Original Report:
Public Health

Traversing Traditions: Prenatal Care and Birthing Practice Preferences Among Black Women in North Florida

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Objectives: Our goal was to explore prenatal practices and birthing experiences among Black women living in an urban North Florida community.

Design: Non-random qualitative study.

Setting: Private spaces at a convenient location selected by the participant.

Participants: Eleven Black women, aged 25-36 years, who were either pregnant or had given birth at least once in the past five years in North Florida.

Methods: Semi-structured interviews were completed in July 2017, followed by thematic analysis of interview transcripts.

Results: Four main themes emerged: a) decision-making strategies for employing alternative childbirth preparation (ie, midwives, birthing centers, and doulas); b) having access to formal community resources to support their desired approaches to perinatal care; c) seeking advice from women with similar perspectives on birthing and parenting; and d) being confident in one's decisions. Despite seeking to incorporate "alternative" methods into their birthing plans, the majority of our participants ultimately delivered in-hospital.

Conclusions: Preliminary results suggest that culturally relevant and patient-centered decision-making might enhance Black women's perinatal experience although further research is needed to see if these findings are generalizable to a heterogenous US Black population. Implications for childbirth educators and health care professionals include: 1) recognizing the importance of racially and professionally diverse staffing in obstetric care practices; 2) empowering patients to communicate and achieve their childbirth desires; 3) ensuring an environment that is not only free of discrimination and disrespect, but that embodies respect (as perceived by patients of varied racial backgrounds) and cultural competence; and, 4) providing access to education and care outside of traditional work hours. *Ethn Dis*. 2021;31(2):227-234; doi:10.18865/ed.31.2.227

Keywords*:* Childbirth, Pregnancy Outcomes, Racial/Ethnic Health Disparities, Infant Mortality, Health Equity

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Introduction

While rates of preterm birth, low birthweight, and infant mortality are declining for the general US population, disparate outcomes between racial-ethnic subgroups remain stark, particularly between non-Hispanic Black women and White women.[1] Quantitative analyses demonstrate that there are positive outliers, or exemplar communities, demonstrating progress toward racial equality in perinatal outcomes.[2,3] Southern states, which are home to a high proportion of US Black persons, are continually disproportionately affected by high Black-White perinatal disparities.[4]

Despite a plethora of quantitative studies addressing racial disparities in US birth outcomes, a qualitative understanding of Black women's patient care experiences (ie, patient-provider communication, shared decision-making processes, etc.) is lacking. Patient experience, a core element of the Triple Aim's definition of quality, is of value in and of itself. Likewise, racial dimensions of patient decision-making tied to discordant communication or culturally dissonant patient care might directly affect the care received, patient adherence to obstetrical advice, and ultimately birth outcomes. Especially relevant might be the use of positive deviance strategies to identify what works for Black women who successfully avoid adverse birth outcomes.[5]

A positive deviance lens can be

applied to perinatal health disparities by qualitatively examining women's prenatal and birthing care experiences. These experiences are important components of understanding disparate perinatal health outcomes, as care during pregnancy is largely considered an indispensable component of perinatal health promotion.[6] For some women, contemporary medical-model prenatal care can appropriately address physical and mental health needs.[7] For many others, this strategy is insufficient in addressing their needs and preferences.[6]

The purpose of this study was to explore prenatal practices and subjective birthing experiences among Black women living in urban North Florida.

For Black women, a difficult history and general mistrust of the medical system has created a paradox between new institutional childbirth norms and women's individual decisions about prenatal care and birthing methods.[8] Therefore, the purpose of this study was to explore prenatal practices and subjective birthing experiences among Black women living in urban North Florida. Given that Black women in North Florida are at an increased risk of experiencing adverse perinatal outcomes,[9] as well as their history of racial mistreatment in the US medical care system,[8] we undertook this study to explore ways in which Black women leverage personal strengths, community resources, and decision-making strategies during pregnancy and birth.

Methods

Study Design

This was a non-random, cross-sectional, qualitative pilot study.

Study Sample/Recruitment

Participants were recruited using convenience and snowball sampling. A flyer was disseminated via social media, text message, and e-mail to potential participants known to the research team. Inclusion criteria included: a) self-identifying as African American or Black; b) gave birth in the counties of interest within the last 5 years or were currently pregnant; and c) at least 18 years of age. Participants self-selected into the study; dates, times, and locations for the interviews were agreed upon during an initial eligibility discussion. This study was approved by the Florida State University Institutional Review Board.

