From a Place of Love: The Experiences of Birthing in a Black-Owned Culturally-Centered Community Birth Center

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Abstract

Introduction: Racial and ethnic disparities in perinatal health outcomes are among the greatest threats to population health in the United States. Black birthing communities are most impacted by these inequities due to structural racism throughout society and within health care settings. Although multiple studies have shown that structural racism and the disrespect associated with this system of inequity are the root causes of observed perinatal inequities, little scholarship has centered the needs of Black birthing communities to create alternative care models. Leaning on reproductive justice and critical race theoretical frameworks, this study explores good birth experiences as described by Black birthing people. Methods: Thematic analysis of two focus groups and three one-on-one interviews conducted with clients at a Black-owned free-standing culturally-centered birth center (n=10). Results: We found that Black birthing persons' concerns centered on three main themes: agency, historically- and culturally-safe birthing experiences, and relationship-centered care. Many participants pointed directly to past experiences of medical mistreatment and obstetric racism when defining their ideal birth experience. Conclusion: Black birthing people seeking care from culturally-informed providers often do so because they have been mistreated, disregarded, and neglected within traditional care settings. The needs articulated by our study participants provide a powerful framework for understanding alternative patient-centered models of care that can be developed to improve the care experiences of Black birthing people in the pursuit of birth equity.

Keywords

health equity; birth outcomes

Cover Page Footnote

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ABSTRACT

Introduction: Racial and ethnic disparities in perinatal health outcomes are among the greatest threats to population health in the United States. Black birthing communities are most impacted by these inequities due to structural racism throughout society and within health care settings. Although multiple studies have shown that structural racism and the disrespect associated with this system of inequity are the root causes of observed perinatal inequities, little scholarship has centered the needs of Black birthing communities to create alternative care models. Leaning on reproductive justice and critical race theoretical frameworks, this study explores good birth experiences as described by Black birthing people. **Methods:** Thematic analysis of two focus groups and three one-on-one interviews conducted with clients at a Black-owned free-standing culturally-centered birth center (n=10). **Results:** We found that Black birthing persons' concerns centered on three main themes: agency, historically- and culturally-safe birthing experiences, and relationship-centered care. Many participants pointed directly to past experiences of medical mistreatment and obstetric racism when defining their ideal birth experience. **Conclusion:** Black birthing people seeking care from culturally-informed providers often do so because they have been mistreated, disregarded, and neglected within traditional care settings. The needs articulated by our study participants provide a powerful framework for understanding alternative patient-centered models of care that can be developed to improve the care experiences of Black birthing people in the pursuit of birth equity.

Keywords: health equity, birth outcomes

INTRODUCTION

Having a child should be a joyous celebration for families; however, this is not the reality all birthing people face or even anticipate. Structural racism, disenfranchisement, and the continued neglect of Black people in the United States (US) have created social and medical environments wherein Black birthing people are often filled with fear and anxiety as they agonize over the fate of their infant as well as their own potential mortality or morbidity (Braveman et al., 2017; Crear-Perry et al., 2021; Wallace et al., 2017). The United States has abysmal maternal and infant health outcomes and perinatal cost when compared to other developed nations (Carroll, 2017; Douthard et al., 2021; Snowden, 2018). Despite decades of technological improvements, maternal and infant morbidity and mortality rates continue to increase—especially for Black birthing people. An emerging body of research points to structural racism as the cause of these pernicious inequities and highlights the need for culturally-centered care models designed to better support Black birthing people (Dominguez, 2008; Liu et al., 2019; Owens & Fett, 2019; Scott et al., 2019; Scott & Davis, 2021). Yet, conversations about creating ideal birth experiences for pregnant people often focus on individual actions or desires and rarely discuss the role of structural racism on an individual's birthing experience (Davis, 2018; Lyerly, 2013).

Structural and interpersonal racism often emerge when providers rely on stereotypes when treating Black patients or when patients feel that stereotypes impact the quality of care they receive (Scott et al., 2019; Wren Serbin & Donnelly, 2016; Yoder & Hardy, 2018). These stereotypes, or implicit biases, are a significant cause of persistent racial health inequities (Blair et al., 2011; Braveman et al., 2015; Burgess et al., 2016; Tajeu et al., 2018; Van Ryn, 2016). Research has focused primarily on the causes of inadequate care, with specific attention paid to how providers can address their own implicit biases to better serve patients (Dehon et al., 2017; Pereda & Montoya, 2018). Maternal and child health scholars, understanding the unique physical and social-emotional nature of pregnancy, have shifted the conversation to consider the needs of those most impacted by care decisions—birthing people (Chambers et al., 2021; Julian et al., 2020; Lyerly, 2013; Scott et al., 2019; Smith et al., 2022). This scholarship reimagines current care systems entirely and considers how contemporary care models can be redesigned to center the needs of those most impacted – a practice known as centering at the margins. The need to center at the margins is a fundamental part of addressing health inequities according to critical race scholars (Ford & Airhihenbuwa, 2010); however, scholarship focusing specifically on the needs of Black birthing people is limited (Black Mamas Matter Alliance Research Working Group, 2020). There is an urgent need to consider what Black birthing people want from interactions with providers during pregnancy and birth, and how centering their ideas may offer a new framework for the ideal birth experience (Crear-Perry et al., 2021; Julian et al., 2020; Lyerly, 2013; McLemore, 2018).

