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# Perceptions of Prenatal Care from Mississippi Mothers: The Role of Race and Insurance Coverage

Brittney Clayborn

# Perceptions of Prenatal Care from Mississippi Mothers: The Role of Race and Insurance Coverage

by

Brittney Clayborn

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Approved by:

Traci Hayes, Ph.D., Thesis Advisor,
School of Health Professions

Melissa Kossman, Ph.D., Director,
School of Health Professions

Sabine Heinhorst, Ph.D., Dean
Honors College

# ABSTRACT

Giving birth in America as an African American woman is a daunting and risky undertaking. African American women are three to four times more likely to die from giving birth and two times more likely to experience severe maternal morbidity than their White counterparts (Wang, Glazer, Sofaer, Balbierz, & Howell, 2020). The disparity seen in maternal health and mortality can partially be linked to other chronic health and medical factors; however, there are even disparities seen in those as well. Attention must be brought to the impact of race and socioeconomic status on the likelihood of survival after giving birth, as both have proven to be reasons for discrimination. The woman's experience in the health care system is strife with discrimination both implicit and explicit, especially for the African American woman, and yields narratives of neglect, miscommunication, and distrust.

This study focuses on the roles race and insurance coverage have in the perception of maternal care received by mothers. Virtual, individual interviews were conducted with nine Mississippi mothers ranging in age from 25 to 36. The questions were asked to gauge how the mothers felt their communication, relationship with their team, and overall quality of care were impacted by their race and insurance coverage. It was concluded that African American mothers express race as having an impact on their maternal care, and that insurance is a very important aspect of the maternal care experience.

***Keywords***: Qualitative Research, Racism, Antiracism, and Race Equity, Pregnancy Complications, Health Equity, Postpartum Care

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| | |
|---|---|
| MMR | Maternal Mortality Ratio |
| SMM | Severe Maternal Morbidity |

# CHAPTER I: INTRODUCTION AND REVIEW OF LITERATURE

In the United States, African American women experience maternal morbidity, post-partum complications, and maternal mortality at higher rates than their white counterparts. The overall maternal mortality ratio (MMR) in the United States is an issue that is only growing, with nearly "seven hundred pregnant women dying every year" (Bridges, 2020). However, when looking at the statistics, African American women are three to four times more likely to die from post-partum complications and two times more likely to experience severe maternal morbidity (SMM; Wang, Glazer, Sofaer, Balbierz, & Howell, 2020). Although many chronic medical factors may contribute to this large disparity (e.g., diabetes, heart disease, and asthma), the African American woman's experiences and differences in treatment within the healthcare field are of particular note. Many African American women express feelings of neglect, miscommunication, and distrust of their caretakers before, during, and after giving birth (Wang et al., 2020). In addition, some women express that the lack of private insurance has caused a shift in their maternal care, and they noticed less communication from their doctors and less attentiveness (Wang et al., 2020). Such shifts can also be linked to misconceptions of pain threshold and biological deviations by medical professionals. According to Hoffman and others, many medical students believe that African Americans are biologically stronger and feel less pain than Caucasians (Hoffman, Trawalter, Axt, & Oliver, 2015). Biases such as these can affect the quality of care received by patients and can even affect the chance of survival in medical emergencies, particularly those common after childbirth.

**Maternal mortality rate and severe maternal morbidity**

The World Health Organization defines maternal death as "a death of a woman while pregnant or within the first 42 days following delivery, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management" (Collier, Qobadi, Cobb, & Martin, 2019). This definition is used to determine the global mortality rate, according to Collier. In the United States, MMR has varied from the years of 2013 to 2016 with the rate being 20.2 deaths per 100,000 live births for that entire period (Collier et al., 2019). A significant factor of the MMR is age, alongside others. It is well-known that the older a woman is the higher the risk of having complications during their pregnancy and giving birth. The risk of possible miscarriage, birthing complications, and maternal morbidity and mortality increases greatly. Women falling in the age range of 35-39 had the highest pregnancy-related mortality rate with 43.4 per 100,000 live births. These rates were even higher for women over the age of 40. Age, however, is not the only disparity we see in the MMR.

