudiak, 2021). However, research indicates that Black women with high incomes, educational levels, and socioeconomic statuses are equally as likely to experience an adverse health outcome or die as a result of pregnancy or childbirth (Thompson-Dudiak, 2021).

The Impacts of Slavery and its Implications on Current Medical Sexism

Slavery as a period in history is significant in understanding women's current perinatal healthcare experiences. From the early 1400s, enslaved Black women were used to advance slave production and reproductive health (Thompson-Dudiak, 2021). Black women were deemed inferior, yet medical professionals were captivated by their bodies as it was viewed as erotic (Hills, 2020). This fascination shaped the belief that Black women were immune to- and experienced pain minimally compared to Caucasian men and women (Hills, 2020; Thompson-

Dudiak, 2021). As a result of this belief, thousands of enslaved Black women became the subject of harmful medical experiments without the use of anesthesia (Hills, 2020; Thompson-Dudiak, 2021). The normalization of degrading medical experiments and the “super-body” perception of Black women’s bodies has continued to influence the present-day treatment and negative health experiences of the Black maternal population (Hill, 2020).

Currently, medical racism and sexism are prevalent issues in healthcare and occurs when the healthcare provider insinuates, disregards, ridicules, or dismisses patient’s health concerns during conversations, treatment, and care (Williams & Mijal, 2019; Sarto et al., 2013; Tucker, 2000). These forms of racism are detrimental because it influences health diagnoses and causes inequities in medical practices and allocation of medical supplies (Williams & Rucker, 2000). Racist practices within healthcare are more prevalent for women because their medical concerns are often disregarded and deemed insignificant by physicians (Mijal, 2019). Regrettably, Black women experience both medical racism and sexism when attaining access to American and Canadian healthcare organizations (Etowa et al., 2015; Mijal, 2019). Experiences of medical biases from women’s subjection of pain and prejudices from being an ethnic minority affects Black women’s ability to obtain sufficient care (Mijal, 2019; Sarto et al., 2013). Mijal (2019) and Ormsby (2018) recognize that many healthcare professionals apply the “color-blind” philosophy within their care practices to prevent medical racism. Although this view is considered harmless, it ignores experiences of racism and racial oppression, rejects cultural traditions, challenges unique perspectives, and annuls the negative health experiences Black women endure in the healthcare system (Mijal, 2019). Ultimately, this philosophy restricts Black patients’ access to medical care, services, and resources that other races have unlimited access too (Mijal, 2019; Sarto et al., 2013). Racial and gender disparities exist. Therefore, race and gender must be

considered when determining the best intervention to utilize when providing care to Black pregnant women (Sarto et al., 2013).

Theoretical Framework: Intersectionality

Intersectionality was the theoretical framework used to explore the Black Canadian perinatal healthcare experience. Intersectionality is a theory under the critical social theory (CST) paradigm (Crenshaw, 1989). Critical theories seek to enhance social conditions by overcoming systemic barriers and challenge existing circumstances to attain human equality (Ngwenyama et al., 1997). Using a CST paradigm within my research study provided me with an analytical framework to question the influence of power in sustaining systemic barriers. Implementing CST within my research study guided my research questions and allowed participants to express their perceptions of organizational structures and societal interactions within their environment as a fundamental component of understanding and challenging the Black perinatal health experience (Ngwenyama et al., 1997). Critical social theory seeks to create meaning and amend incidences of prejudice and oppression Black Canadian mothers often experience. It is important to explore the circumstances which precipitate negative healthcare experiences and harmful health outcomes to ensure equitable care for every Black woman. From a critical social theory standpoint, it is also important for change to be informed by those who are most impacted by injustices because of its direct impact on their healthcare needs (Ngwenyama et al., 1997).

In 1989 Kimberle Crenshaw developed the theory of intersectionality to explain the experience of a Black woman being discriminated by both race and gender in her workplace. Crenshaw (1989) explained how the “single-axis analysis” is detrimental as it fails to recognize the existence of multiple identities Black women simultaneously experience. The

intersectionality framework implements critical social sciences and postcolonial feminist traditions to provide alternate interpretations of concepts that would typically prioritize only one social existence (Crenshaw, 1989). Intersectionality (informed by critical social theory) affirms that individuals should not be defined merely by their race, sex, faith, or sexuality; but that people's experiences intersect social, political, and ideological factors that work collectively to construct negative or positive outcomes (Wilson-Mitchelle & Herbert, 2014). In reference to Black Canadian women, negative health outcomes are evidenced by the high mortality and morbidity rates, lack of access to resources, and their feelings of neglect from healthcare providers (Canty, 2020). Therefore, understanding Black women's maternal disparities should begin with acknowledging their experiences with racism and sexism (Mijal, 2019; Orsmy, 2018).

Typically, Black women's encounters with race and gender-based prejudice are described in relation to White women and Black men's experiences (Crenshaw, 1989; Wilson-Mitchelle & Herbert, 2014). It is important to recognize that Black women's experiences of discrimination can be parallel to, yet distinct from, those experienced by White women and Black men (Crenshaw, 1989). Crenshaw (1989) affirms that this complex affiliation results in many Black women experiencing double-discrimination because of their race and gender. Collins (2000) and Crenshaw (1989) agree that Black women continue to be marginalized because of the utilization of the feminist and race theory. Both theories inadequately address the intersectional experiences of oppression that Black women encounter. Samuels (2008) recognizes that Black women's experiences are unique and research pertaining to their lives must be conducted in ways that explore the implications of privilege and oppression on healthcare experiences.

Despite ongoing efforts to eliminate the inequities within the Canadian healthcare system, minimal improvements have been made to identify and create solutions for the healthcare biases

Black women experience (Etowa et al., 2015). Utilizing intersectionality theory within this research study allowed me to analyze and understand Black women's diverse realities and experiences of prejudice within the health care system. Understanding how distinct elements interact with each other provided acknowledgment of Black Canadian mothers' unique experiences when obtaining perinatal care.

Chapter 4: Methodology

The purpose of this research was to understand the Black maternal healthcare experience within a Canadian context. In this chapter, I will present the research approach, ethical process, strategies which ensured rigor, and plans for dissemination.

My Positionality

As a Black woman who is the daughter of West African immigrant parents, I am passionate about improving the health outcomes for women within my community. In the second year of my master's degree, I completed a qualitative research proposal. It was at this time when I identified an alarming gap within health literature. While working on my Masters' degree, many of my research papers were centered around maternal health. Although I worked in labour and delivery (L&D), I was dismayed by the research evidence and statistics for Black women. Black women and their infants are three to four times more likely to experience adverse health outcomes, some fatal, during the different phases of pregnancy (Chambers et al., 2021). What was even more concerning was the lack of Canadian-specific research on Black maternal health. Evidence indicates that the rate of morbidity and mortality are substantially greater in the Black maternal population compared to other ethnic racial groups, yet Canadian literature fails to adequately acknowledge or identify the roots of this troubling statistic (Etowa et al., 2015). As a Black L&D nurse and woman, I can recognize Black women's' fears surrounding their pregnancy and labour experiences.

Methodology: Qualitative Description

To understand Black mothers in Canada's subjective views on their perinatal experience, qualitative description was the methodology used for this research study. Qualitative description recognizes the existence of multiple realities and seeks to understand the human experience

through studying and interpreting lived experiences (Bradshaw et al., 2017). This research methodology acknowledges that realities are socially constructed by participants and the researcher(s), therefore objective reality cannot be revealed or duplicated by others (Bradshaw et al., 2017; Denzin & Lincoln, 2011). My decision to use qualitative description was based on its ability to utilize naturalistic inquiry while creating a descriptive summary of the data obtained. Qualitative description also provides direct explanations of experiences and perceptions on phenomena not commonly studied. Qualitative methodologies and intersectionality both explore the multi-dimensional experiences of an individual's life and their interpretation with experiences of power and privilege (Hunting, 2014). Hunting (2014) also recognizes how both intersectionality and qualitative methodologies share traditions regarding the framework of research, the significance of exploring the diverse voices of individuals, and the obligation to identify power inequities minorities withstand. Qualitative description within this research study has emphasized Black Canadian mothers' narratives of the challenges they endured, their perceptions of care, and the barriers they experienced throughout the perinatal phases of pregnancy.

Methods: Focus Groups and Interviews

Initially, focus groups were my data collection method of choice. I planned to conduct three focus groups, each containing three to five Black women living in Canada who were pregnant within the past five years. Kruger and Casey (2009) state that focus groups permit participants to explore their perceptions, feelings, and thoughts regarding problems, opportunities, and services they experienced in a controlled and comfortable environment. I chose to conduct smaller focus groups because they are more easily managed by master's students (Kruger & Casey, 2009).