Background and Significance

The persistent racial inequities in perinatal health outcomes for Black birthing people are due to structural racist systems specifically designed to reinforce anti-Black social hierarchies that exist within the United States. Multiple sociological pathways coalesce and create various forms of toxic stress that increase the cumulative risk of adverse perinatal outcomes (Chambers et al., 2018). Specifically, various forms of structural racism occur at both the systemic and the individual level and adversely impact outcomes for Black birthing people (Wallace et al., 2015).

One arena in which the effects of structural racism can manifest is during patient-provider interactions. Patient-provider interactions are also influenced by these structural forces and influence how Black birthing people experience obstetric care. Namely, research shows that Black

birthing people often report experiencing obstetric racism—social and clinical neglect, mistreatment, disrespect, and harm - while seeking perinatal and reproductive health services, often threatening positive birth outcomes and experiences in hospital settings (Davis, 2018). Loss of bodily autonomy, disrespect, abuse, and discrimination are common occurrences for Black birthing people seeking perinatal and reproductive health services (Attanasio & Hardeman, 2019; McLemore et al., 2018; Vedam et al., 2019). These experiences often leave Black birthing people feeling powerless and uninvolved in care decisions (Harrison et al., 2017). A desire to have a more active role in their care decisions and a focus on trust-building have been voiced as essential steps to improving care quality for Black birthing people (Cuevas et al., 2016; Hardeman et al., 2020).

Increased racial diversity within the health care workforce could lead to improved quality of care for people of color, and could potentially reduce racial disparities in antenatal health (Almanza et al., 2019; Greenwood et al., 2020; Hardeman & Kozhimannil, 2016). Additionally, research suggests that midwifery care is associated with reduced odds of small for gestational age births and preterm birth (Johantgen et al., 2012; Loewenberg Weisband et al., 2018; McRae et al., 2018; Renfrew et al., 2014; Sandall et al., 2016). The importance of person-centered high-quality care has been extensively documented (Eliacin et al., 2015; Entwistle & Watt, 2013; Howell & Ahmed, 2019; Kraft-Todd et al., 2017); however, many recommendations fail to consider how alternative maternity care models, like birth center care, can be leveraged to ensure the increased quality of care for birthing people most impacted by maternal and infant health disparities (Hardeman et al., 2020). Furthermore, little attention has been paid to the needs voiced directly by Black birthing people, although this has been identified as a necessary addition to this body of literature (Black Mamas Matter Alliance Research Working Group, 2020).

Building a framework for empirically rigorous methods that analyze and better capture the experiences of Black birthing people is essential to reducing birth inequities. Traditional measures used within health services and reproductive health research can be leveraged in ways that better integrate and center marginalized people (Hardeman & Karbeah, 2020). There is a critical need to invest in models aimed at improving care experiences and outcomes that will reduce the racial disparities that exist for Black birthing people in the US. To achieve this goal, the authors collaborated with Roots Community Birth Center (RCBC), a Black-owned free-standing birth center that employs a culturally-centered care model (Hardeman et al., 2019).

METHODS

Setting and Sample

The results presented in this study represent data generated as part of a Robert Wood Johnson Foundation Interdisciplinary Research Leaders project focused on community-led solutions to achieving birth equity. The parent project examined the role of a free-standing, Black-owned birth center on adverse birth outcomes and breastfeeding initiation in Minneapolis, Minnesota (Hardeman et al., 2019). Roots Community Birth Center (RCBC) is situated in North Minneapolis, a community with a large proportion of residents who are African American (32.7%) and where individuals have a total annual household income of less than $35,000 (Minnesota Compass, 2022). This community also has substantially higher rates of adverse perinatal outcomes (City of Minneapolis, 2015). Although not the only birth center in the city of Minneapolis, RCBC is the only Black-owned birth center in the state. Additionally, when founded, its openness to accept publicly-insured clients made it one of the few birth centers available to low-income birthing

people (Hardeman et al., 2019). The dataset includes focus group and key informant interviews with RCBC clients (n=10).