The overall maternal mortality rate, though significant, actually varies greatly between African American and White mothers. The pregnancy-related mortality rate for African American women is almost three times greater than the rate for White women, making it 51.9 to 64.1 deaths per live birth. The rate for White women only ranges from 18.9 to 36.7 deaths per live birth (Collier et al., 2019). This disparity is very large and causes concern regarding racial disparity within health care and health outcome.

The leading causes of pregnancy-related mortality in Mississippi between 2013 and 2016, according to the Mississippi Maternal Mortality Report, were "cardiovascular conditions, hypertension, and preeclampsia-related conditions, thrombotic embolism, stroke, and infection" (Collier et al, 2019). It should be noted that the conditions that happen at the time of giving birth or shortly after are significant, but there are times when mothers have pre-existing conditions and morbidities, such as hypertension, that can contribute to a greater risk of maternal mortality or maternal morbidity. However, this does not discount the large gap seen between African American mothers and White mothers.

**Bias and discrimination**

The disparity seen in the maternal mortality and morbidity rates of African American as compared to White mothers partially stems from bias and discrimination experienced in the healthcare setting. Discrimination is "behavior directed towards category members that is consequential for their outcomes and that is directed towards them not because of any particular deservingness or reciprocity, but simply because they happen to be members of that category" (Ramiah, Hewstone, Dovidio, & Penner, 2012). Discrimination is quite complex with several types and countless ways of presentation; however, the overall result is essentially the same. Those who are discriminated against reap the negative effects as individuals and as a group. Structural discrimination is "an embedded institutional process…that functions in a way that leads to differential racial treatment or produces differential racial outcomes" (Measuring Racial Discrimination, 2004). Examples of this sort of discrimination outside of the medical field include real estate agents participating in racial steering and banks denying loans due to regulations that disproportionately affect some racial groups over others (Measuring Racial Discrimination, 2004). As explicit as these examples may seem, the actions are often not intentionally biased or discriminatory. Many realtors see themselves as catering to their clients and banks are often simply following the regulations put in place; however, lack of ill will does not erase the ill effects of the actions. In fact, a greater issue presents itself when institutions have no ill intent and are unaware of the discrimination they perpetuate. They see no reason for change or improvement thus institutional and systematic discrimination continues and often worsens. The question then becomes what happens when these very institutions that uphold discriminatory policies and actions are ones that deeply impact a person's livelihood.

Though all forms and types of discrimination are detrimental to marginalized groups in almost every facet of life, discrimination within systems such as the justice system and, even more so, the healthcare system can too often become an issue of life and death. The healthcare system is one in which the quality and span of life are worked to be improved as much as possible, but the very opposite occurs when both implicit and explicit biases are presented within these spaces. These malpractices are a partial reason for many of the disparities we see within healthcare and overall health behavior in minority communities as well as marginalized communities.

**Racial bias in medical care**

In past studies, there has been evidence of racial bias within the general medical care field (Hoffman et al., 2016) that has been shown to have detrimental impacts on patient-provider relationships and the quality of care received by a patient (Hall et al., 2015). According to Hoffman and colleagues, a study showed that many White medical students believed that African Americans had a higher pain threshold and experienced overall less pain than White patients (Hoffman et al., 2016). Such falsified beliefs have the potential to cause more damage than is already present when diagnosing and caring for African American patients. For example, a pain assessment rooted in bias can create a situation where a lack of appropriate medication or medical attention is provided to the patient because of this preconceived notion surrounding pain tolerance. So, a medical issue that may have started off relatively small or easily solvable may then be ineffectually treated by an individual's doctor or healthcare team which then results in further complications or issues which can be both costly to the individual as well as the hospital and may even result in higher rates of mortality or morbidity. If unchecked, biases such as these can and do cause great disparities and health inequities in the world of medicine.