To obtain diverse narratives and perceptions of the Black Canadian maternal healthcare experience, I facilitated three focus groups (each containing two Black women) and two individual interviews. The focus groups and individual interviews were held virtually through Zoom and lasted 30-75 minutes. The decision to obtain data through Zoom was due to York University's research ethics and Covid guidelines. However, this direction benefited the maternal participants as they were able to interview simultaneously while completing personal tasks. I initially set to ask participants five questions pertaining to their perinatal healthcare experiences (See Appendix B). However, after the first focus group, I removed a question specific to the definition of structural racism. The participants were unable to define this term which hindered the flow of the discussion.

Inclusion Criteria

The inclusion criteria for selected participants were a) women who self-identified as Black Canadian women who currently live in the GTA b) 20-45years old c) able to read, write, and speak in English, d) and had at least one pregnancy and actively sought perinatal care within the last five years. Five years was selected as research has indicated that this time frame is adequate to ensure that the study participants remember their perinatal care experiences (Etowa et al., 2015).

Sampling Techniques: Purposive and Snowball

I focused my research within Ontario and specifically the GTA because of the lack of literature surrounding Black maternal health, despite the province's diversity and multiculturalism. I chose the GTA because of its large African and Caribbean population (Statistics Canada, 2019). Using purposive and snowball sampling, I recruited women who met the inclusion criteria and were reflective of the characteristics of Canada's Black maternal

population. Using purposive sampling allowed me to collect significant and insightful qualitative responses, while I was able to recruit additional participants who met the inclusion criteria using snowball sampling. Both sampling methods were beneficial in recruiting participants who provided essential information on the studied phenomenon because of their personal maternal healthcare experiences (Streubert & Carpenter. 2011).

Recruitment

I used a combination of recruitment strategies to recruit participants. I am currently a labour and delivery/postpartum nurse and work directly with Obstetricians (OBs). Three physicians at William Osler Health System were informed of the research study, its goals, and implications for health/patient care. I asked the OBs to place the recruitment flyers (See Appendix C) around their office to attract patients who may meet the inclusion criteria. I also tried to recruit women from three non-profit and social media groups dedicated to Black womanhood within the GTA, one specifically focused on Black mothers. Unfortunately, each organization informed me that I was unable to recruit participants through this avenue as it would be a breach of confidentiality as per their organization's policies.

Snowball sampling occurred when coworkers, friends, and colleagues took my flyer, posted it on their social media and/or sent it to individuals who met the inclusion criteria. After reviewing my flyer, a total of 13 Black women emailed me expressing interest in my research study. Each participant who inquired about the study was provided with additional information on the study's purpose, date, and location of the focus group. All potential participants were informed of the importance of the research study and the significance of their stories being voiced and documented within healthcare literature.

Prior to conducting this study, I was unaware of how difficult it would be to co-ordinate three to five Black mothers and their young children's routines to a pre-scheduled focus group. Conflict regarding childcare and other commitments resulted in five participants missing the focus groups; they eventually resigned from the research study. In total, eight mothers provided insight on the Black perinatal healthcare experiences in Canada. An email was sent to each participant the day before the scheduled focus group; a reminder email was also sent two hours prior to the scheduled focus group meeting time. After the initial focus group, I decided to incorporate semi-structured interviews to my data collection method to accommodate the schedules of the busy mothers. This adjustment created more flexibility and allowed additional mothers to be a part of the research study. Each participant was provided with an honorarium \$20 gift card to Tim Hortons or Starbucks as a thank-you for their participation in my research study. After the completion of the interview and focus group the participants were also provided with a list of available health services within the GTA specific to breastfeeding, mental health, and postpartum support.

Demographics: Description of the Participants

The demographics in Table 1 summarize a group of well-educated Black women. Many of the participants were between the ages of 25-35 years old and worked full-time. Four of the participants were single, two were married, one was divorced, and one was in a domestic relationship. Four participants had a household income of 100K while 2 are below 50K and 2 did not answer. Four of the participants were first time mothers and the other four had more than one child.

Table 1. Participant Demographics

Participant	Age	Education level	Employment Status	Marital Status	Household income	Received prenatal care
Participant 1	35-45	Bachelors/Masters/Doctorate	Fulltime	Divorced	Above 100K	Yes
Participant 2	25-35	Bachelors/Masters/Doctorate	Fulltime	Married	Above 100K	Yes
Participant 3	25-34	Bachelors/Masters/Doctorate	Did not answer	Married	Did not answer	Yes
Participant 4	25-35	Bachelors/Masters/Doctorate	Fulltime	Single	Above 100K	Yes
Participant 5	25-34	Highschool diploma/equivalent	Unemployed currently looking	Single	Below 20K	No
Participant 6	25-34	Other	Fulltime	Domestic relationship	20-50k	Yes
Participant 7	35-45	Other	Fulltime	Single	Did not answer	Yes
Participant 8	25-35	Bachelors/Masters/Doctorate	Fulltime	Single	Above 100K	Yes

Ethics: Protection of Participants' Rights

Ethical approval was obtained from York University's Faculty of Graduate Studies and William Osler Health System Ethics and Review Board. Informed consent was obtained prior to the focus group and interviews. Appendix D outlines the consent form all participants signed prior to the initiation of the research study. I ensured all participants understood the consent form by reviewing the form and answering questions before collecting data. Although I did not anticipate harm to any of the participants, they were made aware that if at any time they experienced any form of emotional strain, the interview could be paused, and the participant could decide whether she would like to continue the interview and the research study. All the consent forms, interview transcripts, field notes, and data analysis information could only be accessed by myself and the research committee through a password protected computer. All data

retrieved from this research study will be destroyed after 7 years as per York University's ethics protocol.

Role of Researcher: Rigor

As the researcher my role was to create an environment where women felt comfortable sharing their maternal experiences. Through detailed conversations, I collected stories from Black Canadian mothers by ensuring trust and respect. This was done by guaranteeing confidentiality and acknowledging their maternal healthcare experiences. As the primary researcher, I was attentive as we conversed about situations that were not discussed since their pregnancies. At the beginning of the focus group and interviews, I disclosed that I was a labour and delivery/postpartum nurse. Recognizing how my identity and background can influence the research process affirmed the importance of maintaining reflexivity throughout the research study. As I completed the focus groups and interviews, I reflected on my personal experiences and made notes to identify the implications of my own assumptions on the research process (Polit & Beck, 2012).

Data Analysis

I engaged in thematic analysis to inductively develop codes and themes. Each focus group and interview were audio-recorded, I also transcribed all recordings into a word document. I began the data analysis process during the first focus group by taking notes. During each focus group or interview, I noted consistent patterns, conflicts, and ideas that emerged from the participants' stories. To immerse oneself in the data, Liamputtong (2009) suggests that novice researchers read each transcript at least three times. The initial transcript reading was completed without taking any additional notes or interpreting the data. When I read the transcript for the second time, I noted interesting, meaningful, and significant thoughts expressed by the

participants. During the subsequent transcript readings, I highlighted symbolic topics that arose from the data and created codes from key words stated by the participants. The codes I created were based on significant and reoccurring concepts expressed by the participants.

After the completion of each focus group and interview, thematic analysis was used to identify patterns, analyze, create codes, and create meaning from the narratives expressed by the participants (Bradshaw et al., 2017). The codes developed were based on the experiences and emotions expressed within the Black women's stories. Each code was reassessed and modified to ensure the analyzed themes were connected between data sets (Braun & Clarke, 2012). I assured that the codes captured the physical, emotional, mental, and social aspects of the Black maternal health experience. After completing my initial analysis and coding of the transcriptions, I was counselled by my masters committee on how I can improve my coding methods. Their feedback enabled me to revisit the transcriptions using an intersectional lens to highlight significant themes. The final codes developed described the perinatal healthcare experiences of Black women living in Canada's Greater Toronto Area (See Appendix E).

Measures to Ensure Rigor and Trustworthiness

Reflexivity is a method to ensure rigor within qualitative research and is more important when positioned within a critical theory paradigm. Reflexivity was used throughout this research process to assess the implications of my personal beliefs, preconceptions, and practices on the research study (Creswell & Miller, 2000). Throughout each focus group and interview, I made notes regarding the participant's comments and my thoughts from the stories communicated. Using a journal, I routinely reflected on my role as a researcher and the research process. I recognize how my position as an L&D nurse and Black women could influence the researcher-participant relationship and the study's findings. I made it a priority to record participants'

comments and my opinions regarding the topic throughout the interviews and focus group. Being an L&D nurse and Black woman allowed me to ask in-depth questions which evoked insightful conversations regarding the Black perinatal healthcare experience in Canada.