The research team's commitment to a health equity and critical race theoretical (Ford & Airhihenbuwa, 2010) approach meant centering at the margins and hearing the experiences and desires of those most impacted by the perinatal inequities that persist in our nation—Black birthing people. To center these voices and experiences, focus groups only included Black RCBC clients and members of the research team who identified as Black (Ford & Airhihenbuwa, 2010). This manuscript presents the qualitative themes identified during our focus groups and interviews with clients at RCBC. These themes build upon the framework presented by Ann Lyerly in her book *A Good Birth* by detailing what Black pregnant people consider to be the most important characteristics of a good birth experience (Lyerly, 2013).

Ethical Considerations

This study was reviewed and approved by the University of Minnesota's Institutional Review Board. This determination was due to the procedures established by the research team to ensure the confidentiality of study participants. Data were managed and analyzed in accordance with university security and privacy standards. All participants gave informed consent and received a gift card for their participation.

Data Collection

Data presented in this manuscript come from semi-structured conversations ranging in size from one to seven Black birthing individuals receiving care at RCBC. Conversations range in length from 30 minutes to two hours. Interview guides were developed in partnership with the research team, including the owner of the birth center, and were designed to elicit client narratives about their birth experiences as well as previous birthing experiences that led them to seek care at RCBC. Consistent with other qualitative public health and health services research scholarship, the research team used an iterative process to develop the interview guide (Bradley et al., 2007). A total of two focus groups and three individual interviews were conducted at RCBC from 2017-2019. Focus groups were conducted at RCBC and followed a standardized set of questions about the factors that led them to seek the culturally-centered care that RCBC offered. Participants received compensation for their participation in focus group interviews.

Embracing these frameworks, the research team endeavored to ensure that focus group participants felt comfortable and welcomed. A significant part of achieving this goal was ensuring that focus group sessions happened in the evening, when RCBC patients were most available to meet. The research team sought to ensure that each focus group centered Black voices by making sure that only members of RCBC who identified as Black or African American were present during focus group meetings (Altman et al., 2019; Dahlem et al., 2015). Additionally, because many of our participants had multiple children, childcare was provided at every focus group meeting. Researchers also took into consideration the fact that many participants had young infants and were breastfeeding and encouraged participants to bring infants to focus groups as needed. The key themes from these interviews are presented in this manuscript.

Analysis

Focus group coding. All interviews were conducted at RCBC. Semi-structured interview questions based on the Lyerly *Good Birth* framework (Lyerly, 2013) were used to better understand how the culturally-centered care at RCBC allowed clients to achieve their ideal birth experience (Figure 1). All interviews were audio recorded and transcribed verbatim by an external firm that specializes in verbatim audio transcription. All transcripts were coded and analyzed by

three of the authors, all of whom are trained in qualitative methods, using Microsoft Excel, version 16.6. Consistent with the aims of this larger research project, the authors used a critical race theoretical framework (Almanza et al., 2019; Ford & Airhihenbuwa, 2010; Karbeah et al., 2019) in conjunction with Ann Lyerly's Good Birth framework (Lyerly, 2013) and inductive coding methods. Coding occurred through an iterative process. All transcripts were coded on individual spreadsheets and a second round of coding was conducted in person to establish intercoder reliability and the validity of each code. A third and final round of coding, conducted by two of the authors, further distilled themes into the three discussed below. This three-step process allowed us to highlight first, what experiences or aspects of care Black birthing people identified as essential to a good birth experience and, second, why they believed RCBC attended to these specific needs. The lead author was involved in every stage of the coding process.

Figure 1: Focus Group Questions

Theme	**Question**
Good birth	What do you consider to be the time frame involved when we talk about birth: When I say that we're going to talk about good births, what time period do you think of? When does the birth experience begin? When does it end?
	Now, I would like you to think back to before you were pregnant or early on in your pregnancy (just after you discovered you were pregnant)…What kinds of thoughts did you have about where you wanted to receive prenatal care and deliver your baby? We often here about just one measure of a good birth—that is, the health of the mom and the baby. But I think that a good birth is made up of a lot of things—the type of care you receive, the space you receive the care in, and many other things.
Complications	If you encountered any unexpected complications during the pregnancy and birth experience, can you tell us how you managed them?
	How did the midwife (provider) manage unexpected complications?
	Were you satisfied with the way the situation was handled? Did these complications affect you and your partner's birth experience in a good or bad way?
Mode of Delivery	How did you feel about the way you birthed your baby (e.g., vaginal, VBAC, planned C/S, unplanned C/S)?
	How did the mode of delivery affect your birth experience, in a good or bad way?
Control/Self-efficacy	How much control did you want throughout your pregnancy? And in your labor and birth? Did you feel you experienced this level of control? Why/why not?
	What contributed to this?