According to another study performed by Hall and colleagues, it is agreed that bias within the medical field can affect medical care in multiple different ways (Hall et al., 2015). Similar to the previous study, findings indicate that African American patients perceive an overall lower quality of care. Additionally, African American patients reported a more negative relationship with their providers than their White and non-Black Latina counterparts. Specifically, African American patients reported liking their care provider less. They also reported being less likely to follow their provider's recommendations regarding their health or fill the prescriptions provided by their physician. The lack of established rapport of a genuine, trusting relationship between patient and provider has been shown to be detrimental in many aspects. Specifically, research indicates that a lack of rapport may compromise patient safety, health, and well-being (Hall et al., 2015). Even the study by Hall and colleagues (2015) indicated that patients' psychological health was negatively affected when their physicians showed bias.

However, patient health may not be the only thing negatively affected by bias. It should be noted that physicians can negatively affect their own practices and skills when harboring bias that remains unchecked and unresolved. Physicians can potentially lose their patients, their practice, and even their licenses if their bias has a greater impact on their ability to do their job as healthcare providers. Too often lives are put in jeopardy due to bias; and despite the role economic bias plays in medical care, racial bias is present everywhere and can be experienced by anyone.

These biases in medical care occur for African American women from all walks of life. One example of this is tennis player Serena Williams who gave an in-depth interview with *Vogue*, discussing her childbirth experiences and many of the complications she endured. Williams gave birth to her baby, Olympia, by emergency C-Section which was described as going "off without a hitch," but the aftermath is when "everything went bad" (Haskell, 2018). Only a day after her surgery, Williams began experiencing shortness of breath and assumed that she was having a pulmonary embolism due to her history of blood clots. She expressed her concerns with a nurse and stated she needed a CT. The nurse dismissed her at first, sending her to get an ultrasound. After nothing was shown on the ultrasound, Williams was then sent for a CT where blood clots were shown within her lungs. This was simply the beginning of her complications after childbirth (Haskell, 2018). Despite her fortune, fame, and healthy lifestyle, Williams was not exempt from the disregard of her vocalized concerns. Williams did not state that she felt her experience was influenced by her race; however, she, along with countless other African American mothers, was added to the ranks of those who experienced maternal morbidity in 2017.

**Financial bias in medical care**

In addition to racial bias, financial bias affects the care received by patients. Proper medical insurance is important to ensure a person is receiving necessary care while knowing the cost can be covered at least partially, if not entirely, by their insurance company. Although health insurance seems to be necessary for proper health maintenance (without the burden of expensive health care costs), many people are uninsured. In fact, according to an article published by the Kaiser Family Foundation, nearly 3.1 million low-income individuals fall into what is considered a "coverage gap" and will remain uninsured (Artiga, Damico, & Garfield, 2015). The coverage gap occurs when there are individuals with income that exceeds what is necessary for Medicaid but the individuals cannot afford the costly Marketplace subsidies. According to the Mississippi Division of Medicaid, a pregnant woman (aged 13-44) with a family size of three must make less than $3,643 a month to qualify for Medicaid ("Income Limits for Medicaid and CHIP Programs"). Also, a family of three in Mississippi can expect to pay nearly $500 premium a month for an average Marketplace plan (O'Day, 2021). The individuals who make more than $3,600 a month but are unable to afford $500 a month for insurance are finding that insurance coverage is almost completely unobtainable for them, leaving them no option but to remain uninsured. According to HealthyPeople.gov, those who are uninsured are more likely to have poor health, experience premature death, and are more likely to not receive medical care (Access to health services, 2020).