Streubert and Carpenter's (2011) criteria for ensuring rigor was applied to this research study. In qualitative research rigor is implemented to ensure the study appropriately embodies participants' lived experiences (Streubert & Carpenter, 2011). Prior to the start of the focus groups and interviews, I contacted the participants via email to introduce myself and the purpose of the research study (Streubert & Carpenter, 2011). Member checking was accomplished throughout each focus group and interview by reiterating the ideas, notes, and themes I noted throughout the conversation with the participants. Trustworthiness of the analyzed data occurred when the participants' lived experiences were consistent with the researchers' description of the phenomena being studied (Streubeurt & Carpenter, 2011). Ensuring trustworthiness of the data obtained allows researchers to reflect on the social, cultural, and historical influences of interpretation (Creswell & Miller, 2000). Once a month I also had meetings via Zoom with my thesis committee members regarding the goals of my research study and the progress of my overall thesis. During these meetings the study's findings were discussed. As a first-time researcher the committee meetings facilitated rigor by validating that the codes, themes, and analyzed findings were consistent between the data set, the committee members, and myself.

Chapter 5: Findings/Results

I was able to obtain rich and important information from this research study. Black maternal participants were eager to tell their stories in a safe and non-judgemental environment. Being both a Black woman and labour and delivery nurse facilitated insightful questions which explored the perinatal experiences of Black mothers. The mothers identified five consistent themes from their perinatal experiences: preconceived health biases, feeling disregarded/unheard, the importance of culture within care, supportive HCPs, and the “strong” Black women stereotype. In this section the perspectives of the participants will be presented.

The Black Maternal Healthcare Experience in Canada

Conversations regarding the Black maternal experience in Canada evoked prominent and consistent experiences amongst the participants. Each participant recognized the positive attributes of Canadian healthcare organizations; however, participants also expressed the insufficiencies rooted in racism within the Canadian healthcare system. Implicit forms of medical racism were apparent when discussing the Black perinatal experience in Canada. Implicit racism is often subtle, and therefore not always recognized as prejudice. In this section, I will group the mothers’ healthcare experiences in two different categories: macro-aggressive and micro-aggressive acts of racism. Each form of racism influenced the mother’s health needs, access to resources, and perceptions while receiving perinatal care.

Macro-Aggressive Acts of Racism

Macro-aggressive actions were seen as blatant prejudices that interfered with the patient-provider relationships and perinatal care experiences. While describing their perinatal stories, the participants recognized how their race and gender played an integral part in their treatment.

Preconceived Health Biases. Some of the maternal participants remembered being falsely diagnosed with medical diseases without any confirmatory diagnostic testing. During her second pregnancy Participant 2's Obstetrician (OB) diagnosed her with gestational diabetes without reviewing her medical history. Participant two stated,

And then he came up with this thing and I don't know how he came up with this idea that I've always had diabetes. And he could tell that I had diabetes before I was pregnant. And I said, no, I never had diabetes.

Participant 2 described how her OB insisted she was a non-compliant diabetic and prescribed her oral anti-diabetic medications. She continued to say,

He put me on medication anyway, regardless of me telling him I don't have it (type I diabetes) after I had the baby, which I didn't take because I don't like taking medications anyway. But after two or three months, he followed up to see if my sugar regulated and if the medication, he was giving me was working. And then I did the blood work and he said, 'oh, it's like you never even had diabetes'. I said, I never had diabetes. It's just gestational. (Participant 2)

Participant 2 believed that her OB did not listen to her because she was Black. Her OB unconsciously associated her race with diabetes without inquiring about her medical health history or doing further testing. Participant 2 refused to take her prescribed medications because she believed she was falsely diagnosed. The participants' stories described how medical racism of Black women led to medical misdiagnoses and improper care of women from this community. Participant 1 also described her experience with medical racism. After a traumatic miscarriage, Participant 1 went to the hospital for a dilation and curettage (D&C). This is a medical procedure which removes remnants of a remaining fetus in-utero after an abortion/miscarriage. During a

hospital visit, Participant 1 remembered the comments made by a nurse who was a part of her care team:

I overheard nurses when I had my miscarriage tell each other, ‘Well, she can have another one, you know’ ... ‘Oh, you know, they pop them out like nothing’. And I'm just like, what are you talking about? Like, I'm a person in pain, and I can hear you. And those kind of biases and racist ideas and what not, you know, is ridiculous. (Participant 1)

The Black mothers agreed that assumptions made about Black women are ignorant, insulting, and demeaning.

The Importance of Culture within Care. Black maternal participants believed that the Canadian healthcare system fails to sufficiently integrate patients’ cultural needs while providing care. The mothers recognized the influence of their cultural customs on their maternal experience, yet care providers ineffectively combined these traditions within the perinatal care plan. Many of the participants wished the healthcare team inquired about the importance of their ethnicity and culture throughout each phase of their pregnancy. Understanding the influence of culture, race, and ethnicity on healthcare needs was viewed as essential to participants in ensuring positive patient health outcomes.

Participant 2 revealed how it took almost three months and a culturally competent physician to finally understand the care needs of her infant son. Participant 2’s son was admitted to the children’s hospital with low blood sugars and jaundice. After weeks of constant blood serum retrievals, using a bilirubin blanket, and being confined to the incubator for light therapy, her son’s bilirubin levels still required medical treatment. When Participant 2 began questioning the care of her son, she was labelled as difficult by healthcare providers. This caused tension between the healthcare staff and Participant 2. She explained:

So then one night I met this doctor. He explained to me what's going on with my son, why they're coming up with all this kind of big terminologies that makes no sense to me. He looked at me like, okay, they keep saying, this boy has jaundice. Are you not African? You guys have like some African herbs and stuff like that, that can work. You know, call your mama up ... And I promise you, the minute I give him a firewater, the green one, the jaundice went away in two or three days, and we've been in the hospital for almost three months. (Participant 2)

Understanding the influence of culture on care prompted the physician to identify why the standard bilirubin treatments were ineffective for Participant 2's son. This story is important because Western trained healthcare providers rarely support the use of natural/cultural medicines in combination with standard therapeutic treatment plans (Etowa et al., 2015).

When the participants were asked how Canadian care providers and organizations can improve care for Black women, Participant 7 stated,

I feel like they can work on their active listening skills, like active listening around the board, trying to just learn the culture because a lot of people are Caribbean Black women. Things are done a certain way. Or we expect like to be told certain things or to be educated a certain way. So just finding out what works or what is usually done by listening, I find listening is great. Yeah, it's key. Just sitting there for two seconds, you know? Are you okay? What do you want to talk about? What works for you? What doesn't work for you? What can we do? What don't you want us to do?

The Black maternal participants hope that healthcare providers begin to acknowledge and integrate each patient's race, ethnicity, and culture within the medical care plan to reduce the incidence of hospital stays and adverse health outcomes. Participant 4 stated,

It would have been nice just for them to acknowledge that we're African or we're Black and we have our way of doing things. We're not a one fix all. I don't know anybody like that, we're a bit different, but don't put us under the same umbrella with you know, the White people.

Micro-Aggressive Acts of Racism

As opposed to macro-aggressions, micro-aggressive actions were more subtle and often indirect and so many of the women only became aware of this form of racism after discussing their perinatal healthcare experiences. When telling their stories, they began to see how these micro-aggressive acts were difficult to recognize and often normalized in their everyday encounters.

Insufficient Perinatal Provisions. In the research study, both first-time mothers and mothers with multiple children recalled the various questions and concerns they had regarding their pregnancy and postpartum care. The participants agreed that throughout their pregnancies, healthcare providers provided minimal information regarding health diagnoses and the plan of care. Participants' experiences illustrated that a lack of knowledge regarding the maternal process disempowers Black women and results in lifetime health issue(s) for themselves and their newborn child. When asked what resources and information was provided during her prenatal visits, Participant 3 stated, "Nobody says anything, I don't even know what resources some people have for pregnant Black women. I've never even heard about it before."

Participant 2 was diagnosed with gestational diabetes and believed she was vaguely educated on the management of this disease. Furthermore, she was unaware of the importance of glucose testing and the impacts of nutrition on the disease process. As a result, her son's health was negatively affected. She said,

Then I had gestational diabetes... and my son came out with issues... my son ended up with low sugar and had to stay in the hospital for almost three months trying to regulate it... and I knew it was because when I had gestational diabetes nothing was done.

(Participant 2)

When healthcare providers fail to adequately provide essential educational material to Black mothers, it can predispose their infant(s) to lasting health problems. To avoid adverse maternal and fetal health outcomes, multiple participants indicated that they used Google to gain a better understanding of their health diagnosis or the pregnancy process. Participant 5 stated, “I was really confused. I wasn’t getting a lot of information through the doctors. I really just looked online and kind of learned on my own through online and videos.” The practice of self-learning was consistent amongst participants. Both new mothers and mothers with multiple children expressed that the internet was one of their main sources for obtaining information throughout the perinatal period. The women believed that HCPs not only provided minimal information regarding health diagnosis and processes, the use of medical jargon by HCPs brought further confusion throughout their pregnancies.