Theme	Question
Safety	Did you feel safe in your surroundings during birth? What contributed to this feeling of safety/unsafety?
	How did this affect your experience?
Relationship with provider	How would you describe the relationship you had with the provider who delivered your baby?
	What kind of impact do you think that relationship had on your experience? Can you explain?
Social support	How did the people around you contribute to your good birth experience? What specifically did they say or do? How did having these people with you make you feel?
Self-esteem/shame	How did your birth experience make you feel about yourself?
	Have you thought about yourself differently since you gave birth?
	Did you learn anything about yourself during the process? [Did anything about the process make you feel: proud, loved, guilty, shameful, etc.?]
	Do you think these feelings contributed to how you feel about your experience of giving birth?
Pain	How did the pain you experienced during labor and birth affect your overall experience? How did you cope with the pain?
	How would you describe the role of pain or pain management in your experience of giving birth?
Use of technology	How did you feel about the level of medical technology that was present and/or used during your birth? Did this level of technology contribute to your assessment of this birth as a good or bad experience?
Postpartum care	Was there anything that occurred after the baby was born that positively or negatively affected your experience?

RESULTS

Three main themes emerged from participants as they talked about their birthing experiences and why they sought care at RCBC. These themes center around: agency, a historically and culturally safe birthing experience, and relationship-centered care. Each theme is described below with direct quotes from participants that illustrate each theme in greater detail.

Agency

Agency describes a birth experience wherein an individual has a sense of both control and autonomy; low agency is often related to experiences of inequity and mistreatment throughout the maternity care process (Declercq et al., 2020; Lyerly, 2013; Vedam et al., 2019). Within this theme, respondents talked about the need for control and self-efficacy during the prenatal period as well

as during childbirth. For some participants, having agency during their birthing process often increased their self-esteem whereas a lack of agency caused individuals to feel ashamed or inadequate when giving birth. One participant spoke about how being allowed to bring her full self—her cultural and spiritual identity—into the birthing space made her feel welcome and in control during her birthing process.

> *I can bring stuff in that I want in order to have the best birth, have a birth that's going to include practices that I do within my own home around my own spirituality and my culture. So I felt safe. I felt like I could have my [inaudible] in the room and that was something that was welcome. I could have my altar in the room. That's something that was welcome, my own pictures, "Let's take this stuff down," because I could do that and I did do that.*

A Historically and Culturally Safe Birthing Experience. Many women anchored their conversation surrounding RCBC in their past birth history, describing their own previous experiences with a hospital-based birth. These experiences were described, predominantly, using the language of mistreatment: experiences of marginalization, discrimination, or complications emerging from a health system that fails to incorporate Black voices.

Discussions of past and ideal birth experiences also highlighted how communal histories of mistreatment shape birth experiences for Black birthing people. When discussing complications in the birth process, we learned that individual and community mistreatment were inextricably linked with birthing people often seeing their mistreatment linked to that of their ancestors and other Black birthing people. We heard how cultural experiences of racialized mistreatment and discrimination were internalized and continued to shape individual experiences during pregnancy and childbirth. One participant, when asked why she sought care at RCBC, referenced the collective experience of other Black birthing people. She specifically pointed to the disparities in maternal mortality and how knowledge of this communal trauma led her to seek out care that could potentially prevent her from experiencing adverse outcomes.

> *I was well aware of health care disparity among African American Women, so it was really important to me to find a black care team. And after my boss, at the time, had Rebecca deliver her son and she and she was like, "You have to use this midwife." And before, she gave me Rebecca's name and I [was] on the website on my list of places to tour. So I Googled the name and I was like okay. Like it's meant to be.*

The experience of birthing while Black at RCBC contributed to participants reporting that their experiences of discrimination and mistreatment—both personal and communally—were being addressed without having to spell it out to their providers:

> *I knew like all of those pieces were in place. It was almost like, I didn't even have to consider how much they knew about **history** because it just showed up in their care, like in the way that they treated me, whereas like, I remember those time coming from the clinic and stuff I'm just like, pissed, pissed mad and thinking about history because I'm like "they have taken into consideration this, this, this, and this" and they're just basically trying to follow me out the door to make me pay my copay. And so ...*

Relationship-Centered Care

Relationship-centered care and the desire for a supportive and welcoming birth environment was a theme that appeared often in our conversations with RCBC clients. Within these themes, respondents identify aspects of the patient-provider relationship that are particularly important to

them as Black birthing people. One respondent discussed how central the patient-centered care relationship was to her decision to receive care at RCBC.

> *She was like talking to my baby. I was like, ooh, I need to switch up [how] I talk to my baby. Like, she's talking to my baby like this. And then, (laughs) but she talked to my baby, like she was like "look baby, like, me and you gonna be friends. We gonna have to get your mamma right." And so, like that is the feeling I got and that was my first visit with her other than the tour, um, and ... in that moment I was like, I really want her to deliver my baby.*

In addition to having a strong and supportive relationship with their clinician, when asked to define a good birth, participants frequently spoke about the importance of having racially concordant care during their birthing process.

> *It would have to be a woman of color. There are only things a woman of color can do for you and for me that would be a black woman because woman of color doesn't necessarily mean black.*

For many respondents, having a Black woman provider meant not only that they would be truly seen and acknowledged by their clinician, but also that they would be loved and taken care of.