Insurance coverage is particularly important during pregnancy and delivery as the average cost of prenatal care and delivery services in the United States ranges from $30,000-$50,000 (The Cost of Having a Baby in the United States, 2013). Additionally, the requirements in terms of the total number of visits and care during prenatal care, delivery, and post-partum stages of pregnancy highlight that insurance coverage is almost a necessity for families to receive proper care. In addition, post-partum care is just as important as prenatal and delivery care, given that almost 45 percent of maternal deaths occur over a week after delivery (McMorrow, Dubay, Kenney, Johnston, & Caraveo, 2020). This means that care received post-partum should be at least adequate enough to ensure everyone is cared for properly to reduce the risk of morbidity and/or mortality for both mother and child. However, over half the women covered by Medicaid during delivery from 2005 to 2013 no longer had coverage at some point within six months post-partum (McMorrow et al., 2020).

The African American community is disproportionately impacted by this "coverage gap" issue and makes up a significant proportion of individuals who are uninsured in the United States. Non-white adults make up 56% of the uninsured population with African Americans making up 30% (Artiga et al., 2015). The long-standing systemic issues within the United States have disproportionately kept African Americans at an economic disadvantage and has impacted access to proper preventative and emergent healthcare. This lack of healthcare may increase the likelihood of more severe complications resulting in hefty healthcare bills and prescription costs, which can be nearly impossible to manage with the income of these families. The cycle continues and tends to follow generations of impoverished African Americans.

Since African Americans are more likely to fall below the poverty line than their White counterparts, the statistics regarding insurance are not shocking but troubling nonetheless and affect many different aspects of the African American health experience.

This economic disparity alone speaks to the health disparity seen amongst African Americans because insurance coverage plays such a large role in health outcomes and health overall. Therefore, the negative consequences of receiving inadequate healthcare are disproportionately impacting African American communities.

The current study focuses on examining the role of race and insurance coverage on the perceptions of prenatal care experienced by African American women as compared to the experiences of Non-African American women, specifically sampling new Mississippi mothers. The current study uses a convenience sample of new (less than 24 months after delivery) mothers both insured and uninsured African American and Non-African Americans. These participants are also Mississippi residents. The interviews broadly focus on attitudes and perceptions regarding whether the mother felt prepared for childbirth, whether the amount and types of information they received from their prenatal healthcare provider were adequate and appropriate, and whether the communication they received from and witnessed between their healthcare team was adequate. It was expected that African American mothers would report feeling as though they received inadequate prenatal care due to their race and or socioeconomic status (lack of private insurance). Findings helped highlight the differences in prenatal healthcare experiences among African American women in the state of Mississippi which provided evidence for the deep-rooted disparity of care experienced by African American women broadly in the United States.

# CHAPTER II: METHODOLOGY

## Participants

The sample was comprised of new mothers ranging from ages 25 to 36 recruited from nearby communities. Participants with different racial and socioeconomic backgrounds participated in this study, which provide a variety of experiences regarding pregnancy, childbirth, and maternity care. The women were Mississippi residents and were no later than two years post-partum. No other exclusionary criteria were utilized.

## Recruitment process and data collection

The study was submitted to the University of Southern Mississippi Institutional Review Board (IRB) and was approved on June 2, 2021. The study conducted semi-structured interviews that utilized a researcher-generated question guide (Appendix A). Participants were recruited from nearby communities via personal contact and/or social media outreach. An email including a recruitment flyer, demographic survey, and an informed consent form was distributed. Once the consent form was retrieved, the participant was contacted to schedule a telephone call or a HIPAA-compliant Zoom software videocall. Once the interview was scheduled, the participants who preferred a Zoom call were sent a Zoom videocall link to their provided email address. At their scheduled interview time, participants used the Zoom videocall link and met with the interviewer for roughly 30 minutes. The interview started with a review of the consent form and went into specific questions regarding the participant's pregnancy and childbirth experiences. Then questions were asked about how they perceived these experiences were impacted by their race and/or class. The questions asked were open-ended to allow participants to answer openly and in their own words. Prompting questions were also asked to allow participants to expound on their answers. Once the interviews were completed, their recordings were transcribed for analysis.

