“It was a pregnancy full of ‘I don’t knows,’ like how to deliver and who can be in the room”: How COVID Affected African American Women’s Experiences with Pregnancy

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ABSTRACT

The COVID-19 pandemic of 2020 exacerbated the US maternal health crisis and reduced access to quality healthcare (Destine, Brooks, and Rogers 2020). Racial minorities, especially members of the Black community, felt these impacts disproportionately. This narrative research study explores African American women's reported experiences with pregnancy and delivery during the COVID-19 pandemic. Semi-structured interviews were conducted via Zoom video conferencing with eight African American women from the Southern region of the US. Two major themes emerged from analyzing the interview transcripts; these themes included: 1) the importance of social support for African American women while pregnant amidst heightened fear and isolation, and 2) reproductive health choices and reasons for getting or declining the COVID vaccine. The research underscores the importance of community support among Black women, family members, and health care providers. Strengthening different forms of support in the Black community is particularly important for recognizing and preserving Black women's agency in their reproductive choices. This is true in the COVID and maternal health crisis, as well as in routine healthcare, including pregnancy and delivery care.

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INTRODUCTION

Beginning in 2020, a health pandemic shaped the United States (US) and the world. The World Health Organization (WHO) refers to this as Coronavirus disease or COVID-19. "People who are infected with this disease experience mild to moderate respiratory illness" and risk a fatal disease outcome (WHO 2020). The coronavirus spread rapidly throughout the world in the early 2020s, disproportionately impacting Black and Brown communities, the elderly, and pregnant women (Kira et al. 2021). Because of this, many safety protocols were put into place to reduce transmission of the virus. For example, initial US policies included social distancing and mask wearing. Medical facilities, such as hospitals, and nursing homes, typically limited visitors or prohibited them altogether.

In this research, I aim to understand the experiences of African American women who were pregnant and gave birth during the COVID-19 pandemic. My interest stems from the historical barriers African American women have faced receiving quality health care, particularly due to institutional racism surrounding Black women's reproductive health (Roberts 2017). I explore Black women's narrative stories of their pregnancies and birthing experiences during COVID-19. For example, the ways they describe the impact of relatives and spouses being present during labor. It took years for spouses/partners and doulas to be allowed in the labor and delivery room, and yet many hospitals' first impulse to battle the virus was to prohibit labor companions from the delivery ward (Davis-Floyd, Gutschow, and Schwartz 2020). Given the higher prevalence of COVID-19 among African

Americans, the pandemic raises important questions regarding African American women's experiences with healthcare during pregnancy (Hill and Artiga 2022). Early in the pandemic, women who tested positive for the virus during labor were not allowed skin-to-skin contact or to breastfeed their newborns (WHO 2020). Such practices may impact women's experiences in childbirth and may contribute to other maternal health outcomes.

The aim of this thesis is to explore how the COVID-19 pandemic affected Black women's reported pregnancy and delivery experiences in one region in the southern US. The narrative analysis is contextualized within the long history of medical neglect, abuse, and mistrust encountered by African American women, especially in seeking reproductive health services (Roberts 2017).

LITERATURE REVIEW

Black Women, Reproductive Health, and Mental Health

Limited access to resources such as adequate health care widens racial disparities in pregnancy outcomes for Black women. In "Reproducing Race," Bridges writes that hospitals are sites where "pregnant women's bodies are excessively problematized and racial inequalities are reiterated" (2011:4). She discusses the inferior and racist treatment minority women receive versus white women. In many hospital settings across the US, pregnant minority women are subjected to more tests such as STD and/or drug tests and are shamed if they lack knowledge concerning prenatal care. And Black women are over three times more likely than white women to die from pregnancy complications (Dyer et al. 2019).

Historically and in contemporary times, fear and distrust of the health care system is not uncommon among Black women for this and other reasons, including the mistreatment and use of African Americans for nonconsensual medical experiments (Washington 2008). A more recent example of this is the Tuskegee experiments in 1932, where hundreds of Black men with syphilis were unethically denied treatment with antibiotics when they became available. These historical examples shape black patients desire to seek medical care and the perceived trustworthiness of providers, even today.

The current COVID pandemic has further accentuated social inequalities in healthcare and in the workforce. Those who could not file for unemployment, for example, were called upon as essential workers. These essential workers were predominantly composed of immigrants and/or Black people who already make less than the average white American (Destine et al. 2020). Destine et al. (2020) noted that essential workers were frequently exposed to COVID in their jobs due to constant contact with persons lacking proper personal protective equipment such as N-95 masks. Pregnant women during this time often feared for their health, and the health of their unborn babies. Similarly, communities that many pregnant Black women live in are low-income neighborhoods with high rates of exposure to illnesses, due to lack of access to quality care and medicine (Washington 2008). Contributing to and compounding the problem of health disparities, African Americans have higher rates of heart disease, cancer, and strokes (Destine et al. 2020). Black women during this pandemic often do not have access to good healthcare and many lack health insurance all together. The type of healthcare

received, often depends on the type of job held. Part-time and service sector jobs are less likely to provide health insurance or access to healthcare.

Even before the COVID pandemic, there was an ongoing maternal health crisis within the Black community (Taylor 2020). COVID has intensified a variety of health disparities given the overcrowding and lack of care available (Altman et al. 2021). Altman et al. (2021) discussed the impact COVID had on pregnancy and birth care. Through interviews with patients and nurses, the authors noticed differences in care related to race and discrimination. They stated how being Black amid a pandemic adds to the levels of racism from providers in the healthcare community. The patients reported a lack of additional support during the pandemic for people of color. Some noticed more hospitality shown towards white patients versus Black women.