Data Collection

Interviews were conducted in July 2017 at a convenient time and in a place that offered privacy for the participants, often in their homes or work office, and some with the participants' children present. Women were given $20 cash for their participation.

Measures

We employed a qualitative approach through semi-structured, individual interviews lasting 15-70 minutes. Times varied due to differences in participants' descriptions about their pregnancies and birthing experiences. Interviews were conducted by a member of the research team – a Black woman – to maintain racial and gender concordance. A 3-minute questionnaire assessed participant demographics and pregnancy outcomes for each of their births (ie, birthweight, complications during birth). Upon obtaining written consent, participants discussed their prenatal decisions and experiences, describing the strategies they employed to ensure a healthy birth and infancy for their child. The interview guide had eight open-ended questions and pre-defined probes related to the study's objectives (Table 1).

Data Analysis

All interviews were audio-recorded and transcribed verbatim. Data were analyzed and coded using a thematic analysis approach between two trained coders. Parent codes were developed using the interview guide and transcripts for direction. Afterwards, coders reviewed the transcripts a second time for an in-depth application of codes to each interview transcript. Since each participant's experiences were variably unique and complex, attention to positive events and cases was emphasized.

Results

This study group consisted of 11 women aged 25-36 years (M=30.77, *SD*=3.95; Table 2). Most women (n=8; 72.7%) had at least a bachelor's degree, followed by some college (n=2; 18.2%), and high school diploma/GED (n=1; 9.1%). Almost half of the participants (n=5; 45.4%) were married, followed by single/never married (n=3; 27.3%), living with a partner (n=2; 18.2%), and divorced/separated (n=1; 9.1%). Three participants reported ever having a miscarriage, two reported having gestational diabetes or (mild) preeclampsia, and one reported a premature birth.

Four main themes emerged from this study: a) decision-making strategies for employing alternative childbirth preparation and practice; b) having access to formal community resources to support participants' desired approaches to pregnancy and birth; c) seeking advice from other Black women with similar perspectives on birthing and parenting; and, d) being confident in one's decisions.

Table 1. Interview guide

1. I see that you have been pregnant ___ times in the last 5 years. Tell me a little bit about your pregnancy experience, from receiving prenatal care to giving birth.
    a. What health or medical concerns, if any, did you or your medical provider have about your pregnancy, such as high blood pressure, anemia, or gestational diabetes? (If any) Tell me more.
2. Did you see a medical provider for your pregnancy?
    a. (If yes) When did you first see your medical provider?
    b. (If no) What prevented you from going to the doctor before, during and after your pregnancy?
3. Tell me about negative and positive health care experiences before, during or after your pregnancy.
4. If you could change something about your health care experiences before, during and after your pregnancy, what would you change?
5. What things in your community helped you have a healthy, or are barriers to having a healthy, pregnancy?
6. What does the term "healthy pregnancy" mean to you?
7. What kinds of things were stressful during your pregnancy? What things did you do to deal with your stress? What other things could have helped you with your stress?
8. What advice did your mother, grandmother, other family, or friends give you about staying healthy before, during and after your pregnancy?
9. Is there anything else you would like to tell me related to what we've been discussing?

Decision-Making Strategies for Employing Alternative Prenatal Care and Birthing Practices

Seven women spoke specifically about how they arrived at their decisions to employ alternative prenatal care and birthing practices. Broadly defined by the group, alternative practices typically de-emphasized some of the more common contemporary obstetric care trends and required less-invasive medical procedures or interventions. Women reported: the use of midwives and/or doulas for prenatal care and

Table 2. Participant demographics and pregnancy characteristics

Participant number	Age	Marital status	Education level	Currently pregnant	# of miscarriages	# of live births	# of births <37 weeks	GD or preeclampsia
1	25	living with partner	some college	yes	1	1	0	no
2	27	married	college or beyond	no	0	2	0	no
3	28	single/nm	college or beyond	no	0	1	0	no
4	32	married	college or beyond	no	1	1	0	yes
5	35	married	college or beyond	yes	0	4	0	no
6	N/A	living with partner	high school/ged	no	0	2	0	no
7	29	divorced/ separated	some college	no	1	1	1	no
8	28	married	college or beyond	no	0	1	0	no
9	36	single/nm	college or beyond	yes	0	0	0	mild preeclampsia
10	31	single/nm	college or beyond	no	0	2	0	no
11	36	married	college or beyond	yes	0	2	0	no

delivery; non-medicated births; herbal practices during pregnancy; out-of-hospital (OOH) births; and delayed cord-clamping and bathing for their newborns. Specifically, five women reported use of midwifery at some point in their pregnancies, four indicated preference for an OOH midwife or doula-supported births, and two had OOH births.