The Use of Medical Jargon. Participants specified that the use of constant medical jargon from HCPs during their prenatal care affected how they perceived information regarding their pregnancy. Failure to explain a health diagnosis using layman’s terms led to miscommunication and misunderstanding of health issues. Participant 5 was a first-time mom; she discussed her vaginal birth experience. She explained being confused about the process of epidurals and the progression of labour as the healthcare team failed to use everyday language while providing care. At 10 cm dilation, Participant 5 was instructed to begin pushing. Once pushing was initiated, her daughter began to experience fetal heart rate decelerations, which is a

critical situation that resulted in her being moved to the operating room for a possible emergency c-section. The labour ended in the use of an assistive device to deliver the newborn and a fourth-degree laceration which had to be sutured by the physician. Throughout the whole ordeal, Participant 5 expressed being confused as the nurses and OBs rarely discussed the clinical situation using language she could understand. She stated, “I don't know, everybody looks at you like they expect that when they say something, you should automatically know what that means or why they're doing something. There's no kind of explanation” (Participant 5). Use of medical jargon by HCPs is harmful and often results in patients' missing significant medical information regarding their medical diagnosis and mismanagement of symptoms. The Black maternal participants agreed that the inadequate provision of health material and use of medical jargon by healthcare providers is a major source of adverse health outcomes for mothers in the Black community.

Feeling Disregarded/Unheard. Throughout the focus groups and interviews, the participants voiced that their questions and concerns were often disregarded or overlooked by physicians and nurses. The participants disclosed that healthcare providers failed to pay attention, actively listen, and remain attentive to their health concerns and needs; unfortunately, this happened during many of their prenatal visits. Patients' uncertainties were frequently deemed as ‘normal pregnancy occurrences,’ and dismissed by care providers. Participant 4 proclaimed, “Most of the times when I make complaints to my doctors, they usually just discount it like, ‘Oh, it's normal’ or ‘it's okay’.” When care providers devalue health concerns, it negatively impacts how Black patient's view the healthcare system. Participant 7 voiced,

It's sad to say, but I kind of lost hope. Just because I feel like they (HCPs) don't listen.

And it goes from certain nurses, unfortunately, to certain doctors in the hospital, outside of the hospital that just, you know, don't listen.

Most participants admitted to having similar feelings when seeking answers to their prenatal and postpartum related questions.

Participant 1, a first-time mother shared her experience of being constantly dismissed by HCPs and how it negatively impacted her newborn daughter's health for years after her delivery. Participant 1 had a healthy pregnancy; however, at 37 weeks of gestation, she was diagnosed with gestational hypertension. Every day for a week, she went to her L&D department voicing concerns of decreased fetal movement, constipation, and general feelings of malaise. She was repeatedly discharged without any healthcare provider actively investigating her concerns. At her 38-week scheduled prenatal appointment, her OB observed meconium, a sign of fetal distress. She was instructed to immediately go to her L&D unit, where an emergency c-section was decided by the on-call physician.

I had an emergency C-section. And then finally they just cut me open and took my baby out. And she was not breathing. There, there's no life. She was just covered in poo, and they rushed her away. And I knew something was wrong because she didn't cry. They just kept telling me, 'She's so beautiful. Everything's going to be okay.' And that was it.
(Participant 1)

Participant 1 was diagnosed with gestational hypertension; this is considered a high-risk pregnancy. High-risk pregnancies require a higher level of observation, diagnostic testing, and additional patient education, yet several healthcare providers did not provide Participant 1 with the care necessary for a safe delivery and healthy child. This adversely influenced the health of

her child. Participants 1 and 2 discussed the medical neglect that both their children experienced within the Canadian healthcare system. During the focus group, Participant 1 said to Participant 2, “It's all preventable. What happened to your son? Preventable. What happened to my daughter? Preventable. The only reason why it happened is simply because we're Black women!” (Participant 1)

When the participants were asked how Canada can reduce racial prejudices within healthcare, they recommended employing more Black physicians and obstetricians. Participant 3 expressed, “I think we need more Black doctors, to be honest. I don't really know how much there are. But at first, I was trying to find like a female Black gynecologist. I don't really think there is much.”

Hasty OB Appointments. The participants criticized the lengths of their prenatal care visits. The participants’ agreed that each OB visit consisted of the physician checking the fetal heart rate and their vital signs, however, minimal time was allocated for patient concerns and questions. Participant 4 recalled,

I wait the whole month...And when I go, it's like 5 minute like, okay, how's this? How's that? Okay, bye. See you next month. I actually am a person. I like to know everything. I have a lot of questions, so, like, I don't want to feel rushed.

Feeling rushed during each prenatal visit was a shared experience by most participants. The mothers indicated that they were unable to thoroughly express their concerns or ask pregnancy related questions as their physician appointments would last approximately 10 minutes. Participant 8 explained,

I didn't have enough time to sit with my doctor and tell my doctor, oh, you know, two days ago, I woke up and my heart was beating really fast, or two days ago my chest was

hurting really bad ... And not feel rushed to just come into the office, check the baby's heartbeat and go home.

The mothers noted that it was important that care providers provide a non-judgemental environment for patients where their health questions and concerns could be adequately answered. The Black maternal participants shared that the brief OB appointments further precipitated their anxiety, worries, and concerns.

The Importance of Support

Supportive HCPs. Although the participant's discussed feeling unheard and the use of medical jargon by care providers, the participants did acknowledge the support received by their OB throughout their maternal journey. Participant 1 indicated that she experienced a disconnect with her unborn child after a previous miscarriage. She remembered how encouraging words from her OB gave her courage throughout her pregnancy. Participant 1 stated, "The best advice that my OB told me was just to have faith that I would carry this baby to term because I am healthy, I am strong. And she's like, your mind is the most powerful thing." Participant 1 recalled how the positive affirmations expressed by her OB gave her strength to carry her daughter to term. For Participant 5, the support came from a physician she visited at a walk-in clinic. After discovering she was almost five months pregnant, she began feeling lost and confused. She details her encounters with this physician:

I did have a Black doctor and he was the one that referred me to the gynecologist. He was very particular about the type of doctor that I go to. He was very helpful in some ways. He pushed me to start looking online and doing things to like research about like pregnancies and stuff. If it wasn't for him, I would pretty much just be really confused,

but he was very helpful... I was very scared. I was asking him a bunch of questions; you can sense how much he cared about the journey of my pregnancy. (Participant 5)

Participant 6 also spoke about her experiences with supportive health care providers. She works for a hospital as non-medical staff which gave her the opportunity to utilize the staff directory to find her OB. She created a rapport with her OB where she felt comfortable and supported to ask questions regarding the maternal process. Participant 6 stated,

I have to say that it being my first, I don't necessarily have any complaints because my OB, she tried to make it as easy as possible. She went above and beyond to make sure I'm comfortable in contacting her if I have any questions, because being new, I had a lot of questions and like if something felt off to me, like I had the opportunity to call her and ask her questions. Or when I was going in, I just pull up my list of questions, 'Oh, is this normal kind of situation?'

Each of the participants acknowledged that the relationship formed with their OB facilitated a personal bond, where their health concerns were prioritized. However, the participants did divulge the inconsistency of HCPs being supportive throughout the perinatal period. This left many participants seeking familial support as they transitioned into motherhood.

Familial Support. The Black maternal participants identified the postpartum period as the phase where minimal support was provided by care providers and health organizations. Each participant narrated stories of family members going above and beyond to assure their health needs were adequately met. After delivering her third baby via c-section, Participant 2 began feeling overwhelmed. She was unfamiliar with the available community resources, prompting her to move to Nigeria for three months to get help from her mother. She stated, "I had to go all

the way back to Nigeria to go see my mom and literally so she can help me heal and look after the baby because I don't have support.” (Participant 2)

After recovering from a traumatic birthing experience, pain limited Participant 5's ability to provide care for her daughter. She mentioned being unaware of the management of postpartum pain and the postpartum community resources available to her. She relied on her family members to ease the transition into motherhood. She explained,

I couldn't like, you know, I couldn't do a lot of things. My mom did help me. I was at my mom's house. She supported me physically, letting me sit in a bucket of water and steam. And, you know, she held the baby a lot. And my family helped a lot when it came to the baby. (Participant 5)

Many of the participants agreed that upon discharge healthcare providers did not inform them of available community resources and services within their area. The mothers felt that limited resources impacted their health outcomes, requiring one mother leaving the country to seek support from family abroad.