Hartnett and Brantley (2020) report that Black women are more likely to be unhappy about pregnancy than white women, whether planned or unplanned. Low economic status and a lack of spousal support are key factors that have led to this reported unhappiness. The term for this is “pregnancy desirability” and this is one of the main factors that shapes maternal and fetal outcomes. Similarly, they found that Black women experience higher levels of stress and have less access to adequate health insurance in comparison to white women, which is one of the factors that contributes to poor treatment from medical providers. Black women experience various types of racism such as structural and gendered. Stereotypes about pregnant Black women from being young mothers (e.g., children having children) to having babies without an active father further heighten stress levels during

pregnancy (Hartnett and Brantley 2020). And it is important to note that poor mental health during pregnancy increases the risk for prematurity and infant mortality (Hartnett and Brantley 2020). Regarding the harsh life-lessons Black women often face, they are also given the role to teach their children about racialization at a young age. It is usually the mother's responsibility to teach their children that they were born into the system that was not created to protect Black women or Black people. Being Black in America and living in this reality also adds to Black women's unhappiness during pregnancy (Wilson 2001).

There is reluctance from Black people to seek treatment for their mental health due to a health care system that overlooks their needs and even actively discriminates against Black people (Wilson 2001). Adkins, Turner-Musa, and Chester (2019) note that depression rates for Black women are positively related to experiences with discrimination.

Taylor (2020) mentions the "demonization of Black mothers" being perceived and characterized as 'unfit' for years. Taylor (2020) shows how the government used various tactics to sterilize Black women preventing them from reproducing. This institutionalization of eugenics was framed as an effort to promote social wellness by reducing the number of low-income Black mothers. We see how this framing lead to legislation tactics being used against Black women.

Legislation during this time was focused on limiting the access Black women had to public assistance. Instead, politicians wanted financial assistance to be funneled to white women. When abortion became legal in 1973, Black women worked hard to make sure their voices were heard in a system that silenced them. A

dominant phrase used within this legislation was “if she chooses.” Black women narrowed in on the importance of this language due to a history of sterilization, including being forced to accept sterilization to receive government benefits or even sterilization without consent (Taylor 2020). Taylor (2020:511) states, “multiple factors impact a woman’s ability to have healthy pregnancies and positive birth outcomes.” These involve aspects such as health status, socioeconomic education, income, and exposure to toxins.

In “Killing the Black Body,” Roberts (2017) writes about the history of Black women giving birth. She examines how race and racism dominate our world. In fact, racism, particularly anti-Blackness, affects the length and quality of one’s life. She observed that controlling Black women’s reproduction is linked to social disadvantage for African Americans (Roberts 2017). Her writing addresses the stigma of poverty often associated with the reproduction of Black children by Black women. She examines the history of insufficient care received by Black women and children in hospitals and how health providers offer less empathy for health issues when treating members of the Black community.

This history of insufficient treatment raises questions about how Black women experience pregnancy and birth during the pandemic, and whether they perceive their voices are heard during childbirth. Roberts (2017) wrote about how during the crack epidemic Black women were subject to numerous drug tests during their pregnancy, and this added to the perception that Black women were unfit parents. When women tested positive, children were taken away at birth, without mothers getting to hold their newborns. This history may affect a Black woman’s mental

health and trust in the health care system even today. Particularly, in an era of COVID, fears and distrust may loom large when mothers are tested, or other restrictions are imposed on social support. This unknown and restrictive environment may catalyze fears that perhaps mothers have done something wrong and endangered their babies during pregnancy. This action could make Black women, especially first-time parents, feel inadequate or lack confidence in pregnancy, birth, and infant parenting.

Background on Coronavirus

Coronaviruses are a large family of viruses that are commonly found in people and different species of animals (American Academy 2020). SARS-CoV2 is the medical term for the virus that is affecting people across the globe, including the US. The disease origin is believed to be from bats at an animal reservoir (American Academy 2020). This virus is widely known as COVID-19 because it appeared in the year 2019. It is believed that the pandemic first emerged in China, Western Europe, and then the US. On January 31, 2020, the US Department of Health and Human Services declared the spread of COVID-19 a public health emergency, and during this time, many countries responded with a nationwide lockdown. In response to this policy, many people were left unemployed, while others worked remotely from their homes and/or continued with their education. Many struggled with completing work and school responsibilities at home, in part due to lack of access to the internet and home computers. Big and small businesses closed, unemployment rates spiked, and many workers left their jobs due to unsafe working conditions. There was a period of

nationwide panic when stores sold out of toilet paper, cleaning supplies, and meat. Hospital ICU admissions increased as well as the need for more medical equipment and masks within hospitals (Lagesse 2020). During the pandemic, health professionals from the Food and Drug Health Administration (FDA) advised that the best way to prevent the spread of the virus was to avoid exposure (FDA 2021). They recommended frequent handwashing, mask wearing, and social distancing. The Centers for Disease Control and Prevention (CDC) monitored the total and daily numbers of cases, hospitalizations, and deaths by state and city (CDC 2020). In 2020 there were 46 vaccines being tested in clinical trials on humans and nearly 100 preclinical trials with animals (Corum, Wee, and Zimmer 2020). Vaccines typically take around three years to produce, but through an accelerated plan, effective vaccines were developed less than a year after the virus appeared (CDC 2020).