> *And they have to have been through they, what we've been through as black women.*
> *That's the piece that I would say is personal with us, so I would also say like, yes, a woman of color, and I think that though I didn't connect ... Rebecca actually was not a part of ... [00:58:00] She was a part of maybe one or two of my prenatal visits. So she was not really there a lot. But, what ... I remember my first visit though, with her, because it felt like it was from a place of love.*

For our participants, receiving care from a Black woman provider provided an opportunity to be cared for by someone who had a shared history. Someone who would treat you like family. Someone who would care for you and your baby in ways that often only family can.

> *And so, it just felt very, very loving, like she cared about what happened. Like, if I did at a hospital, I'm like, I'm sure they think it's bad when a baby dies, but because it's fundamentally like, "Oh, a baby's dying or something right? But I don't think that they really care. I think it's like they have to do what's necessary, and the list of things to do, but I'm like, I feel like she built a kind of connection that.. was like, like she cares deeply about every single child that she's caring for. Um, and so, it's just a, it's just a different feeling when you know. It's almost like if your mom was doing it.*
> *I think it's like sisterhood, because its' just like us black women just throughout history, have always had been the ones that care of the families…that take care of the communities, that take care of the neighbor ...whoever it may be. And then to come here and find that as well, and it's coming from a place of love. Um, it's just like sisterhood. Really, I don't know how to describe it. But it's just on the meeting of women getting together and having real conversations, you know?*

When thinking back on the care they received, participants noted how different their appointment experiences at RCBC were from the experiences they had in traditional care settings.

> *…it didn't feel like an office visit. It felt like walking into a family member's house. Like you can take off your shoes and they offer you water or tea or whatever and then also, yes, the whole personal-I have struggled with...I struggle with a relationship with my mom and*

> *Rebecca would remember everything you would talk about. And the other people who are in my life, in place of my mom, she remembered their names and talked to this person. Are you going to therapy and all these different suggestions that, it was like, "You actually care. You're actually taking the time to remember something we talked about, you know, three visits ago. Like I've seen two different midwives since I last saw you and you remember to ask me these things."*

For many respondents the care and connection offered at RCBC differed significantly from the care they had received in other care settings. The respondent below notes how they often didn't feel like they had a relationship with their provider and how this desire for a relationship with their provider led them to seek care at RCBC.

> *I did tons of research. I wanted to feel safe, I wanted to feel like what I was going to experience, everybody was gonna be there for me. And being in a hospital, sometimes the doctor doesn't even really know your name until they come into see you, and I had that experience quite a few times where I would go in and he would be like, "Uh ... [name], right?" And I'm like, "I came here like two, three times, like you should know my name by now."*

Further support for this quote, and the nature of the patient-clinician relationship that exists at RCBC, can be seen in the number of survey respondents who report that their provider used medical language that they did not understand, as well as individuals reporting that they felt that they were treated poorly because they had different opinions than their provider. In our interviews, we also heard participants express the need to have a care team that could acknowledge the risks they faced as Black birthing people and work to ensure a safe and healthy pregnancy.

RCBC clients often noted wanting to feel truly cared for as one of the reasons they sought care at RCBC. Specifically, participants highlighted the care they received once complications arose, noting that they felt RCBC staff explained all conditions thoroughly and continued to provide care even when clients were admitted to the hospital. One participant shared how touched she was that Rebecca Polston, owner of RCBC, stayed by her side even after she was diagnosed with preeclampsia and was admitted to a hospital.

> *…the care towards the end of my pregnancy ... So, two days before ... No, a day before he was born, I came up here, stayed at the mill, and my blood pressure got shot up, like way high…I was going to be delivering in a hospital. So, I was like, broken hearted. Like, I don't want to go to the hospital. And we did a blood panel. She ended up sending me to the hospital that night... But she was just like, even if you have to go to the hospital, I'll be there. And I was like, you don't have to wake up to be there because I'm transferring out if I have go over at a hospital. She's like, if you have to [go], like she developed a plan. It was, we're going to go to Saint John's. She had called a doctor she had known, she knows, and he said he would take me on if I had to deliver. Like, it was like she actually cared. Versus, have you gone into a hospital with high blood pressure for prenatal, they had you up in the hospital, induced you, and you'd been like having the baby that night. Like she'd do everything she could to delay that.*

Through these stories we see how both RCBC and this culturally-centered model of care can center and uplift the needs and voices of Black birthing people, which are often overlooked or ignored.

This quality of care is often rare for this population and is highly valued and sought after, as demonstrated by this quote from one participant.