The Stigma of Asking for Help: The Strong Black Woman

The stereotype of the “strong” Black woman presented true amongst these mothers. The constraint of being fearless and emotionless, yet courageous was discussed between the mothers. Many of the women admitted to feeling alone and were reluctant to tell their perinatal challenges to family, friends, and healthcare providers. Fears of being ridiculed, scorned, and devalued prevented Black mothers from sharing their emotional and mental turmoil. When Participant 8 was asked why she believed Black women rarely seek help when facing a physical, emotional, or mental dilemma she replied,

I think Black women are unfortunately maybe hard to deal with because we want to keep to ourselves. You don't feel like you can open-up and express. You feel like you are alone, even though everybody pretty much is in the same boat, you don't feel that comfort to communicate... You look around and you see like, who can you talk to? You know what I mean? You feel like there's nobody, because sometimes there really isn't. But there are. But you're just scared because you don't like again, you don't want people to shut you down. (Participant 8)

Many of the Black participants agreed that throughout the perinatal period they experienced some form of emotional or mental distress, yet they were hesitant to share this information with their family members or care providers. Participants admitted to being surrounded by people who genuinely loved and cared for their well-being, however being viewed as weak, irresponsible, or oblivious deterred them from seeking additional assistance. The participants recognized this as a prevalent issue within the Black community that is seldomly discussed or addressed. The fear of being perceived as weak and the reluctance in asking for help has contributed to the 'strong' Black women stereotype.

As a first-time mother Participant five began to feel anxious but was afraid to ask for assistance because of society's pressures of being the perfect mother. Participant 5 explained,

Today I just need a break, you know, like, I just don't want to be around the kid right now. I just need to collect my thoughts. So, I think sometimes when you have those mind frames, I think a lot of people think that something's wrong with you when you just need 20, 30 minutes to maybe just whether express, get away or whatever, and then you're back to normal. (Participant 5)

The participants agreed that Black women are conditioned to be strong, fearless, and resourceful beings, which leaves them feeling guilty or questioned when they require a maternal break. This can lead to depression, which was the reality for Participant 8. She shared, “Yeah, and after having my son, I felt much better. Prenatal depression was gone. Unfortunately, a month later, I was hit with postpartum. And yeah. Here I am now” (Participant 8).

The mothers expressed feeling like they were constantly required to be strong and resilient regardless of their social, emotional, physical, or psychological well-being. This pressure often results in Black women being reluctant in acquiring social services. Although the maternal participants were aware of the benefits of additional medical and social support, they questioned whether these services accommodated Black women’s’ needs. Black mothers in this study suggested the creation and promotion of resources specific to Black health as means to decrease the poor health outcomes women from the Black community experience.

Chapter 6: Discussion

Race is a social concept which influences every aspect of Black women's lives. Pregnant Black women have higher incidences of pregnancy-related health complications because of their position within society (Sergeant, 2022). The participants were ethnically diverse well-educated mothers, yet they each experienced negligence, were stereotyped, and had an adverse health outcome during the perinatal period because of their race. Acknowledging the Black maternal morbidity and mortality rates means understanding how gender and race influences Black women's care within the Canadian healthcare systems (Crenshaw, 1989; Sergeant, 2022). Black mortality and morbidity are influenced by intersectional oppression, sexism, and prejudice which has been evident throughout the maternal process for many Black women living in the GTA (Crenshaw, 1989). In this section, I will discuss how medical sexism contributes to Black mothers' mistrust of the healthcare system. Medical mistrust of Canadian healthcare organizations deters Black women from seeking support and utilizing the available resources. This forms the 'strong Black women' stereotype where Black women's health needs are unable to be adequately met.

The Effects of Medical Sexism

Black Canadian women are more likely to experience both medical sexism and racism (Etowa et al., 2015). Although the term 'medical sexism' was not explicitly stated, the maternal participants discussed how their questions, concerns, and worries were often overlooked by care providers. Black maternal health literature recognizes that Black women's health experiences are frequently invalidated by healthcare providers, which increases their risk of pregnancy complications, morbidity, and/or death (Mijad, 2019; Nuru-Jeter et al., 2009; Owens & Fett, 2019). As noted in my literature review, compared to other ethnicities, Black patients are less

likely to receive essential health amenities and clinically necessary procedures in a timely manner (Salm Ward et al., 2013). Many of the participants in this study were diploma/degree educated, supported by their family members throughout their pregnancy, and had access to the available health resources, yet were still predisposed to medical neglect and poor patient health outcomes. Paradies et al. (2013) and Lui et al. (2019) recognized that this is a common issue for Black women. These circumstances force Black women to constantly advocate for the health, safety, and rights of themselves and their child(ren).

Mistrust of Healthcare Organizations

Micro-aggressive actions by healthcare providers in the form of medical sexism has influenced Black women's perception of the Canadian healthcare system (Arnett et al., 2016; Etowa & Eghan, 2015). When Black women expressed their health concerns, it was often viewed as being difficult and non-compliant (Arnett et al., 2016; Chambers et al., 2020). The participants agreed that medical neglect and disregard from care providers forced Black women to self-advocate to ensure their health needs are adequately met (Khemani, 2020). In this study, Participant 2 was labelled as 'difficult' when she challenged her son's plan of care. Being identified as a problematic patient by care providers can create poor healthcare experiences for Black women (Arnett et al., 2016; Kwate et al., 2003). Unpleasant healthcare experiences combined with medical sexism results in Black women mistrusting care providers and the healthcare system (Wells & Gouda, 2020). Medical mistrust deters Black women from seeking additional support and accessing essential healthcare resources (Washington, 2022; Wells & Gowda, 2020). Similar to women in Etowa et al. (2015) study, Black women in this study instinctively relied on familial support to avoid medical biases and racial prejudices, as they transitioned into motherhood.

Reluctance in Seeking Help: The Formation of the ‘Strong’ Black Woman

Black women’s reluctance in seeking additional support and accessing health resources are rooted in slavery and sociopolitical history (Ward et al., 2009). Black enslaved women were mistreated, and their bodies were manipulated for the development of gynecology and reproductive health (Chinn et al., 2021). Limited laws and human protection rights subjected Black women to immoral experiments without their consent (Hill, 2020; Thompson-Dudiak, 2021). Historical practices have contributed to Black women’s negative feelings towards health services and resources; this is known as cultural mistrust (Ward et al., 2009). Through subconscious messages by family and community members, and personal experiences, Black people have been conditioned to believe that healthcare organizations are created solely for Caucasians (Chambers et al., 2021). This skewed view results in Black women denying additional help from healthcare organizations. My findings reflect Howell et al. (2018)’s study, where the participants believed that the available health services failed to integrate Black mothers’ health needs. The participants from this study and Chambers’ et al. (2021) study believed that the accessible resources seldomly improve the life and health of Black mothers’ and their families, therefore, accessing these resources were deemed useless.

While some mothers in the study chose not to utilize the available health services and resources, others were unaware that there were resources and programs specific to Black health within the GTA. Healthcare providers, health organizations, and community centers fail to properly publicize programs catered to the Black community. When Black mothers are uninformed about existing community support programs, they are forced to take on roles and responsibilities that non-minority groups typically outsource. As participants in this study indicated, Black women are expected to self-manage while taking on more tasks and are praised

for dealing with struggle and oppression rather than supported. These circumstances have contributed to the cycle of the “Strong Black Woman”.

The ‘Strong Black Woman’ (SBW) stereotype, a positive portrayal of the Black women, is a birthright of strength as Black females transition into womanhood (Leath, 2019). The SBW stereotype stemmed from slavery and the belief that Black women could bear more hardship, pain, and work than women from other ethnicities (Hill, 2020). Despite the hardships of slavery, intersectional oppression, and marginalization, Black women are still required to embody power, be self-sufficient, nurturing, and invulnerable, while holding their families and communities together (Baker et al., 2014; Leath, 2019). The SBW stereotype is used as a coping mechanism to conceal the adversities and trauma Black women have endured while experiencing racialization, discrimination, and repression in their everyday lives (Leath, 2019; Manke, 2019). Although used to uplift Black women, this facade is problematic as it facilitates behaviours deemed ‘acceptable’ for Black women to uphold within society. This causes Black women to minimize any visible forms of emotional, mental, and physical distress, thus denying their own pain and suffering to fulfill obligations of being a parent and spouse (Baker et al., 2014; Manke, 2019). Abrams et al. (2019) recognizes that Black women are less likely to seek tangible and intangible support to avoid being perceived as a burden. Participant 8 revealed she had postpartum depression after both of her pregnancies; yet, her OB was unaware, and she was reluctant to utilize the available health resources within her community. Research reveals that many Black women suffer in silence to maintain the guise of strength (Davis et al., 2018; Leath, 2019). Micro-aggressive actions, intersectional oppression combined with the ‘Strong Black Woman’ stereotype place Black women at a higher risk of experiencing mental health disturbances and having poor health outcomes (Baker et al., 2014; Davis et al., 2018). The Canadian healthcare

system and healthcare providers must find innovative ways to reach members of the Black community, while community health resources must find ways to make their services more accessible for marginalized groups (Davis et al., 2018).