COVID caused many businesses to go remote or to shut down all together. Some of these businesses were essential to the Black community such as community centers. In fact, COVID caused many health centers to close and the ones that remained open saw a lack of in-patient visits, decreased staff, and increases in virtual consultations (Corallo and Tolbert 2020). Community health centers are vital to the Black community because they provide not only care, but actual knowledge of the health disparities the Black community faces. COVID testing centers were less accessible to the Black community, with rapid tests to return to work costing over $100 without insurance coverage during the early pandemic (Destine et al. 2020). Many people were unable to afford such an expense, but also could not afford to miss work. This heightened the risk of infection spreading within

the community and created a higher risk of death. In places such as Philadelphia, there was an increase in women choosing to be induced to control the amount of time spent within the hospital (Gantz 2020). Induced labor increases the risk of pregnancy complications not only for the baby, but also the mother.

We are still increasingly learning more about the virus and who is being given adequate help to prevent and treat it. Three COVID vaccines known as Pfizer, Moderna, and Johnson & Johnson were released with vaccination priority given to essential healthcare workers. However, many racial and ethnic minority laborers considered "essential" to the economy, such as food service workers, did not have priority access to the vaccine (CDC 2020).

In this convergence of current COVID issues and issues that have long affected the health of African American women, the primary research question guiding this research is how has the Coronavirus environment impacted African American women's experiences with pregnancy and hospital delivery?

METHODOLOGY

Narrative Analysis and Recruitment

The best method for understanding Black women's experiences with childbirth during the Coronavirus pandemic was through qualitative research. I gained IRB approval at Middle Tennessee State University, details of which can be found in Appendix A. I chose to conduct a narrative analysis (Creswell and Creswell 2016) in order to give voice to Black women through open-ended interviews. A narrative approach is defined as a study of experiences "as expressed in lived and told stories by individuals" (Creswell and Creswell 2016:70). Women were

encouraged to reflect upon and to tell their stories, sharing their experiences with the health care system and their concerns throughout pregnancy and delivery. It is from their stories I was able to identify themes and the common meanings behind each of their experiences in relation to my study.

I used two techniques, convenience and snowball sampling, to recruit eight participants from Murfreesboro, Nashville, and Memphis, Tennessee. One participant, from Memphis, now resides in and gave birth in Atlanta, Georgia. I combined convenience and snowball sampling strategies to recruit African American mothers who had given birth after the March 2019 COVID restrictions. Convenience sampling is choosing participants who are close at hand, because they are a convenient source of data (Lavrakas 2008). Relying on this technique, I initially found my participants by starting with a select group of women in my close network who had recently given birth. Snowball sampling is a research method used to recruit participants in a research study with the help of those already participating in the study (Allen 2017); this proved effective relying on my initial sample of participants. The project's participants were African American women who had recently given birth during the COVID-19 pandemic. Each of the participants had a newborn under the age of one year. There was no monetary compensation offered to participants.

Prior to all interviews, participants verbally communicated consent and gave permission for audio recording. I used a semi-structured interview guide, available in Appendix B, to shape the conversation. Some of the questions in the survey were inspired by a report posted on the Maryland Health Department's web page, which

reviewed the hospital experiences of African American women. A total of eight one-on-one Zoom interviews were conducted between July 2021 and September 2021. The first two interviews were conducted with the camera on, but in order to offer participants more privacy, the remaining six were conducted with the camera off. There were various benefits to doing a Zoom interview such as scheduling, reduced cost, and increased safety from COVID (Oliffe, Kelly, Montaner, and Yu Ko 2021). There was also more privacy for the new mothers when interviewing by video from their homes. Interviews ranged in length from 30 to 45 minutes. I found that the participants were initially nervous to participate, but were also very excited to share their stories.

Data Analysis

Audio recordings and transcriptions are helpful features of the Zoom software. Upon completion of an interview, audio and word files were downloaded onto a password-protected computer. Transcriptions were cleaned, corrected, and refined for clarity and then re-organized into specific codes/patterns. I used coding to organize the data and to summarize and compare each participant's experience, searching for major themes. The primary themes that emerged included: 1) the importance of social support for African American women while pregnant amidst heightened fear and isolation, and 2) reproductive health choices and reasons for getting or declining the COVID vaccine.

I analyzed the data by reading the interview transcripts several times to identify themes and code the transcripts for patterns. This type of analysis is a technique used to simplify significant statements, phrases, or words into categories

(Stemler 2000). Coding is a way to identify different forms of meaning in the data by labeling them with a descriptor (Linneberg and Korsgaard 2019). Coding allows the researcher to look at the data more analytically and find patterns easily overlooked. I used deductive coding, which is using existing literature to guide the researcher to the issues most important to code (Linneberg and Korsgaard 2019). I also used inductive coding by using significant phrases by participants that stood out in the research (Linneberg and Korsgaard 2019). I then selected the two major themes and selected representative quotes. While minor edits were made to the quotes to offer clarity, these changes did not alter the meaning of the statements.