Women indicated several underlying factors during pregnancy that drove their desires for non-traditional practices, including wanting a more intimate connection with their health care professionals. While OBGYNs were sources of support for about half of the women, many indicated that the hospital and doctor's office settings imposed time constraints that were significant barriers to their desired patient-provider rapport styles. For example, one woman stated:

> "The doctors did try when I told them like, you know 'I'm not getting what I need from you.' They did try to change it up. But they were always so busy…"

Conversely, midwives and doulas were cited as a resource for women who were looking to engage in more in-depth discussions with their providers. Here, the same woman shared:

> "I started off with an OB-GYN with my first baby, and then when I entered my second trimester I switched to a midwife outside of the hospital environment…I was looking for something more personal; somebody who would talk to me about, like, my day-to-day activities…"

In agreement, another woman indicated:

> "I could see why women would stress out when they were in those four white walls. And I just...didn't want to have any part of it. Just because it's not a natural environment, period… the white building, the four walls, you know people in white coats…they don't know you."

Women also reported that midwives and doulas helped educate them on methods available for a safe delivery without invasive medical procedures. Here, women described working with their midwives or doulas to treat their health concerns in ways that they felt were more "natural and holistic," (ie, probiotics to address yeast infections vs a medicinal regimen).

Lastly, women expressed an interest in non-medicated births. Many addressed concerns regarding epidurals, long hospital-based labors, and fear of having their birth preferences disregarded within a medical setting, specifically, pressure to undergo unnecessary cesarean deliveries. One woman shared her rationale for selecting a midwife-supported home birth, saying:

> "I've always been in the mindset of women are able to give birth without any assistance naturally and so I knew I didn't want an epidural [and that] I didn't want to go to the hospital and then have, you know, the whole slew of things happen [that can] cause you to have a C-section or an epidural and all that. So, it was something I just knew that I wanted to do was to at least try to have a home birth and try to have a non-medicated birth."

Similarly, other mothers also endorsed OOH births that allowed them to have a greater sense of control during their labor, indicating preferences for being able to move around freely during labor and to use natural pain management techniques (ie, bathing/showering, massaging).

Accessing Formal Resources for Pregnancy and Childbirth

To support their pregnancy and delivery desires, all the women sought resources within their local communities. Although women acknowledged the availability of resources that could enable their desired pregnancy and childbirth experiences, they also indicated that these resources were not easily accessible or inclusive. Specifically, women expressed a desire for resources and educational opportunities that were available during non-traditional business hours and that were inclusive of Black women and mothers. For working mothers in the sample, it was important to be able to obtain information that would support their needs (ie, birthing and breastfeeding classes), but many struggled to find classes that they could take outside of regular business hours, including evenings and weekends.

The limited options that working women were left to choose from

often left them feeling a sense of cultural disconnect. Participants expressed discomfort in participating in classes that were run primarily by White women, perceiving that they were not able to truly connect with the instructors and program staff. One mother shared the following:

> "Their resources were really good you know. We did one class every Monday. They had a little video and worksheets and a lot of information… But the people who ran it… it was like Christian based. They had volunteers from [a local university and] all the women who worked there were White so there was just a disconnect there you know?"

If the community had a greater degree of client-provider racial/ethnic concordance, in which providers and clients shared a common racial and cultural bond, women felt there would have been a greater degree of comfort and knowledge transfer – something that they felt is currently lacking within their local community.

Seeking Advice from Other Black Women with Similar Perspectives on Birthing and Parenting

Where community resources were insufficient in supporting expectant mothers, women reported that getting advice from other Black women who shared similar perspectives on birthing and parenting was a critical factor in their decisions to engage in alternative pregnancy and birthing options. For example, five women often spoke about familial supports as a component of their decision-making strategy. Several women from the sample indicated that their birthing desires were influenced by their mothers, grandmothers, and influential women in their partners' families. Other trusted Black women in their communities were also used for information and support. It was evident that trust within the community had been built with other Black women over time through "sister circles" (units of Black women with similar thoughts and ideas), having a long-standing community presence advocating for and educating others on topics related to birthing and parenting (ie, breastfeeding, managing postpartum depression, and early child education). For women with a desire to follow an alternative path for pregnancy and delivery, it was particularly important to seek advice from other women, which gave them access to new learning opportunities.