**Data analysis**

The data was analyzed using a 6-phase thematic analysis, and steps included: familiarizing of data, code generation, theme search, theme review, theme naming, and production of a report in that order (Braun & Clarke, 2006). Once the data was transcribed, two researchers separately familiarized themselves with each transcript. Each transcript was coded for significant concepts. The coded data was then studied to find patterns and reoccurring ideas that were collated to fit under themes. These themes were then broadened to better encompass the data for the purpose of this study. Data and notes specifically pertaining to the four themes were extracted, divided, and put into a spreadsheet to produce results. Initially, the first three steps of this analysis method were performed separately by the two researchers with two of the nine transcripts to ensure that their coding was corresponding with the other. The final steps of the analysis were performed together to best identify the themes of the data.

Four main themes emerged from the thematic analysis that pertained to women's perceptions of the prenatal and delivery care received while pregnant in Mississippi and how race and insurance coverage impacted that care. The themes, which relied heavily on the interview questions asked, were the impact of race, the impact of insurance coverage, quality of communication, and overall quality of care.

## Measures

### *Demographics*

The demographics measure distributed to participants before the interview consisted of five researcher-created questions specifically assessing age, race/ethnicity, the total number of children they have, the age of the mother at most recent childbirth, and the county where their prenatal care was primarily received (Appendix A).

### *Quality of communication*

The interview also included research-created questions assessing the quality of communication between the patient, prenatal team, and delivery team. Specifically, the questions assess what topics were discussed by the mother's prenatal care team as well as the communication between the mother and her care team (Appendix A).

### *Quality of care*

The interview additionally included research-created questions evaluating their overall quality of care. Specifically, "How would you describe the quality of care received from your prenatal team?" (Appendix A).

### *Insurance coverage and racial influence*

Lastly, the interview includes research-created questions inquiring about whether the mother was insured during her pregnancy and whether she believed that her race/ ethnic background played any role in her prenatal and delivery care experiences (Appendix A).

# CHAPTER III: PRESENTATION OF RESEARCH

## Results

The interviews conducted were meant to gain an understanding of how prepared or unprepared the mother may have felt during her time of pregnancy as well as the relationship that was cultivated during that time as well. The interviews are also meant to gauge whether the race of the mother or her insurance coverage had any perceived effects on said experience and relationships.

There was a total of nine participants who were between the ages of 25 and 36. Participants were predominately African American (67%) and under the age of 35 (89%). Over half of the women had two or more children (55%). Lastly, all participants were residents of Mississippi as required by the study; however, 33% did give birth in Tennessee.

### *Impact of race*

Of the six African American women interviewed, two believed race did at least partially influence the quality of care they received in a negative way. Three of the four who believed race did not impact their experience, did have a Black OB-GYN and/or majority Black nursing staff. Some moms even expressed that having an African American on their prenatal and or delivery team was beneficial for their experience as they believed they "listened more" and "fought harder" for them

> *"I feel like if I were another color, they would have immediately done an ultrasound."*

*"I stressed to find that [an African American OB-GYN] …because I think they fight a little harder for us when it's an African American person. They believe me a little more."*

*"The hospitals sometimes don't believe you're in pain or don't believe anything is wrong."*

Of the three white women, none expressed race having any impact on the quality of care they received.

***Impact of insurance***

Eight of the nine women had some form of insurance (private or government) during the entirety of their pregnancy and delivery. The individual who was uninsured during most of her prenatal term did express that the lack of insurance had an impact on her experience. She considered having a homebirth to reduce the cost of childbirth and even stated she did not receive the proper support and resources she felt she needed until gaining Medicaid. Though she was the only individual uninsured, she was not the only individual that discussed the obstacles provided by insurance. Of the women insured, many could not definitively say that their insurance impacted their quality of care but did express the importance of understanding insurance and the many obstacles it creates such as late payments, out-of-pocket costs, and an overall addition of stress.