Table 1

Participant Demographics

PARTICIPANT	AGE	MARITAL STATUS	EDUCATION	RELIGION	REGION	RACE
CORA	26	Married	Bachelors	Christian	East, TN	Black
TAMMY	26	Married	Bachelors	Christian	Middle, TN	Black
PATTY	27	Married	Bachelors	Baptist	East, TN	Black
JANA	21	Single	Associate	Christian	East, TN	Mixed
SHONDA	31	Single	Bachelors	Church of God and Christ	East, TN	Black
ANNA	28	Single	J.D	N/A	Northwest, GA	Black
TINA	26	Married	Bachelors	N/A	East, TN	Black
LESLIE	25	Engaged	Bachelors	Christian	East, TN	Black

All the participants gave birth during the pandemic and their ages ranged from early twenties to early thirties. Four of the eight participants were married, three were single, and one was engaged. Educational attainment included one participant holding an associate's degree, one a Juris Doctorate (J.D.), and the remaining six, a bachelor's degree. Six participants identified their political party affiliation as democratic, and two did not identify a party affiliation. Six participants self-identified as Christian, while two did not identify a religious preference. This information can be found in Table 1: Participants Demographics. I use pseudonyms for the participants throughout this document.

FINDINGS AND DISCUSSION

Social Support, Heightened Fears, and Isolation

It is important to understand the affects the pandemic has had on African American mothers, specifically their pregnancies and delivery experiences. While some women reported uncomplicated experiences, others did not. When I listened to the interviews and read through the transcriptions, the primary and most significant theme was the importance of social support the women needed during a time when social distancing was required, and hospitals were only allowing one birth support person.

Prior studies have concluded that Black women experienced high levels of loneliness during COVID and high levels of stress and depressive symptoms (Giurgescu et al. 2021). These symptoms were also found with connection to

social support during pregnancy (Giurgescu et al. 2021). A study by Terhune (2008) shows how confined many Black women feel when living in white communities. In predominantly white communities and even predominantly Black communities, Black women in this study expressed the need for more support networks during an important phase of their life, especially in the context of a global pandemic.

Tammy, who lives in the middle Tennessee region of Murfreesboro, a majority white community, highlights this. She spoke of the importance of support from her family and husband, and the only source of support from a Black woman outside of her family she could rely on was a Black doula from church. Tammy explained,

> All my friends and family were super supportive, and I would say their support was unmatched. Outside of them, my doctor was amazing and my church member who was also a doula offered me great advice.

Most of the participants relied on their families for advice. Anna who lives in the metropolitan area of Atlanta, which is a well-known Black majority community, had few people outside of her family to rely on. Living in this predominantly Black space did not guarantee social networks of support for Anna to connect with other local pregnant Black women during a pandemic. She was unable to rely on a network of women who looked like her to help her navigate pregnancy. Anna stated,

> My support system was not in Atlanta where I lived. My support system here was a bit lacking. Due to the pandemic people really couldn't travel to me and I was limited on activities we could do. I mainly had to rely on my doctor for advice.

Roberts (2017) discussed how when the government controls the reproduction of disadvantaged people, they can control the spaces in which they inhabit. This is an example of how the Black maternal health crisis has existed for years. Anna not having access to more Black spaces in a predominantly Black area divulges the lack of access and resources Black people experience.

In a similar vein, family support was the primary form of support for the women in this study. The women in this study were all formally educated women with good family support systems during their pregnancy. However, some families such as Anna's and Shonda's relied on virtual interaction due to geographic distance and safety precautions. The threat of COVID prevented these women from sharing their pregnancy surrounded by other expecting Black moms. The participants in the sample all lived near or in large cities where it was common for predominantly white spaces to be more accessible than Black spaces for services. All the women except Tammy did not report relations with Black women such as Black doulas and childbirth educators. Inaccessibility like this could, as Taylor (2020) mentions, instigate poor health outcomes for Black women.

Social events around pregnancy such as gender reveals, baby showers, and other events in which the mom-to-be is surrounded by loved ones were missing from many of the women's stories. Participants reported a need to forgo many of these events or create alternatives due to the pandemic. Cora held a drive through baby shower where friends and family drove up and dropped off their gifts; masks were still required due to a short period of close contact to get the gifts from the cars. Still, other participants were simply too fearful to risk having an event to celebrate their baby's conception. A few participants stated that during their pregnancy they were quite fearful of contracting COVID and were nervous to participate in a variety of daily activities (e.g., grocery shopping and going to work).

Tammy, for example, who was nervous about the exposure related to these daily activities, did contract COVID while pregnant. She stated, "I felt like my baby came early because my body was trying to fight off the virus and it was not giving enough nutrients to my baby." She still had to try and take care of herself and her husband, because visitors were not allowed to visit. Although their parents called and dropped off items, it was not the same as having parents present to comfort and care for them. Tammy stated,

> It was super scary for me because you can't take care of yourself like everyone else can. I was waking up in puddles of sweat and could barely breathe and all I could take was Tylenol.

There was a clear pattern that the pregnant women had to socially isolate to ensure the protection of themselves and their child. The women had an expectation of their pregnancies being completely different. They lost those moments of being surrounded and celebrated by loved ones. They had less freedoms and more restrictions than before the pandemic started.

Cora, experiencing her first pregnancy and her first year of marriage, was thrilled to be starting a family. Having grown up an only child in a single-parent household, Cora explains how important it was to have her mom present at the hospital, stating,

> The only vision I had, even though I'm married, was having my mom in the delivery room. I found out about my pregnancy in February and COVID hit in March. So, it was a pregnancy full of "I don't knows," like how to deliver and who can be in the room.

She really wanted that experience of her mom who birthed and raised her as a single parent being in the hospital room. Cora indicated that she wanted her child to come into this world surrounded by those who loved her most. When she brought the baby home, her husband did not have a lot of time for paternity leave, so she spent many days secluded by herself. The pandemic was a very isolating time for many and with a new baby, even more isolating.