> *So when I found out I was pregnant, I called around and I specifically asked for... because I was thinking about my ancestry and what did they do and they had midwives. And so I called around and I said, "Do you have a black midwife there?" And I called here because I had some questions [inaudible 00:05:14] but I'm looking for a Black midwife. And they said, "Yeah, we have one and she owns the place." Even better!*

This relationship-centered care model is so highly sought after that some participants noted their willingness to travel further distances in order to receive care at RCBC. One participant recounts driving past multiple other institutions on her way to RCBC.

> *I think on the way here we counted all the hospitals we passed. There's three or four.*

DISCUSSION

This analysis provides empirical support that highlights the role that a community-informed perinatal and reproductive health services model can play in reducing the glaring and persistent perinatal health inequities facing Black birthing communities in the United States (Julian et al., 2020). These disparities are the result of structural inequities that prevent pregnant Black people from having what researchers like Ann Lyerly describe as a *good birth* (Lyerly, 2013). To effectively address the perinatal disparities facing Black birthing people, we embrace care models that center reproductive justice and culturally-centered frameworks that center the needs of Black birthing people first and foremost. The themes of agency, a historically and culturally safe birthing experience, and relationship-centered care highlighted by our sample contribute to a body of literature that has aimed to describe the birth, prenatal, and postpartum health care experiences of Black birthing people (McLemore et al., 2018). Our study differs by focusing on an alternate care setting—a free-standing birth center—that for many of our participants provided a rare avenue through which they can actualize their ideal birth experiences. Woven in all of our qualitative themes, respondents noted that the care received at RCBC was starkly different from the care they've received in traditional care settings where they felt disrespected and neglected—experiences that mirror existing data (Vedam et al., 2019). Our findings also reiterate existing literature by Beach and colleagues that suggests that relationship-centered care, or the relationship between a patient and a provider, potentially impacts both quality of care and patient outcomes (Beach et al., 2006). Our study is unique in its focus on the needs specifically identified by Black birthing people to truly center at the margins.

CONCLUSION

The generalizability of this study is limited due to our small sample size in both our qualitative and quantitative samples. However, our findings suggest that the model of care at RCBC provides a roadmap that can be used to reimagine perinatal care models that better serve Black birthing people. Respondents overwhelmingly report feeling cared for and empowered when receiving care at RCBC. These comments are in stark contrast to the reports of disrespect and stress-related discrimination that are linked to adverse perinatal and reproductive health outcomes (Pullen et al., 2014; Slaughter-Acey et al., 2016).

REFERENCES

Almanza, J., Karbeah, J. M., Kozhimannil, K. B., & Hardeman, R. (2019). The Experience and Motivations of Midwives of Color in Minnesota: Nothing for Us Without Us. *Journal of Midwifery & Women's Health*.

Altman, M. R., Oseguera, T., McLemore, M. R., Kantrowitz-Gordon, I., Franck, L. S., & Lyndon, A. (2019). Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth. *Social Science & Medicine, 238*, 112491.

Attanasio, L. B., & Hardeman, R. R. (2019). Declined care and discrimination during the childbirth hospitalization. *Social Science & Medicine, 232*, 270-277.

Beach, M. C., Inui, T., & Network, R. C. C. R. (2006). Relationship-centered care: A constructive reframing. *Journal of General Internal Medicine, 21*(S1), S3-S8.

Black Mamas Matter Alliance Research Working Group. (2020). Black maternal health research re-envisioned: best practices for the conduct of research, with, for, and by Black mamas. *Harvard Law Policy Rev, Winter*.

Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: where do we go from here? *The Permanente Journal, 15*(2), 71.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Services Research, 42*(4), 1758-1772.

Braveman, P., Heck, K., Egerter, S., Dominguez, T. P., Rinki, C., Marchi, K. S., & Curtis, M. (2017). Worry about racial discrimination: A missing piece of the puzzle of Black-White disparities in preterm birth? *PloS one, 12*(10), e0186151.

Braveman, P. A., Heck, K., Egerter, S., Marchi, K. S., Dominguez, T. P., Cubbin, C., Fingar, K., Pearson, J. A., & Curtis, M. (2015). The role of socioeconomic factors in black–white disparities in preterm birth. *American journal of public health, 105*(4), 694-702.

Burgess, D. J., Beach, M. C., & Saha, S. (2016, Sep 15). Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients. *Patient Educ Couns*. https://doi.org/10.1016/j.pec.2016.09.005

Carroll, A. E. (2017). Why Is US Maternal Mortality Rising? *Journal of the American Medical Association, 318*(4), 321-321.

Chambers, B. D., Arega, H. A., Arabia, S. E., Taylor, B., Barron, R. G., Gates, B., Scruggs-Leach, L., Scott, K. A., & McLemore, M. R. (2021). Black women's perspectives on structural racism across the reproductive lifespan: a conceptual framework for measurement development. *Matern Child Health J, 25*(3), 402-413.