Knowledge Dissemination Plans

By the end of each focus group and interview, the research participants recognized the importance of their stories. They each informed me that they partook in this research study to ensure other Black women are not subjected to a similar fate because of the Canadian healthcare system. From our conversations, I knew that this research study had to be disseminated to physicians, healthcare providers and organizations, and community health resources within the GTA. I plan to present my research findings to the OBs and physicians within my department at William Osler Health System (WOHS). Bringing awareness to the health experiences of Black women WOHS providers cared for facilitates changes within the OBs/physicians, nurses, and other allied health partners' personal practices. Although I was unable to recruit participants from the community and social organizations, they commended me for implementing this research study. I plan to share my findings with community health resources within the GTA and discuss how their services can be more accessible within our community. The mothers will be invited to attend the presentations to listen to the study's findings and recommendations. Having the mothers join the presentations will emphasize the importance of their stories in advancing Canadian health literature and practice standards. Finally, as a future educator, I will incorporate ways nursing students and nurses can provide culturally competent care to Black women and other ethnic minorities while providing perinatal care. My overall goal is for this research study to highlight the Black Canadian maternal healthcare experience, thus improving the care this population receive.

Chapter 7: Implications/Recommendations

In this research study, the mothers expressed how macro-aggressive and micro-aggressive discriminatory actions from the Canadian healthcare system and healthcare providers impacted their perinatal healthcare experience. Many of the mothers were educated, supported, and had access to healthcare services, yet their race and gender influenced the quality of care they received throughout the perinatal period. To successfully confront structural racism within Canadian healthcare organizations, policies and practice standards must be refined to target racist and bias practices which harm Black women living in Canada (Sergeant, 2022). When asked what provisions the Canadian healthcare system and care providers can implement to support Black women in Canada, the participants proposed that the education system, practice standards, and policy guidelines be revised to ensure all Black women receive equitable care throughout the perinatal periods.

Policy Modifications

For ethnic minorities representation matters. Representation occurs when an organization assures a multiracial group of providers to service patients from distinct socioeconomic backgrounds, cultures, and ethnicities (DeCamp et al., 2019). In Canada there is a lack of diversity amongst healthcare providers (Khemani, 2020). In Ontario, only 2.3% of physicians are Black (Nnorom, 2020). A lack of representation in healthcare creates cultural and racial disparities when providing care to minorities (DeCamp et al., 2019; Nnorom, 2020). Employing more Black physicians and obstetricians can reduce racial prejudices within healthcare. Similar to previous Black health literature, the mothers acknowledged the importance of having a doctor who ‘looks like them’ (Khemani, 2020). Research indicates that when ethnic care providers care

for patients with a similar cultural background, it leads to better healthcare experiences and outcomes (DeCamp et al., 2019; Nnorom, 2020).

Research states that the lack of diversity within healthcare leadership roles and policy legislations are contributing factors to the Canadian Black morbidity and mortality rates (Sergeant et al., 2022). Khemani (2020) and Wynn (2020) emphasized that health organizations must place more Black women in a position of power within policy and legislation roles. However, several barriers inhibit racialized individuals and females from obtaining leadership positions, this includes limited access to network opportunities, prejudiced coworkers, and a historically biased organization which deems white male's superior (Sergeant et al., 2022; Wynn, 2020). Sergeant et al. (2022) and Khemani (2020) stress the importance of cultural diversity within leadership, because it facilitates conversations regarding the inequities marginalized groups endure and provides insights on how health policies can be reformed to ensure the health needs of minorities are effectively met.

Education/ Practice Improvements

Micro-aggressive actions are often caused by unconscious biases and prejudices from healthcare providers (Mijal, 2019). Taylor (2020) recommends that every care provider receive continuous and process-oriented training specific to culturally competent care. Anti-discriminatory lessons should be integrated with professional practice training to ensure all physicians, nurses, and allied health members understand safety procedures for adequate maternal care (Taylor, 2020). Taylor (2020) recognizes that a culturally competent health system acknowledges and promotes the distinctive health needs of Black women and other minority patients. The standard of care should include all HCPs collaborating and coordinating with

patients and their family members to develop a care plan which incorporates their medical history and health needs (Taylor, 2020).

The historical discrimination and exploitation of Black women has created the ‘Strong Black women’ stereotype (Baker et al., 2015). This stereotype is detrimental to members of the Black community as it creates negative thoughts and views towards accessing healthcare resources and mental health services (Kwate et al., 2003). Many Black adults are hesitant to utilize health services, specifically mental health amenities because of the fear of being perceived as weak. The stigma surrounding mental health makes conversations regarding this topic difficult to have, further impeding Black women from obtaining the necessary care to assure health. As mental health services and other health amenities are rarely used by Black women, Davis et al. (2018) and the study’s participants suggests that the healthcare system and care providers create innovative techniques to reach members of the Black community. A suggestion made by Baker et al. (2015) and Davis et al. (2018) is to ‘bring care to Black women’. Health services essential to Black women should be offered in familiar settings, like community centers and religious-based establishments. The participants agreed that offering programs and services in comfortable and recognizable spaces will improve Black women’s accessibility to the resources and programs provided by the Canadian healthcare system. Accessible services increase the utilization which will improve patient health outcomes for Black Canadian mothers (Davis et al., 2018).

Chapter 8: Conclusion and Final Thoughts

This research study explored the perinatal experiences of Black women living in Canada's Greater Toronto Area. Documenting the Black perinatal Canadian experience is essential in improving practice standards and policy guidelines. The Black mothers emphasized the importance of incorporating culture within care, discussed feeling disregarded by care providers, preconceived health biases, and how the 'Strong Black woman' stereotype deters the Black community from accessing health services and resources. The evidence from this study, advises Canadian healthcare organizations to integrate culturally competent education within their professional practice training. It was also recommended to employ more Black physicians and policy makers within health organization leadership to ensure Black patients are properly represented, appropriately cared for, and their health needs are adequately met. Lastly, health amenities should be specific to the care needs of Black mothers, easily accessible, widely publicized, and held in comfortable environments.

This research supports the need for the Canadian healthcare system to act and revise current policy, procedures, and practice standards to ensure all childbearing women in Canada receive equitable care. This research also supports the need for additional studies focusing on Black maternal health within Canada. Additional research and changes in policy reforms will support Black women living in Canada to have unbiased equitable care.

Limitations

This research study had potential limitations. Due to the participants being busy mothers, only eight Black women were questioned about their perinatal healthcare experiences. Although each participant was only interviewed once, I was able to engage in 30–75-minute in-depth conversations where the women were able to speak about their perinatal experiences in a safe

environment. All the participants were English-speaking heterosexual females which means that this research study did not explore the healthcare experiences of members from the LGBTQ2s+ community. While conducting this study, I did not intend to generalize all Black mothers' maternal experiences, rather I wanted to describe and provide insight on the perceptions of care and healthcare experiences of Black women living in Canada.

Despite these limitations, this research study has many areas of strength. First, with minimal Canadian literature focusing on Black maternal health, this research study adds to addressing the dearth of knowledge pertaining to this phenomenon. Secondly, this research study provides insight for healthcare organizations, healthcare providers, and community health resources on Black women living in Canada's perceptions of the Canadian healthcare system. Third, this research study allowed Black women in Canada to discuss the implications of intersectional oppression on their perinatal healthcare experiences. Finally, this research study informs policy makers on the ways policies, programs, and guidelines should be revised to ensure equitable care for every Black woman living in Canada.

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Appendix A

Search Strategy:

A total of 43 qualitative and quantitative research articles pertaining to Black mothers (ages 18-45 years old) were reviewed; Only three of the articles reviewed were Canadian based, and one article was specific to the antepartum period. I initially used the search terms, “Black maternal health” and “North America/Canada,” “Black Canadian health” and “pregnancy”. These search terms resulted in articles that centered around structural racism and its relation to Black women’s antenatal, and postpartum lived healthcare experiences. Additional search terms included “Structural racism” and “prenatal care”, “prenatal care,” “healthcare experiences” and “racism”.

The research studies that were included for the literature review discussed: Black mothers’ perceptions and experiences of care during the antenatal phase of labour; challenges American and Canadian Black women experience during pregnancy and labour; the impacts of slavery on the current Black maternal health crisis; the causes of antepartum racial and ethnic disparities in America and Canada; the cause of the American and Canadian high Black maternal morbidity and mortality rates; and structural racism and personal racism experienced by Black mothers during the antepartum and intrapartum phases of pregnancy.

Inclusion and Exclusion Criteria for the Literature Review

The articles used for the literature review focused on English speaking American and Canadian women who self-identified as Black, were over 18 years of age, and experienced childbirth within the last 5 years. Research articles excluded from the review were based in the

United Kingdom, discussed the postpartum period of pregnancy, or failed to identify how structural racism impacts the Black maternal population.