Cora also indicated that she had to learn that even during the pandemic she still had to prioritize her own health. She indicates that this was possible because of the support she received from her extended family community.

Cora stated,

> I did learn to not feel like I'm neglecting my daughter. It's important to take time for yourself. If you don't have yourself together physically and mentally, you can't be there for them. It takes what I call 'the village' and that's my mom, aunt, stepmom, and God Mom.

Tina, who was in her second pregnancy during the rise of the Delta variant of COVID, lived in an area highly populated by those who did not follow the mask mandate. She had loved ones who died due to contracting COVID and it added to the fear of being out in public. Her fear was heightened because her husband is a police officer and constantly surrounded by other people. She shared her views on COVID, and the ensuing isolation when her baby was born.

> Yeah, it made motherhood harder because like I say, you couldn't just get the baby in the stroller, stroll around, you know? Marshalls… anywhere freely without worrying about COVID. Or, you know? Certain people will not wear a mask, you know? So like I say, here where I live they don't wear masks. And we don't let anyone visit us. We go to them. When we, you know, have a new home so we don't let anyone visit us, only close relatives, you know? Like my mom and my husband's mom and cousins and other relatives. No one comes over.

Tina and her husband established rules to protect them and their family when they had to leave the isolation of their home. Ensuring that their oldest son consistently wore a mask in school and always had hand sanitizer with him was

important. Guests had to wear a mask and shoe covers because they had a baby who was learning to crawl, and they wanted to reduce contact with germs. While Tina's family thought such efforts were a bit extreme, they still did it to protect them and their children.

Anna was a 27-year-old from Memphis who had relocated to Atlanta, Georgia in her mid-twenties. She had always been independent, and she lived alone when discovering she was pregnant with a longtime friend. She had no relatives in Atlanta, so it had always been just her and her friend network. Pregnancy during the pandemic uniquely altered how she saw her first-time pregnancy. She emphasized her isolation as a primary feature of her experience, stating,

> My support system was not necessarily in Atlanta where I live. And, you know, because of the pandemic like the people really couldn't travel. So I think my mom was able to come visit maybe once or twice. It really was not the same, because of the pandemic so I think my support system here was a little bit lacking. And even if you know there were people here, we really couldn't do much like in person, so I did spend most of my pregnancy by myself.

Anna holds a J.D. and works as a project manager. Although Anna benefited from a financial status that afforded her to pay for her pregnancy-related expenses, this quote also reveals her lack of emotional support from any local friends and family.

Shonda, was in her second pregnancy in a year-and-a-half. Shonda had previously experienced a stillbirth, which causes her to face periods of depression and anxiety. When she found out she was pregnant once more, she was elated but also fearful of losing a baby again. She wanted to make sure this baby was okay, and did everything to prevent COVID exposure, such as isolating herself. She was not close to her child's father, but her mom and sisters were her closest companions. Shonda started working from home to better accommodate her needs during pregnancy. The pandemic triggered prior fears and moments of loneliness that she decided to continue therapy during her pregnancy. Shonda explained,

> I had a stillborn birth before this pregnancy, so I was terrified to go anywhere or do anything to put the baby at risk. I worked from home and would have the baby's father pick up the groceries and drop them off for me. I couldn't see my sister or mom and had to update [them] on the phone all the time and they were worried about me and couldn't see me.

Many of the hospitals during this time only allowed for one support person to be present during labor and delivery. Some hospitals required COVID-testing prior to participants being escorted to a room. For many of the women, the child's father was the person chosen to be in the labor and delivery room. However, many of them indicated a preference for their mother or other family members.

Johnson and Loscocco (2015) and Potucheck (1997) explain that Black American women are socialized to be emotionally savvy and in tune with their

emotions; therefore, they are responsible for managing their emotions. Many of the participants chose their partners as their social support person and for them to share that experience. However, it is plausible the reason many of these women wanted their mothers in the room is because they can relate to the pain and pressure they are under. They may have felt a need to compose themselves so their partners who could not fully understand their pain, would not worry.

One participant, Jana, chose her mom to be her one labor support person. She did not feel comfortable with the child's father attending her labor, stating, "I personally did not want him to go with me." Jana explained that her family members provided food and shelter for her while she was pregnant; resources she desperately needed after she quit her job. For the few doctors' appointments she was allowed to attend with people, she chose to be accompanied by family and friends. Jana's mom supported her emotionally given Jana had never given birth before. She was continuing a family tradition in which her mom was supported by her own mother when it was time to deliver. Jana indicated that she felt overwhelmed in the hospital and that having her mom help her emotionally, particularly in managing her stress from labor, was important.

Another participant, Shonda, chose to have the baby's father in the labor room with her. She indicated that she wished it could have been her mother, but that she did not want to deprive him of the experience. Shonda felt as if she had to coach him on how to be supportive for her. However, not every participant communicated a similar experience as Shonda and Jana. Instead, the commonly

encountered one-person hospital rule did allow others to have a more intimate birth experience. Cora, who is married, reflected on her husband and her hospital stay, and felt COVID added to a good memory of her pregnancy experience, stating,

> The only thing COVID affected was the visitors, and my mom couldn't come. She was really hurt. But afterwards, I was glad it was only us. I did want my mom there but, in the end, I was glad it was the two of us, so no unnecessary company. We still didn't allow visitors for a while.