*"So, that was kind of always at the forefront of my mind that we would have to pay out-of-pocket cost even being insured."*

*"Before the Medicaid…having a baby is very expensive, so there's only so much you can do. So, it was really discouraging."*

*"It is essential for expecting moms if they do have some kind of healthcare coverage to understand what is all available for them."*

*"Then you call insurance, and they tell you that it all depends on what invoice they end up getting. So, kind of a big run around. You have no idea what it's going to cost you. You're just kind of just 'fingers crossed,' hoping it doesn't bankrupt you and your new family."*

***Quality of communication and overall quality of care***

In this study, the quality of communication related to the overall quality of care received by the women. Many of the women who expressed receiving good quality care from both their prenatal and delivery teams also expressed a great level of communication with these teams. The women were not only able to receive valuable information from the medical professionals who oversaw their care, but they also expressed the ability to speak about their concerns and feel heard. The individuals who expressed their primary OB-GYN and/or nurses as not being effective communicators saw a negative impact on their prenatal and postnatal experiences. Also, the lack of discussion on topics such as insurance and postnatal care tended to make the experience more complicated than originally anticipated. The moms who felt they received the adequate amount and type of information seemed to have a smoother transition from pregnancy to delivery, and those who felt their medical team provided good communication, felt the most prepared and comfortable.

*"Having that type of open communication…really made me feel like she [OB-GYN] truly cared."*

*"She [OB-GYN] did a great job with providing me with the information that I needed to have a successful pregnancy."*

*"They were always forthcoming with information... I knew everything I needed to know."*

Also, nurse interactions proved to largely shape the quality of both prenatal and delivery care. Eight of the nine mothers mentioned nurses as being either the most supportive or least supportive in their prenatal and delivery teams. A few mothers even believed their nurses provided more support than their primary OBGYN and held many helpful, decisive conversations with them.

*"The nurse who came and took care of us after delivery, she was amazing, and she made sure we had everything we needed."*

*"I feel like there was one nurse and she was amazing like 'Okay, I'm going to show you how to breastfeed if you need help with this.' Just really communicative."*

*"I would say at the time of labor and delivery definitely the doctors on call at the hospital [were most supportive], and probably more so the nurses than the doctors."*

*"In the hospital giving birth, my delivery nurse was much more attentive and very engaged…It was a really good experience. We enjoyed the nurses we worked with. We have this really beautiful picture of right when my son was born, one of the nurses is so excited for us and you can tell she loved her job and just seeing that little life come into the world which is so exciting and never lost the magic for her. So, that was just kind of a fond memory."*

Though many mothers expressed positive interactions with their nursing team, it should also be noted that a couple of mothers expressed negative experiences with their nurses that impacted not only how they felt but also how they communicated.

*"Yes. [there was someone on the team that she felt least supported by] When I was pushing, I guess I was pushing from the bottom, and she [a nurse] was kind of getting frustrated instead of coaching."*

*"But she [a nurse] was just coming off real 'you are an unfit mama. You don't know what you are doing'…once she came in with the attitude, it made me feel uncomfortable, just coming and talking to her about stuff… not wanting to say anything because maybe she [the nurse] is going to think this is a stupid question and act like I am dumb again."*