Chambers, B. D., Baer, R. J., McLemore, M. R., & Jelliffe-Pawlowski, L. L. (2018). Using Index of Concentration at the Extremes as Indicators of Structural Racism to Evaluate the Association with Preterm Birth and Infant Mortality—California, 2011–2012. *Journal of Urban Health*, 1-12.

City of Minneapolis. (2015). *Infant Mortality by Community*. Retrieved June 24 from

Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health, 30*(2), 230-235.

Cuevas, A. G., O'Brien, K., & Saha, S. (2016). African American experiences in healthcare:"I always feel like I'm getting skipped over". *Health Psychology, 35*(9), 987.

Dahlem, C. H. Y., Villarruel, A. M., & Ronis, D. L. (2015). African American women and prenatal care: perceptions of patient–provider interaction. *Western Journal of Nursing Research, 37*(2), 217-235.

Davis, D.-A. (2018). Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing. *Medical anthropology*, 1-14.

Declercq, E., Sakala, C., & Belanoff, C. (2020). Women's experience of agency and respect in maternity care by type of insurance in California. *PloS one, 15*(7), e0235262.

Dehon, E., Weiss, N., Jones, J., Faulconer, W., Hinton, E., & Sterling, S. (2017). A systematic review of the impact of physician implicit racial bias on clinical decision making. *Academic Emergency Medicine, 24*(8), 895-904.

Dominguez, T. P. (2008). Race, racism, and racial disparities in adverse birth outcomes. *Clinical obstetrics and gynecology, 51*(2), 360-370.

Douthard, R. A., Martin, I. K., Chapple-McGruder, T., Langer, A., & Chang, S. (2021). US maternal mortality within a global context: Historical trends, current state, and future directions. *Journal of Women's Health, 30*(2), 168-177.

Eliacin, J., Salyers, M. P., Kukla, M., & Matthias, M. S. (2015). Patients' understanding of shared decision making in a mental health setting. *Qualitative health research, 25*(5), 668-678.

Entwistle, V. A., & Watt, I. S. (2013). Treating patients as persons: a capabilities approach to support delivery of person-centered care. *The American Journal of Bioethics, 13*(8), 29-39.

Ford, C. L., & Airhihenbuwa, C. O. (2010, Oct). The public health critical race methodology: Praxis for antiracism research [Article]. *Social Science & Medicine, 71*(8), 1390-1398. https://doi.org/10.1016/j.socscimed.2010.07.030

Greenwood, B. N., Hardeman, R. R., Huang, L., & Sojourner, A. (2020). Physician–patient racial concordance and disparities in birthing mortality for newborns. *Proceedings of the National Academy of Sciences, 117*(35), 21194-21200.

Hardeman, R., Karbeah, J. M., Almanza, J., & Kozhimannil, K. B. (2019). Roots Community Birth Center: A culturally-centered care model for improving value and equity in childbirth. Healthcare,

Hardeman, R. R., & Karbeah, J. M. (2020). Examining racism in health services research: A disciplinary self-critique. *Health Services Research, 55*(Suppl 2), 777.

Hardeman, R. R., Karbeah, J. M., & Kozhimannil, K. B. (2020). Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism. *Birth, 47*(1), 3-7. https://onlinelibrary.wiley.com/doi/10.1111/birt.12462

Hardeman, R. R., & Kozhimannil, K. B. (2016). Motivations for Entering the Doula Profession: Perspectives From Women of Color. *Journal of Midwifery & Women's Health, 61*(6), 773-780. https://doi.org/10.1111/jmwh.12497

Harrison, M. E., Clarkin, C., Rohde, K., Worth, K., & Fleming, N. (2017). Treat me but don't judge me: a qualitative examination of health care experiences of pregnant and parenting youth. *Journal of pediatric and adolescent gynecology, 30*(2), 209-214.

Howell, E. A., & Ahmed, Z. N. (2019). Eight steps for narrowing the maternal health disparity gap: Step-by-step plan to reduce racial and ethnic disparities in care. *Contemporary ob/gyn, 64*(1), 30.

Johantgen, M., Fountain, L., Zangaro, G., Newhouse, R., Stanik-Hutt, J., & White, K. (2012). Comparison of labor and delivery care provided by certified nurse-midwives and physicians: a systematic review, 1990 to 2008. *Women's Health Issues, 22*(1), e73-e81.

Julian, Z., Robles, D., Whetstone, S., Perritt, J. B., Jackson, A. V., Hardeman, R. R., & Scott, K. A. (2020). Community-informed models of perinatal and reproductive health services provision: a justice-centered paradigm toward equity among Black birthing communities. Seminars in Perinatology,

Karbeah, J. M., Hardeman, R., Almanza, J., & Kozhimannil, K. B. (2019). Identifying the Key Elements of Racially Concordant Care in a Freestanding Birth Center. *Journal of Midwifery & Women's Health*.