Tammy, who is also married, described her husband's support,

> Yeah, I think he knew he needed to be calm. And I have videos. I was super excited, but I did have anxiety. But I knew I had to get it together. You can't put that kind of pressure on yourself. Especially with Black women, you hear that we are not well taken care of in hospitals, and they feel like we're super strong people and don't attend to us like they should. I was like, "I have to speak life and power into this birth," and he was like "you know we are," and he was super excited.

During a time of uncertainty, these women needed emotional as well as physical support. With so much social distance efforts occurring during the pandemic, these women identified and communicated the importance of face-to-face support during such an isolating time.

Reproductive Choices Amid Restrictions

Another prominent theme surrounded the importance of choice for the women in the study. Who these women chose to support them during birth affected their successful management of emotions. Coronavirus restrictions created a context for these women that, while restricting, nonetheless gave them opportunity to exercise agency and voice. Choosing a support person, was an expression of some control over how they would experience their delivery.

The issue of choice raises the question of agency in childbirth for Black women, and in their reproductive health, more generally (Roberts 2017). Women of color have been denied reproductive freedom and justice historically, so it is not surprising that African American women are healthy skeptics when addressing isolation in pregnancy and birth, required testing, and mandated vaccinations. Another area of choice that the participants addressed with varied opinions, surrounded whether to receive the COVID vaccine. Many of them faced this choice only after they had given birth. This individual vaccine choice depended on factors such as career and location.

The COVID-19 vaccines—Johnson & Johnson, Pfizer, and Moderna—were approved in 2020 by the FDA for Emergency Use Authorization, first for individuals ages 16 years of age or older (FDA 2021). The first administration of the vaccine caused quite a stir throughout the US. Some Americans thought that it was unsafe and came out too quickly; others worried about accessibility; and others were concerned and resisted the idea of mandated requirements (Hoffman and Schaff 2021).

Participant responses when asked if they were vaccinated were similarly varied. Cora stated that she did not feel it necessary to get the vaccine if there was still a possibility she could contract COVID. She preferred to take a vaccine that 100% prevents you from contracting it. Current mandates require healthcare workers to get the vaccine to protect patient health and safety. There was a heightened response from healthcare workers about this mandate and a debate about bodily autonomy ensued. Cora lives in a dual-income house, and this probably affects her choice to get it versus someone who lives on a single income. Cora could afford the time off work versus someone living on one income. Jana, Shonda, and Tina stated they got vaccinated due to a work requirement. Tina is currently pregnant with her second child during a pandemic and got the vaccine while she was pregnant. She did some online reading, but she communicated there was not a lot of information on pregnant women who had received the vaccine. She is still nervous about side effects, but she also felt forced into the decision by her employer. She works from home for the government and did not understand why it was so crucial, considering she barely left the house. Tina had already planned to get vaccinated due to experiencing family and friends who had contracted COVID. But she felt a bit rushed into the decision. Tina stated,

> I wasn't going to get it, but my job was forcing us to get the vaccine. Because I work for the federal government, and they did force us even

> though I work from home. So, I went on and I got it due to my job and because of my close relative seeing what she had experienced.

Even being in a dual-income household, Tina needed to keep her job to help support her family so the added stress from lack of choice is not very surprising. Anna was not for or against the vaccine. She works from home and felt that it was her duty as a mother and sole provider for her child to get vaccinated. She knew if she contracted it that she could not afford to take time away from paid work. It seems that because she had options, her decision was based on her being the sole caretaker for her son. She does not have any nearby family outside of the child’s father so instead of entrusting him in someone’s care she made the decision to be able to care for him herself and lessen the chance of a hospital stay if she contracted the virus.

Anna stated,

> I got vaccinated basically so in the event if I got COVID I couldn’t really afford the downtime being sick or have a hospital stay, things like that. So that’s what really influenced my decision to get vaccinated. I am not necessarily an anti-vax person but I wasn’t too keen on initially getting this vaccine, but I am a mom to a young child, so I felt it was the right decision.

For Anna, her statement encompassed how limiting her choice to get vaccinated was. This vaccine requirement, even for employees working from home, could reflect the then mandates from the Biden administration, which required employers with over 100 employees to ensure their employees are vaccinated. Those who

work under that business spectrum may be required to be vaccinated since it is so readily available at most pharmacies.

Since 6 out of 8 participants got vaccinated, their reasoning reveals how the theme of choice emerged throughout this study. As previously mentioned, Black women have not always had a choice in what happens to their bodies. This is evident in access to health care such as, birth control, abortions, and proper prenatal care (Roberts 2017). The vaccine was first only given to essential workers but has been made widely available as of 2021. If Black women had improved access to doctors and medicine, then maybe they could better protect themselves against COVID. The pandemic highlighted the importance of accessibility, and the right for women to make decisions concerning their own bodies.

CONCLUSION

Findings in this research focus on the importance of social support for Black women. It also focuses on the importance of reducing the growing maternal health crisis. We have to start by acknowledging the causes of inequalities separate from and embedded within the health system.

The bodies of literature within this study highlighted the maternal health crisis for Black women. Black women have always been limited within their reproductive choices. This has been an ongoing issue even before COVID and will continue to be one after if more attention and advocacy is not brought to this

issue. As stated above, Black women are more likely to have various health issues during birth and have higher rates of maternal mortality. If these women contracted COVID, they were at higher risks for illnesses such as hypertension, diabetes, and obesity (Stephenson 2022). Women had to choose between the right not to be vaccinated or work to provide for their children. All these women had some form of formal higher education and were able to think through their birth stories and experiences that stood out to them. These women having high levels of educational attainments likely means they are quite familiar with the issues Black women face during pregnancy.