Search no.	Search words	CINHL	Medline (PubMed)	ProQuest
s1	Black maternal health AND racism	11,000	117	48
s2	Perinatal care AND Canada	4,542	2032	467
s1 + s2	Black maternal health AND Canada AND perinatal care	7, 701	0	2
s3	Structural racism AND perinatal care	2, 559	14	8
s4	Structural racism AND Black health	6,583	398	109
s5	Structural racism AND Black maternal health	6,400	34	13
s6	Black maternal AND health AND Canada	41, 289	193	22
s7	Structural racism AND maternal mortality	994	18	7

Appendix B

Interview Guide

Welcome and Overview of the Topic

Good morning/afternoon everyone and welcome! Thank you for taking the time to join us to discuss your pregnancy experiences! My name is Berlinda Afranie. I am a Registered nurse and currently work in labour and delivery as well as the postpartum unit at I am also a master's student with York University. I am currently working on my thesis, which is focused on the antenatal healthcare experiences of Black Canadian women living in the GTA. This focus group will discuss your pregnancy experiences and last about 60-90 minutes. Throughout the discussion I will be using pregnancy and antenatal/antepartum period simultaneously, both phrases mean from the time your pregnancy was confirmed until right before you went into active labour. I want to hear your pregnancy experiences, challenges you endured, coping mechanisms used, and your perception of care during your pregnancy. My goal is to create a space where Black women can discuss their healthcare experiences. The discussion today will be used to disseminate the findings within my labour and delivery unit. Each one of you were invited because you have a story to tell, that can and will change how healthcare providers treat and manage Black women's pregnancies. I hope this research study contributes to additional studies exploring the Black maternal healthcare experiences in Canada.

Ground Rules

There are no wrong answers, only differing opinions. Please feel free to share your point of view even if it varies from what others have said. Today's discussion will be recorded because we don't want to miss any of your comments as I can't write all your experiences fast enough! We will be on a first name basis today, and we won't use any names in our reports. What is said in this focus group will remain confidential.

My role today is to guide the discussion. I will ask several questions, but my job is really to listen. This will be more interesting if we treat this more like a conversation rather than an interview. If someone says something, feel free to follow-up on it or share a different point of view. However, you do not need to agree with other comments, but we must all listen respectfully as others share their views. You don't need to address all your comments directly to me. It will help if only one person speaks at a time, that way I will not miss any of your insightful comments! If you have a cell phone, please put it on silent mode. I may need to interrupt to get through every question, I do apologize for this in advance. If you need to take a call, please step out and then return as quickly as possible.

As a reminder, our research team strives to maintain participant confidentiality. However, it is not possible for us to control what any of you discuss outside of this focus group. Please respect each other and today's discussion, and what is discussed here today should remain between us.

Let's begin! Let's find out more about each other by going around the table. I would like everyone to say their names and what interested you in this study.

Opening question

1. Tell me about your pregnancy experience?
 - a. During your initial prenatal visit with your healthcare provider what topics, information, and resources were provided to you and/or throughout your pregnancy?
2. What challenges did you experience during your pregnancy? These challenges could be emotional, physical, and/or mental?
 - a. How did you cope with these challenges?
3. How has your antenatal experience impacted your perception (the way you view) of the Canadian healthcare experience?
4. Do you know of another Black Canadian women who shared a similar experience as yourself, or another participant?
5. When you hear the term 'structural racism' what comes to mind?

Closing Questions

1. In your opinion what can healthcare providers and organizations do to improve the care Black Canadian women receive during their pregnancy?
 - a) What would have improved your experience?
2. Is there anything we missed today in our discussion that is important for this topic?

Wrap-up

I would like to thank each of you for taking time out of your schedule to participate in my research study! Your insight and stories are important to me and the goal of my research. I would like to reiterate that your names will be kept confidential, but your stories will be retold in health literature because of its importance in providing Black women an opportunity to finally voice their personal experiences. I appreciate your honesty, perceptions, and suggestions. Again, thank you for your participation!

Appendix C

YOUR PARTICIPATION IS NEEDED!



Are you a...

- Black mother?
- Living in the GTA?
- Over the age of 19?
- Had a baby in the last 5 years?

A voluntary research study would like to hear about your pregnancy experiences and how you obtained care for you and your baby!



If you are interested and would like to know more,

please contact berlinda@yorku.ca

*This research study has affiliation with York University and William Osler Health System



**William Osler
Health System**

Going Beyond

YORK U

Appendix D



Informed Consent Form Focus Groups: Black Maternal Health in Canada

Date:

Study Name: Black Mothers from Canada's Greater Toronto Area's Perceptions of their Perinatal Healthcare Experiences

Researcher: Berlinda Afranie-Frimpong, berlinda@yorku.ca

Purpose of the Research: The purpose of this research study is to explore the lived perinatal health experiences of Black women living in Canada's Greater Toronto Area. This research study seeks to identify the health inequalities Black mothers experienced during pregnancy and identify potential solutions to the issues expressed.

What You Will Be Asked to Do in the Research: Participants will engage in a focus group with other Black women via ZOOM. Topics related to their pregnancy, accessing resources, and the impacts of structural racism on their antenatal experiences will be discussed. Each focus group will last 60-90 minutes.

Prior to the start of the focus group each participant will be emailed a Qualtrics survey link with the purpose of collecting essential demographic data for the purpose of the research study.

Participants may be asked to partake in an additional follow-up focus group. During this focus-group discussions pertaining to the narratives expressed by the Black participants will be discussed. The participants will be asked if the themes identified by the PI are consistent with their narrative of their antenatal healthcare experiences or the experience of a Black women they know. Confidentiality will be provided throughout each focus group.

This research study will use the Dataverse to collect data, which is an externally hosted cloud-based service. When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). Further, while York University researchers will not collect or use IP addresses or other information which could link your participation to your computer or electronic devices without informing you, there is a small risk with any platform such as this of data that is

collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements (where possible) for you to participate, perhaps via telephone. Please contact the researcher for further information.

Recordings (audio/video) will be saved in a password protected file to research team members' local computer, not the cloud-based service. Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting / data collection session.

Risks and Discomforts: I do not foresee any physical risks throughout your participation in this research study. You have the right not to answer any questions. If at any time the question(s) or discussion make you uncomfortable or evokes emotional distress, you are free to disregard the question(s) asked or leave the focus group.

Benefits of the Research and Benefits to You: You may not experience any direct benefit from participation in this study. This research study aims to provide evidence of the maternal inequalities' Black Canadian women within the GTA endure during their pregnancy. This research study will provide Black Canadian women the opportunity to vocalize their antepartum experiences, with the hopes of changing healthcare practices and standards.

Compensation: As a token of my appreciation, each participant will receive a \$20 gift card as a thank you gesture.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of your relationship with York University, your obstetrician, or the organization you were recruited from, either now, or in the future. Also, the care (current or future) which you receive at William Osler Health System will not be impacted by your decision to participate or not.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you decide to. Your decision to stop participating, or to refuse to answer questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. However, if data analysis has already begun at the time you decide to withdraw your consent, we will not be able to withdraw your data.

Confidentiality: Unless you choose otherwise all information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. The focus groups will be recorded, and notes will be taken throughout the interviews. Your data will be safely stored in a locked facility and only research staff will have access to this information. The data will be stored for 7 years (until 2029), then archived in York University's database. Confidentiality will be fully provided possible by law.

The online survey is hosted by Qualtrics, which stores data on servers located in Canada. Collecting data using technology over the internet or using apps/tools/devices can increase

potential risks to privacy and confidentiality. The data will reside on an external server and no assurance can be made about its confidentiality or that it will only be used for this research purpose.

Please note that communication via e-mail is not secure. We do not recommend that you communicate sensitive personal information via e-mail.

This study will obtain video and audio recordings. The study team will ensure that all data/recording are stored in a secure manner, and de-identified whenever possible. It is important for you to know that we do not have the capability to de-identify video recordings.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact Berlinda Afranie by e-mail at berlinda@yorku.ca or my supervisor, Ruth Rodney at rrodney@yorku.ca.

This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's and William Osler's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact:

- York University: Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).
- Dr. Herbert Brill, Chair of the William Osler Research Ethics Board at 905-494-2120 ext 50448.

Legal Rights and Signatures:

I, consent to participate in *Black Mothers from Canada's Greater Toronto Area's Perceptions of their Antenatal Healthcare Experiences* conducted by Berlinda Afranie. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature
Participant

Date

I, agree to allow video and/or [digital images or photographs] in which I appear to be used in teaching, scientific presentations and/or publications with the understanding that I will not be identified by name. I am aware that I may withdraw this consent at any time without penalty.

Signature

Date

Appendix E

This is not a comprehensive list of all the quotes used from the identified codes/themes during the focus group/interview. Rather this list highlights the codes/themes identified from the narratives expressed by the participants.