Kraft-Todd, G. T., Reinero, D. A., Kelley, J. M., Heberlein, A. S., Baer, L., & Riess, H. (2017). Empathic nonverbal behavior increases ratings of both warmth and competence in a medical context. *PloS one, 12*(5), e0177758.

Liu, S. Y., Fiorentini, C., Bailey, Z., Huynh, M., McVeigh, K., & Kaplan, D. (2019). Structural Racism and Severe Maternal Morbidity in New York State. *Clinical Medicine Insights: Women's Health, 12*, 1179562X19854778.

Loewenberg Weisband, Y., Klebanoff, M., Gallo, M. F., Shoben, A., & Norris, A. H. (2018). Birth outcomes of women using a midwife versus women using a physician for prenatal care. *Journal of Midwifery & Women's Health, 63*(4), 399-409.

Lyerly, A. (2013). *A good birth: finding the positive and profound in your childbirth experience*. Penguin.

McLemore, M. (2018). What blame-the-mother stories get wrong about birth outcomes among black moms. *Children's health matters*.

McLemore, M. R., Altman, M. R., Cooper, N., Williams, S., Rand, L., & Franck, L. (2018). Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. *Social Science & Medicine, 201*, 127-135.

McRae, D. N., Janssen, P. A., Vedam, S., Mayhew, M., Mpofu, D., Teucher, U., & Muhajarine, N. (2018). Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: a population-based cohort study comparing antenatal midwifery and physician models of care. *BMJ open, 8*(10), e022220.

Minnesota Compass. (2022). *Webber-Camden Neighborhood*. Retrieved December 4 from https://www.mncompass.org/profiles/neighborhoods/minneapolis/webber-camden

Owens, D. C., & Fett, S. M. (2019). Black maternal and infant health: historical legacies of slavery. *American journal of public health, 109*(10), 1342-1345.

Pereda, B., & Montoya, M. (2018). Addressing implicit bias to improve cross-cultural care. *Clinical obstetrics and gynecology, 61*(1), 2-9.

Pullen, E., Perry, B., & Oser, C. (2014). African American women's preventative care usage: the role of social support and racial experiences and attitudes. *Sociology of health & illness, 36*(7), 1037-1053.

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., Silva, D. R. A. D., Downe, S., Kennedy, H. P., & Malata, A. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet, 384*(9948), 1129-1145.

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane database of systematic reviews*(4).

Scott, K. A., Britton, L., & McLemore, M. R. (2019). The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in "Mother Blame" Narratives. *The Journal of perinatal & neonatal nursing, 33*(2), 108-115.

Scott, K. A., & Davis, D. A. (2021). Obstetric Racism: Naming and Identifying a Way Out of Black Women's Adverse Medical Experiences. *American Anthropologist*.

Slaughter-Acey, J. C., Sealy-Jefferson, S., Helmkamp, L., Caldwell, C. H., Osypuk, T. L., Platt, R. W., Straughen, J. K., Dailey-Okezie, R. K., Abeysekara, P., & Misra, D. P. (2016). Racism in the form of micro aggressions and the risk of preterm birth among black women. *Ann Epidemiol, 26*(1), 7-13. e11.

Smith, K. L., Shipchandler, F., Kudumu, M., Davies-Balch, S., & Leonard, S. A. (2022). "Ignored and Invisible": Perspectives from Black Women, Clinicians, and Community-Based Organizations for Reducing Preterm Birth. *Matern Child Health J*, 1-10.

Snowden, J. M., Guise, Jeanne-Marie, Kozhimannil,Katy B. . (2018). Promoting inclusive and person-centered care: starting with birth. *Birth, 45*, 232-235.

Tajeu, G. S., Halanych, J., Juarez, L., Stone, J., Stepanikova, I., Green, A., & Cherrington, A. L. (2018). Exploring the association of healthcare worker race and occupation with implicit and explicit racial bias. *Journal of the National Medical Association, 110*(5), 464-472.

Van Ryn, M. (2016). Avoiding unintended bias: strategies for providing more equitable health care. *Minnesota medicine, 99*(2), 40.

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., & Rushton, E. (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive health, 16*(1), 77.

Wallace, M., Crear-Perry, J., Richardson, L., Tarver, M., & Theall, K. (2017). Separate and unequal: Structural racism and infant mortality in the US. *Health & place, 45*, 140-144.

Wallace, M. E., Mendola, P., Liu, D., & Grantz, K. L. (2015). Joint effects of structural racism and income inequality on small-for-gestational-age birth.(Report)(Author abstract). *105*(8), 1681. https://doi.org/10.2105/AJPH.2015.302613

Wren Serbin, J., & Donnelly, E. (2016). The impact of racism and midwifery's lack of racial diversity: a literature review. *Journal of Midwifery & Women's Health, 61*(6), 694-706.

Yoder, H., & Hardy, L. R. (2018). Midwifery and antenatal care for black women: a narrative review. *SAGE Open, 8*(1), 2158244017752220.