All the participants expressed the importance of the theme of emotional support during pregnancy. This theme helped answer the question of how Coronavirus affected African American women's pregnancy experiences. Most of the participants experienced heightened fear, isolation, and some experienced anxiety and depression. These responses to the coronavirus environment were amplified due to social distancing restrictions, but the narrative stories also suggest that Black women may experience isolation and barriers to support in their everyday non-COVID environments. This was particularly the case when Black women lived away from family or did not have supportive Black communities readily available.

The goal of this study was to gain better insight on how this multi-year pandemic has affected pregnant African American women in a racist healthcare system. Further research is needed to improve understanding of how

Coronavirus influences the experiences of African American women in pregnancy and delivery. The results offer insight to foster more support to African American women should this pandemic continue for years to come. It also emphasizes the importance of advocating for Black women and emphasizes the ever present maternal health crisis within the Black community. Social policy should address ways in which emotional support can be enhanced in community centers that bring Black women and their supportive advocates together to safely share experiences during pregnancy. Social support matters within Black spaces and Black communities and these women did the best they could during the pandemic. However, there is room to foster more growth in support for Black women.

Appendix A. IRB Approval

IRB
INSTITUTIONAL REVIEW BOARD
Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd
Murfreesboro, TN 37129
FWA: 00005331/IRB Regn. 0003571

IRBN001 - EXPEDITED PROTOCOL APPROVAL NOTICE

Monday, October 25, 2021

Protocol Title	***How Coronavirus Affected African American Women's Experiences with Pregnancy, Delivery, and the Post-partum Period?***
Protocol ID	**21-2188 7v**
Principal Investigator	**Latara bates** (Student)
Faculty Advisor	Adelle Monteblanco
Co-Investigators	NONE
Investigator Email(s)	*lrb5c@mtmail.mtsu.edu; adelle.montelblanco@mtsu.edu*
Department	Sociology
Funding	**NONE**

Dear Investigator(s),

The above identified research proposal has been reviewed by the MTSU IRB through the **EXPEDITED** mechanism under 45 CFR 46.110 and 21 CFR 56.110 within the category *(7) Research on individual or group characteristics or behavior.* A summary of the IRB action is tabulated below:

IRB Action	**APPROVED for ONE YEAR**		
Date of Expiration	**6/30/2022**	*Date of Approval*: 6/1/21	*Recent Amendment*: 10/25/21
Sample Size	TEN (10)		
Participant Pool	*Target Population:* Primary Classification: **Special Population - Adult Pregnant Women** Specific Classification: **Self-identified as African American**		
Type of Interaction	☐ Non-interventional or Data Analysis ☒ Virtual/Remote/Online interaction ☐ In person or physical interaction – Mandatory COVID-19 Management		
Exceptions	1. Contact information is permitted to coordinate the interviews. 2. Voice recording is approved.		
Restrictions	**1. Mandatory ACTIVE Informed Consent.** **2. Other than the exceptions above, identifiable data/artifacts, such as, audio/video data, photographs, handwriting samples, personal address, driving records, social security number, and etc., MUST NOT be collected. Recorded identifiable information must be deidentified as described in the protocol.** **3. Mandatory Final report (refer last page).** **4. Not approved for in person data collection**		
Approved Templates	*IRB Templates:* Zoom Interview Informed Consent *Non-MTSU Templates:* Recruitment Script		
Research Inducement	NONE		
Comments	NONE		

IRBN001 (Stu) Version 2.0 Rev 08/07/2020

Post-approval Requirements

The PI and FA must read and abide by the post-approval conditions (Refer "*Quick Links*" in the bottom):

- ***Reporting Adverse Events:*** The PI must report research-related adversities suffered by the participants, deviations from the protocol, misconduct, and etc., within 48 hours from when they were discovered.
- ***Final Report:*** The FA is responsible for submitting a final report to close-out this protocol before **6/30/2022** **(Refer to the Continuing Review section below)**; REMINDERS WILL NOT BE SENT. **Failure to close-out or request for a continuing review may result in penalties** including cancellation of the data collected using this protocol and/or withholding student diploma.
- ***Protocol Amendments***: An IRB approval must be obtained for all types of amendments, such as: addition/removal of subject population or investigating team; sample size increases; changes to the research sites (appropriate permission letter(s) may be needed); alternation to funding; and etc. The proposed amendments must be requested by the FA in an addendum request form. The proposed changes must be consistent with the approval category and they must comply with expedited review requirements
- ***Research Participant Compensation:*** Compensation for research participation must be awarded as proposed in Chapter 6 of the Expedited protocol. The documentation of the monetary compensation must Appendix J and MUST NOT include protocol details when reporting to the MTSU Business Office.
- ***COVID-19:*** Regardless whether this study poses a threat to the participants or not, refer to the COVID-19 Management section for important information for the FA.

Continuing Review (The PI has requested early termination)

Although this protocol can be continued for up to THREE years, The PI has opted to end the study by **6/30/2022** **The PI must close-out this protocol by submitting a final report before 6/30/2022 Failure to close-out may result in penalties that include cancellation of the data collected using this protocol and delays in graduation of the student PI.**

Post-approval Protocol Amendments:

The current MTSU IRB policies allow the investigators to implement minor and significant amendments that would fit within this approval category. ***Only TWO procedural amendments will be entertained per year*** *(changes like addition/removal of research personnel are not restricted by this rule).*

Date	Amendment(s)	IRB Comments
07/07/2021	The item 12 of the informed consent is amended.	NONE
10/25/2021	The geographic location of the participants is expanded.	IRBA2022-308

Other Post-approval Actions:

The following actions are done subsequent to the approval of this protocol on request by the PI/FA or on recommendation by the IRB or by both.