Support from familiar and trusted Black women may be particularly salient for expectant Black women. One woman shared:

> "You know, I'm not used to [being well represented within perinatal education groups]...I'm used to, you know, if you go to a birthing class [or] breastfeeding class, you don't see a lot of us [Black women] there. You see more White women. The [name stricken] group just gives me, it makes me feel comfortable, like I'm able to even talk about different things."

By accessing the informal networks of Black women within their own communities, women in our study were able to find supports that were not formally available to them. This allowed women to seek out answers to questions they felt may be culture-specific, or to address concerns that they were uncomfortable sharing in majority-White groups of women.

Along with informal networks within their communities, women often used social media to seek advice during their pregnancies. One woman indicated that after becoming pregnant, she felt she received advice about more contemporary parenting practices from other women on social media platforms, saying:

> "a lot has changed [since I last gave birth]. There's a lot of information out there… but it's just so much [that] I didn't even know until joining these groups now, so I'm learning a lot."

Through social media, mothers were able to learn about and explore alternative care options that they felt were in the best interest of their infants.

Being Confident in One's Decisions

Networks of Black women with shared perspectives and experiences also helped to empower expectant mothers to feel confident in their decision-making processes, as did having supportive partners. One woman offered her perspective, which reflects the consensus among nine of the women in our sample. She shared:

> "No amount of research or educating somebody is gonna make them change [their opinion if] they think that it's right. So, instead of that, you need to have at least one person who understands and supports your decision and who's rooting for you."

Women also shared that they felt more confident to make their pregnancy decisions when they sought out educational supports. Women reported relying on a variety of educational resources, ranging from formal supports to more informal materials. Among women who relied on formal supports, they reported accessing scientific literature, educational pamphlets, and books. Regarding more informal educational materials, women reported accessing new information via apps and Internet searches. Regardless of the formality of the educational materials, when women felt they had enough knowledge about their pregnancy and birth options, they indicated feeling more empowered overall in their decisions.

Discussion

This small pilot study of mostly college-educated Black women provides qualitative evidence of ways that expectant mothers seek to optimize their prenatal and birthing care experiences. These participants represent a subset of Black women who felt empowered to explore a diverse array of maternity care and birthing practices. These particular Black women valued working together to ensure that they were able to have the birth of their choice. They also expressed concern over the lack of culturally relevant and available resources to support their birthing preferences. While half of participants sought out care from midwives or doulas, nine of the eleven women gave birth in hospital, and the remaining two women gave birth OOH by a midwife or doula. For context, less than 8% of Florida births in 2018 were attended by midwives[10] and 1.8% of Florida births occurred OOH.[11] Across racial-ethnic lines, non-Hispanic White women used OOH births at a rate two to four times higher than that of any other racial-ethnic group and showed a significantly greater rise in OOH utilization trends from 1990-2012 than did Black women.[12] Regionally, OOH births are substantially lower in the South.

These particular Black women valued working together to ensure that they were able to have the birth of their choice.

Our study participants emphasized their own preferences for natural birthing methods. These women reported finding information and educating themselves on diverse maternity care and birthing options using online resources, including apps, and Internet searches. Participants also utilized online and in-person support groups for Black women, as well as trusted members of their family and community. For many, the personal relationships developed from these supports became predominant sources for information sharing and empowerment, especially regarding alternative birthing practices. From a positive deviance standpoint, women's willingness to engage in alternative strategies for perinatal care and to form strong community-based supports is representative of a strategic approach to health promotion in a region of the state that is characterized by disparate birth outcomes.

Our participants did not consistently raise issues of cost or insurance coverage, although this could be a barrier to patients' ability to obtain alternative birthing care. Doulas and OOH births may generate higher out-of-pocket costs to the patient, although total cost of care might be lower than those for an in-hospital birth. Further research is needed to elucidate these cost/value issues.

Implications for Practice

Implications for childbirth educators and health care professionals include: 1) recognizing the importance of racially and professionally diverse staffing, including having more Black providers as well as midwives and doulas in obstetric care practices; 2) empowering Black patients to communicate and achieve their childbirth

desires; 3) ensuring an environment that is not only free of discrimination and disrespect, but that embodies respect (as perceived by patients of varied racial backgrounds) and cultural competence; and 4) providing access to education and care outside of traditional work hours.