# CHAPTER IV: SUMMARY, IMPLICATIONS, CONCLUSIONS

## Discussion

The purpose of this study was to determine if race and socioeconomic status (insurance coverage) played a part in how women perceived their prenatal care. The results of this study confirmed that many mothers of color perceive their maternal care to be impacted by not only their race but also the race of their care providers while their White counterparts did not. Women who felt as though race had an impact on their care experienced situations that threatened their life and the life of their child, and this was likely due (at least partially) to implicit bias held by their care providers that were left unchecked and or unnoticed. As evidenced during the interviews, a mother's experience of neglect nearly caused her to lose her life when proper protocol and simple listening could have likely prevented such trauma. Another's mother's experience with a rude medical professional of the opposite race caused her to halt communication and prevented her from getting what could have been valuable information on the proper care of her newborn child; however, the opposite is also true. Black women who had a majority black medical team felt the most taken care of and supported during and after their pregnancy, but this sort of experience should be ubiquitous across all medical facilities, professionals, and patients regardless of race or any other discriminatory factor. While these women all survived and had overall successful pregnancies, this is not always the case. Any one of these six African American women could have experienced the maternal mortality that they are three times more likely to experience (Collier et al., 2019) and one was very close. It is evident from these women's accounts that many of the complications or negative experiences could have been avoided or better handled if race was not a factor as all the White women who experienced any inconvenience or complication were quickly treated and expressed no negative interactions. In fact, all the White women expressed confidence that they were experiencing adequate to excellent care at all points of their pregnancy and delivery, and every expecting mother should have that same confidence. The race of the patient and/or medical staff treating them should never be the cause of mortality or morbidity, though it clearly plays some role in the quality of care which can overall affect the health and well-being of the patient and child.

This study also demonstrated that though insurance was not always perceived to directly affect the quality of care provided, it did often engender unnecessary obstacles, confusion, and stress. Though this study did have only one mother who was partially uninsured, her narrative is still valid and important to note, as 56% of the uninsured population is non-White (Artiga et al., 2015). The uninsured individual did express discouragement and a lack of resources during her uninsured period and nearly opted for an at-home birth. While home births are common, they “are associated with a higher risk of infant death and seizures than are planned hospital births.” (Mayo Foundation for Medical Education and Research, 2020). It is imperative that a woman does not have to risk or sacrifice her health or the health of her baby due to cost and or insurance barriers. A woman also cannot endure added stressors (that could potentially affect her and her child’s health) at an already high anxiety time due to insurance. A few mothers in the study both African American and Caucasian expressed added frustration and confusion when insurance policies were ambiguous. There were often back-and-forth calls between departments, which led to little understanding, missed payments that led to later stress, and unbeknownst extra cost.

Lastly, communication was proven to impact the quality of care as well. Many of the women who expressed good quality of care also expressed effective communication between their primary OBGYN and/or their nursing staff. It is when the patients felt the most heard and informed that they also felt the most prepared to have a child. Also, when the women did experience unexpected complications, they expressed still being able to have a successful birth when their doctors provided all the necessary information; and even though many of the moms conveyed that the overall communication and experience were good, they still would have preferred more communication on topics such as procedure processes, medication purposes, test results, and postnatal care for their babies. Additionally, those who described less than adequate care often expressed issues regarding communication with their care team whether that was an overall lack of communication or team members not possessing the necessary communication skills such as listening, maintaining eye contact, and amiable attitudes. It is important that communication is taken as seriously as treatment since it can affect the overall outcome of patient care and perception.

**Future research**

For research in the future, it would be beneficial to study medical professionals and their interactions with their patients. Studying professional interactions would allow for the assessment of bias and discrimination within the field and how that may present itself in care provision, creating space for awareness and discussion that would hopefully lead to change. It would also be useful to specifically study the kind of information provided to different patients. The current study does not go into depth about the content that is provided to each patient and whether it is uniform to provide uniform care. If the information were proven to differ among patients (especially between different races) then it could be evidence of implicit or even explicit bias in the field, allowing for a greater chance for improvement, intervention, and policy reform if necessary. Lastly, future research would benefit from studying insurance policies and information. As stated before, the role of insurance seemed to be to provide more confusion rather than coverage, studying not only the insurance knowledge of expectant mothers but also of professionals in medical facilities would highlight many of the inconsistencies and obstacles that insurance cultivates. Expectantly, such data would allow medical facilities to see the need for insurance education for both their staff and their patients to ensure all available resources are known and utilized by these new mothers. There is much potential for future research and reform with this study to ensure that all mothers regardless of race and/or socioeconomic class are given the highest quality of care and can comfortably and confidently bring life into the world, knowing that they and their babies are taken care of.