Date	IRB Action(s)	IRB Comments
07/07/2021	The protocol approval status changed from "conditional" to "approved."	NONE

COVID-19 Management:

The PI must follow social distancing guidelines and other practices to avoid viral exposure to the participants and other workers when physical contact with the subjects is made during the study.

- The study must be stopped if a participant or an investigator should test positive for COVID-19 within 14 days of the research interaction. This must be reported to the IRB as an "adverse event."
- The MTSU's "Return-to-work" questionnaire found in Pipeline must be filled by the investigators on the day of the research interaction prior to physical contact.
- PPE must be worn if the participant would be within 6 feet from the each other or with an investigator.
- Physical surfaces that will come in contact with the participants must be sanitized between use
- **FA's Responsibility:** The FA is given the administrative authority to make emergency changes to protect the wellbeing of the participants and student researchers during the COVID-19 pandemic. However, the FA must notify the IRB after such changes have been made. The IRB will audit the changes at a later date and the FA will be instructed to carryout remedial measures if needed.

Data Management & Storage:
All research-related records (signed consent forms, investigator training and etc.) must be retained by the PI or the faculty advisor (if the PI is a student) at the secure location mentioned in the protocol application. The data must be stored for at least three (3) years after the study is closed. Additional Tennessee State data retention requirement may apply (*refer "Quick Links" for MTSU policy 129 below*). The data may be destroyed in a manner that maintains confidentiality and anonymity of the research subjects.

The MTSU IRB reserves the right to modify/update the approval criteria or change/cancel the terms listed in this letter without prior notice. Be advised that IRB also reserves the right to inspect or audit your records if needed.

Sincerely,

Institutional Review Board
Middle Tennessee State University

Quick Links:
- Post-approval Responsibilities: http://www.mtsu.edu/irb/FAQ/PostApprovalResponsibilities.php
- Expedited Procedures: https://mtsu.edu/irb/ExpeditedProcedures.php
- MTSU Policy 129: Records retention & Disposal: https://www.mtsu.edu/policies/general/129.php

Appendix B. INTERVIEW QUESTIONS

Introductory Questions

1. How are you feeling today?
2. How is your new baby?
3. Tell me about yourself?

Pregnancy Experience Questions

1. Tell me about when you first realized you were pregnant with your most recent child?
    a. Probe: How many weeks along were you?
    b. Probe: Who did you tell first?
2. How did you envision your birth?
    a. Probe: What did you expect or want?
3. Can you tell me about your pregnancy experience?
4. Did you have any form of support during your pregnancy?
5. Who or where did you go to for any sort of questions that may have arisen?
    a. Probes: Do they live nearby? Were they helpful?
6. Did you have medical insurance for your prenatal, birth, and post-partum care? If so, what kind?
7. What was it like using your insurance?
    a. Probes: Did you get the provider and/or settings you wanted? Were there any issues?

8. Can you tell me a little about the prenatal care you received?
    a. Probe: What influenced you to get prenatal care?
    b. Probe: Were you able to attend all your visits? If not, why?

Pregnancy During The Pandemic

9. Where did you go when you left the house?
10. What precautions did you take when you left?
    a. Did you wear your mask?

Labor and Delivery Experience Questions

1. What was most memorable about your labor and delivery experience?
2. Was your significant other allowed to attend?
    a. How did they assist you during this time?
3. How did you feel about the medical staff during your labor and delivery?
    a. Did you feel like all you concerns were addressed?
    b. Did you feel like they communicated well?
4. Did any staff member provide you with any form of emotional support during your delivery?
5. Were any family members allowed in the delivery room? If so, how many?
6. What type of delivery did you have?
    a. Is that what you and your provider had planned?
7. How long did you stay in the hospital after delivery?

8. How much did COVID-19 affect your hospital experience?
    a. How did the Doctors/Nurses treat you?
    b. How long did you stay at the hospital?
    c. Was there a room available?
9. Was labor and delivery what you thought it would be?
    a. What would have made it easier?
    b. Do you plan to have more children?

Experience with Post- Partum Questions

1. Did you go for a post-partum visit? If not, why?
2. What could have been done to encourage you to go?
3. What was it like when you first took your baby home?
4. What is you and the baby's sleeping schedule ?
    a. Do you breast feed?
5. Are you able to rest/relax when your baby is being taken care of by someone else?
6. Who supported you during the postpartum phase?
7. Has anyone talked to you about postpartum depression?
8. Whose helping you take care of the baby at home?
9. Has COVID-19 added to any negative/positive emotions you might having during postpartum?
10. What are your feelings towards the vaccine?

a. Have you been vaccinated? Why or why not?

11. Is there anything else you would like to tell me about the way you are feeling?

12. How has the pandemic affected how you care for your child?

Demographic Questions

1. What is your age?
2. What is your Ethnicity?
3. What is your gender?
4. What is your sexual orientation?
5. What is your highest level of education you have completed?
6. What is your marital status?
7. Where do you currently live?
8. Do you have any other children?
9. What is your religious identity?
10. How would you describe your political views?
11. When's the baby's birthday?

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