Currently, there are a number of promising programs that have implemented components of these recommendations, including the Every Child Succeeds (ECS) home-visiting program, which provides women with connections to community resources to help promote healthy family development.[13] Likewise, the Healthy Babies are Worth the Wait (HBWW) Community Program offers resources to support expectant and new mothers and promote community engagement.[14] Although ECS and HBWW are examples of programs that help to promote community engagement among mothers, additional programmatic efforts are needed to help ensure that women have access to culturally relevant perinatal care services for diverse birthing desires.

In 2017, the state of Minnesota launched the Integrated Care for High Risk Pregnancies (ICHRP) initiative, which helps to meet some of these goals. The ICHRP initiative collaborates with Minnesota community health leaders to link women to resources that provide doula care, social workers, parenting classes, educational resources, and community clinics that address perinatal health needs via culturally specific practices.[15] The ICHRP initiative may serve as an exemplar model for other states looking to introduce additional measures for closing the Black-White gap in adverse perinatal outcomes. Importantly, ICHRP emphasizes the need for culturally specific care during the perinatal window, though the programmatic details regarding what is considered culturally specific are unclear.[15] Results from this study may help clarify some of the desired mechanisms through which Black women would like to receive care, including midwife or doula support, community-based care, strong patient-provider rapport, and greater degrees of provider-client racial concordance.

Implications for Future Research

Several studies have identified the importance of employing an intersectional framework when investigating birthing outcomes, especially among Black women.[16-18] However, these studies highlight intersecting variables such as race, age, and socioeconomic status among young mothers with low education levels. In some ways, our study reflects a segment of the Black population which is understudied, since most participants in the current sample had at least a college degree, were married, and had a mean age >30 years. Broad sampling using intersectional frameworks will be necessary to represent the diverse heterogeneity within the Black population, in order to understand the spectrum of perspectives and values and preferences to address when educating and counseling Black women.

Further, studies examining disparate perinatal health outcomes increasingly suggest needing to measure how social and interpersonal experiences collectively shape women's health experiences. This study suggests that the most important factors in prenatal and birthing decision-making are: 1) cultural support and empowerment from other mothers who have experienced both the highs and lows of birthing; and 2) support from their partners. These findings illustrate the critical role of community engagement and support in achieving optimal pregnancy and birthing experiences. Future research should explore the ways that interpersonal factors (ie, provider engagement styles and racial concordance with their patients) may affect perinatal health outcomes. Additionally, consideration for practice location, hours, and the types of payment accepted can address traditional definitions of accessibility. Further qualitative research is needed to better define cultural acceptability and relevance for perinatal support and health promotion.

Study Limitations

This study provides a broad-brush picture of themes to explore in further research. It was limited by small group size and a non-randomly selected study population. To further explore the effects of positive deviance, future research should aim to differentiate the experiences and perspectives of Black women who had positive birthing experiences and outcomes, relative to those with negative experiences or adverse perinatal outcomes.

Conclusions

Results suggest that culturally relevant and patient-centered deci-

sion-making might enhance Black women's perinatal experience, although further research is needed to see if these findings are generalizable to a heterogenous US Black population. In our study, women were proactive about using community and online resources to locate information related to their birthing desires. Much of their decision-making strategies highlight the need for more culturally relevant and patient-centered approaches to prenatal health for Black women. Additional studies are needed to learn about experiences and preferences of a larger group of women, who more broadly represent the heterogenous US Black population. Further research is also needed to understand specific behaviors, communication styles, and practice patterns that Black women perceive as respectful and culturally relevant, as well as those that are problematic, culturally dissonant, biased, or disrespectful. Finally, further research is needed to tie together all three aspects of the Triple Aim, to understand the inter-relatedness of the patient experience, clinical outcomes, and cost/value of services.

Acknowledgements

The authors would like to acknowledge the team of public health and medical professionals who aided in the conceptualization of this research study: Drs. Les Beitsch, Samantha Golfarb, and Jessica De Leon. Additionally, Kierra Goosby is appreciated for her assistance transcribing the interview data. All are affiliated with the Florida State University College of Medicine. We would also like to thank the study participants and community members who endorsed and shared in the recruitment efforts for this study.

Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: Deichen Hansen, James, Sakinah, Speights, Rust; Acquisition of data: Deichen Hansen, James; Data analysis and interpretation: Deichen Hansen, James, Sakinah; Manuscript draft: Deichen Hansen, James, Sakinah, Speights, Rust; Statistical expertise: Deichen Hansen, James; Acquisition of funding: Rust; Administrative: Deichen Hansen, James, Sakinah, Speights, Rust; Supervision: Speights, Rust

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