**Limitations and conclusions**

This study had a few limitations. First, it should be noted that state-level maternal health data is limited. Though MMR and SMM are rising issues across the country, there is little data to support the anecdotal experiences of women of color in the state of Mississippi. Another limitation of this study is possible bias in responses given the use of self-report data which could be subject to biases such as social desirability bias in answering, filtering the information provided, or an inability to accurately recall information or events. In addition, the study sample focuses on the experiences of

Mississippi women and is relatively small (it did not reach the recruitment goal of twelve individuals), so the results may not be general to the experiences of other women outside the state. Despite these limitations, the study is unique in that it helped to address the lack of research on prenatal care within the state of Mississippi and shed more light on the disparities in health care experienced by African American women. Even more so, this study aimed to cultivate discussion surrounding the health of expectant mothers and nurture an environment in which all new mothers in Mississippi are granted a greater chance of life after birth without the burden of morbidity. Every child deserves their mother, and every mother deserves her child, and that privilege should not be taken in spaces where it is meant to flourish and at the hands of those who are supposedly committed to serving all.

# APPENDIX A: INTERVIEW GUIDE

**Demographic survey**

1. What is your age?
2. What is race/ethnicity?
3. How many children do you have?
4. At what age did you have your most recent child?
5. In what county did you primarily receive your prenatal care?

**Interview questions**

6. How prepared did you feel for childbirth?
7. What topics did your prenatal care team discuss with you during your pregnancy? Was the information provided to you by your prenatal care team regarding your pregnancy adequate? Why or why not? What other information would have been helpful to receive?
8. How was the communication between you and your prenatal care team? How about with each other? Which members of your prenatal care team did you feel most supported by? Least supported by? In what ways could the communication between you and your prenatal care team be improved? In what ways could the communication between members of the prenatal care team be improved?
9. How was the communication between you and your delivery team? Which members of your delivery team did you feel most supported by? Least supported by? In what ways could the communication between you and your delivery team be improved? In what ways could the communication between members of the delivery team be improved?

10. Were you insured during your pregnancy? How about at the time of delivery? How would you describe the quality of care you received from your prenatal care team during your pregnancy? How would you describe the quality of care you received from your delivery team? Given that you [did or did not] have insurance during your pregnancy, how much do you think this impacted the quality of care you received while pregnant and after? In what ways was the quality of care impacted given that you [did or did not] have insurance?
11. Was there ever a time during your pregnancy or delivery that you felt that your racial or ethnic background impacted the quality of care you received? In what ways was your quality of care impacted by your race or ethnic background?
12. Was your primary OB-GYN Black or non-Black?
13. Did you experience any complications during or after delivery? If so, did you feel everything was communicated to you properly and timely in order to have a successful pregnancy?
14. Is there anything else related to your prenatal or delivery care that you would like to discuss that was not asked of you previously?

# APPENDIX B: IRB APPROVAL LETTER

Office *of*
Research Integrity

THE UNIVERSITY OF SOUTHERN MISSISSIPPI

118 COLLEGE DRIVE #5125 • HATTIESBURG, MS | 601.266.6576 | USM.EDU/ORI

**NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION**

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident template on Cayuse IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER: IRB-21-86
PROJECT TITLE: Perceptions of Prenatal Care from Mississippi Mothers: The role of race and insurance coverage
SCHOOL/PROGRAM: Public Health
RESEARCHER(S): Brittney Clayborn, Traci Hayes

IRB COMMITTEE ACTION: Approved
CATEGORY: Expedited

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

PERIOD OF APPROVAL: June 2, 2021

Donald Sacco Jr.

**Donald Sacco, Ph.D.**
**Institutional Review Board Chairperson**

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