Black Maternal Health Research Study: Coding

Code	Definition	Verbal Example	Notes
Recognizing the importance of the Black maternal health research study	Participants understanding the importance of the research study in changing Canadian practice standards.	“Just forgive me. I want to unmute myself. I’m, like in Walmart. I’m trying to multitask here” P2	Although busy, P2 makes participation in this study a priority.
Hasty OB appts	Patients complaining of hurried OB appointments where questions go unanswered.	“So, I had an OB where her office was always busy. She always had like millions of pregnant women there to see her. She just checks for the baby’s breathing. Then just tell me, okay, everything’s fine”. P2	
Lack of referrals to specialist/additional resources	Healthcare providers failing to inform patients of essential prenatal resources.	“And then I had gestational diabetes. She did not refer me to see anybody” -P2	During her second pregnancy P2 was dx with GDM.
Failure of HCPs in addressing health concerns and the negative health impacts on the fetus/newborn.	The implications on the fetus when HCPs fail to listen to the concerns of patients.	“And then I had gestational diabetes... and my son came out with issues... my son ended up with low sugar and had to stay in the hospital for almost three months trying to regulate it... and I knew it was because when I had gestational diabetes nothing was done.” P2	P2 son was hospitalized for 3 months, after having GDM
Lack of information regarding health dx.	Marginal educational information provided by the HCP regarding pregnancy and fetal health dx.	“And then I had gestational diabetes. She did not refer me to anybody to see anybody. She did not tell me how to manage it or if I should manage it.” P2	
The impacts of COVID on prenatal care	How COVID-19 changed practice standards and affected the way prenatal and intrapartum care is delivered.	“I chose my OB... I didn’t see him 1:1, which I felt like that would have helped a lot. Most of our conversations were over the phone”- P2	
Preconceived health assumptions	Unconscious biases or opinions by an HCP regarding a patient’s health without any proof or evidence.	“And then he came up with this thing and I don't know how he came up with this idea that I've always had diabetes. And you could tell that I had diabetes before I was	

		pregnant. And I said, no, I never had diabetes” P2 “And then I did the blood work and he said, oh, it's like you never even had diabetes. I said, I never had diabetes. It's just gestational. I don't know how they came up with that” P2	
Insufficient resources, support, and education provided during the prenatal/intrapartum/PP care period	Marginal educational information provided by organizations regarding pregnancy, pregnancy dx, and PP expectations.	“nobody says anything about, I don't even know what resources some people have for pregnant black women. I've never even heard about it before.” P2	
Inadequate education provided by HCPs regarding the patient/newborn's healthcare plan	Healthcare providers either use medical jargon or do not completely explain health diagnosis' to patients. This results in miscommunication and a misunderstanding of health problems.	“And I don't know, everybody looks at you like they expect that when they say something, you should automatically know what that means or why you're doing something. There's no kind of explanation on what your son's going through this, so we're going to do this for him because he's going through that. And this is what we're hoping to get” P2	
Community support/involvement	The importance of community during the prenatal period.	“I come from a big community where, you know, it's such a well, I'm in a church, I belong to a church where we're always helping out people. So it'll be nice to know if there are actually programs for black women that are pregnant that they could attend and be part of that would help them through their pregnancies and of them understanding why their body is in a certain way and stuff like that” P2	
Feeling unheard/disregarded	Occurs when healthcare providers fail to pay attention, do not actively listen, and are not attentive to the concerns and needs expressed by patients.	“Because most of the times when I make complaints to my doctors, they usually just discount it like, Oh, it's normal or It's okay.” P2	
Familial support	The importance of family during the transition into motherhood.	“And my mom would always take me to the washroom because I also had a fear that I would give birth and she would drop in the toilet.” P1	P1 was in labour for a week. She feared having her newborn in the toilet.
Participants sharing common experiences and providing positive affirmations.	Participants' acknowledging similarities in their experiences and pregnancy stories.	“Can I. Can I say something to P1? Oh, my God. I'm so sorry. You had to go through that. And here I was, like, complaining about my own shit. Sorry.” P1	

Acknowledging areas of concerns within the healthcare system.	Recognizing how Canadian healthcare organizations have areas which require improvement.	“Everybody goes through something, and the stories shouldn’t be happening, quite frankly. But they are happening. It’s teaching you something. It’s all preventable. What happened to your daughter and your son? Preventable? What happened to my daughter? Preventable. The only reason why it happened is simply because we’re black women. And for some reason, society thinks we have a higher tolerance of pain” P1	
Early Discharges	Healthcare organizations discharge patients within 24hours, after patients met the “discharge criteria”.	“That I was sent home a day after my C-section, by the way. They sent me home a day after they cut me like I slept. I had the baby in the evening and then we went home the next day in the afternoon, they said, because it was Christmas Eve, and they need the bed” P2 “And I kept telling myself I should not have left the hospital yet. It was not time for me to go home, you know. So, I don’t know why they did that or if that was allowed, but they should not have sent me home a day after C-section. That was just horrible. I don’t know where they came up with that idea of it was okay for them to do that, but they should not have. P2	
Minorities experiencing higher rates of negative health outcomes.	Minorities are 2x more likely to experience negative health outcomes. This is evidenced by the high minority admission rates in the NICU.	“I started looking around and that place was filled with black women. Filipino women. Latina. And Indigenous women. I’m like, why are our babies in here? We’re the white babies. No offense, but where are the white babies? One or two speckled here and there. But nowhere compared to what we had to endure. And I started talking about what I went through, and I realized the same story I was hearing from different women. Something’s wrong.” P2	
Being labelled “difficult”	The assumption that a patient is difficult if their views misalign with the healthcare team’s diagnosis ‘and opinions.	“The doctor actually literally came into the room to say, we heard that I was being difficult and that he’s probably going to have to refer me to a social worker because I’m starting to act belligerent. And I said, yeah. So, I said, well, that’s fine if you think me fighting for my	

		son is a bad thing, that's okay. Go ahead. I don't care. I'll see a social worker. But nobody's coming in here to pick my son again unless they know what they're doing" P2	
Recognizing the relationship between culture and care	Understanding how culture/race/ethnicity impacts the health of patients.	"So then one night I met this doctor. He explained to me what's going on with my son, why they're coming up with all this kind of big terminologies that makes no sense, and why I should not even pay attention to all this terminology because it's not true. He looked at me like, okay, they keep saying, this boy has jaundice. Are you not African? You guys have like some African herbs and stuff like that that can work. You know, call your mama up ... And I promise you, the minute I give him a firewater, the green one, the jaundice went away in two or three days, and we've been in the hospital for almost three months." P2	P2 son was in the hospital for 3months, which required blood work 3-4x a day.
Appreciation towards the healthcare system	Despite its shortcoming, participants express the benefits of the Canadian healthcare system.	"Our health and everything is amazing. I'm grateful for it because I know other people don't have that opportunity whereby, you know, I can just get up and go to the doctor like ten, 15 times and not have to worry about paying a dime, you know. For that. Bill. I'm grateful for that"	
Unreasonable expectations of pregnancy, labour, and postpartum.	The unrealistic picture society has created about pregnancy and the postpartum period.	"It was an incredibly painful experience to breastfeed my child. I did not give up. I was able to do it. But had someone warned me ahead of time, I would have appreciated that. Same with everything that happens after giving birth. You know, there's no conversation. Like, what do you expect when you're expecting? I don't want to read all these nice things. I want to read really and truly the truth about what is going to happen to my body, what is happening to my hormones, what is going on with my hair, what is going on with my skin? No one talks about any of that." P1	
Additional hospital cost	Unexpected cost during the labour/PP period.	"The stress when you were talking about the formula, that triggered me as well, because I just remember thinking to myself, like, how am I	

		going to afford all of this? Formula is a lot, at least breast milk. It's free. You know, it's from me. But again, it was a struggle. I had to borrow a machine from the hospital and pay to rent that. And I thought that was absolutely ridiculous. Like, why am I paying to rent a machine that's supposed to provide for my Child With what they need to survive? Like there's just certain costs and expenses that should not be applied in certain situations.	
Dr. Google	Patients turning to Google after HCPs fail to adequately provide enough information regarding health diagnoses.	"So, I mean, even if that was the case, I wasn't even told anything about classes. And, you know, it was only my doctor that told me about prenatal care as far as taking pills. But I was really confused. I wasn't getting a lot of information through the doctors. I really just looked online and kind of learn on my own through online and videos". P5	
Feeling alone	The feeling of having no one to talk to about the pregnancy/postpartum challenges.	"So emotionally, I was very alone, you know, and have no one to talk to. And it was during that time, a lot of people were really busy. I never really particularly had a friend that I can express myself and be 100% real with, you know? So emotionally, I was really confused. I was really all over the place, didn't know who to turn to and who I can enjoy this experience with or somebody who's had this experience." P5	
Relief from motherhood/fatherhood	The stigma of taking a break or asking for help as a mother.	"Today I just need a break, you know, like, I just don't want to be around the kid right now. I just need to collect my thoughts. So, I think sometimes when you have those mind frames, I think a lot of people think that something's wrong with you when you just need 20, 30 minutes to maybe just whether express, get away or whatever, and then you're back To normal" P5	
Depression		"Yeah. And after having my son, I felt much better. Prenatal depression was. Gone. Unfortunately, a month later, I was hit with postpartum. And yeah. Here I am. Now.	

		Been two years now, literally been two years. I think the postpartum has lessened a lot. But it's still there" P8	
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