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“After this experience, I'm just shook”: Using a Mixed Methods Approach to Explore Black Women’s Maternity Care Experiences Influence on Subsequent Pregnancy and Birthing Intentions

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Research Article

Keywords: person-centered care, Black women, pregnancy, reproductive decision-making, birthing intentions, birth experiences, mistreatment, obstetric racism

Posted Date: June 24th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9890842/v1

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Additional Declarations: No competing interests reported.

Abstract

Background: Black women in the United States experience disproportionately higher rates of maternal morbidity and mortality, alongside persistent mistreatment and obstetric racism while receiving perinatal care. Prior research has documented these experiences and their impact on patient satisfaction and postpartum care utilization; however, less is known about how these experiences shape Black women's subsequent pregnancy and birthing intentions.

Methods: We used an explanatory sequential mixed-methods design with Black women (≥18 years) who delivered at five Cincinnati-area hospitals (April 2023–September 2024). All participants completed a survey assessing subsequent birthing intentions and maternity care experiences using the Person-Centered Maternity Care Scale–U.S. (PCMC-US). Descriptive, bivariate, and binary logistic regression analyses were conducted. A subsample of participants completed semi-structured interviews, which were analyzed using reflexive thematic analysis to contextualize quantitative findings.

Results: Among Black women surveyed (n=241), 66% indicated they would return to the same hospital for a future birth. The mean PCMC-US score was 81.7, with 73.9% reporting Optimal/Good person-centered maternity care. Participants who intended to return to the same hospital had a mean PCMC-US score in the Optimal range, whereas those preferring a different hospital, a home birth, or not giving birth again based on their care experience had mean scores in the Fair or Poor range. Differences in birthing intentions by PCMC level were statistically significant ($p<0.001$). Participants receiving Fair/Poor person-centered care had 11 times higher odds of reporting that their care influenced their intentions regarding future pregnancy and birth setting compared to those who received Optimal/Good care (OR=11.36; 95% CI: 5.76–22.43). Our subsample of interview participants (n=24) further illustrated how care shaped decision-making surrounding pregnancy, with themes including (1) seeking autonomy in birth, (2) fear or hypervigilance toward subsequent pregnancies, and (3) reproductive decisions influenced by mistreatment.

Conclusions: Person-centered maternity care is a critical determinant of Black women's future pregnancy and birthing intentions, shaping trust in health systems and decisions to seek hospital-based care. Advancing patient-centered approaches is essential to reducing preventable maternal morbidity and mortality and ensuring that Black women not only survive childbirth but also experience care free of harm.

Background

Black and other women of color are more likely to be mistreated within hospitals and health systems in the United States (U.S.) while receiving perinatal care (1). This is of particular importance for Black reproducing communities, who face disproportionately higher rates of adverse maternal outcomes (e.g., maternal mortality and morbidity) and acts of obstetric racism (e.g., non-consented or coercive procedures) by healthcare providers (2–7). Prior studies have found that Black women's care experiences influence pregnancy and birth-related outcomes. For instance, a cross-sectional study of birthing experiences in the U.S. found that approximately 71% of Black women are worried about pregnancy and birthing experiences for themselves and their community, and these worries were heightened when experiencing mistreatment during childbirth (9). Healthcare providers are also cognizant of the ways in which hospital systems fail to provide quality care for Black pregnant and birthing patients (10), yet the practice of obstetric, hospital-based childbirth remains unchanged and a threat to the physical and emotional safety of the Black reproducing community. Research has also examined the influence of discriminatory care experiences among birthing patients of all races on their desires to return for postpartum care (8); however, less is known about how maternity care experiences influence Black women's subsequent pregnancy and birthing intentions.

Scholars have developed numerous validated tools and assessments that can be used to measure experiences of care, including respect, autonomy, mistreatment, obstetric racism, and person-centered care, to facilitate the quantitative examination of various associations (1, 11–14). For example, the Mistreatment Index has been used to assess perinatal care experiences of women across the U.S., with Black women and other women of color reporting higher rates of mistreatment than White women (1). Additionally, the patient-reported experience measure of obstetric racism, or the PREM-OB Scale™ suite, was developed with a Black feminist approach to capture the hospital-based perinatal care experiences that contribute to or mitigate obstetric racism (11, 14). While these measures have advanced understanding of prevalence and predictors of mistreatment and obstetric racism, there is limited assessment of the downstream consequences of these experiences, particularly for Black women and birthing people.

Black and other women of color have requested that hospitals and health systems provide person-centered care to improve their pregnancy and birthing experiences (15), which constitutes a key component of high-quality maternity care provision(16). Person-centered care prioritizes the patient's preferences and aspirations over those of the provider, ensuring respect, trust, dignity, support, autonomy, and effective communication(16). Person-centered care influences mothers' and birthing patients' experiences, expectations of care, and future care-seeking behaviors (12, 17). The Person-Centered Maternity Care Scale – U.S. (PCMC-US), an adaptation of the PCMC Scale initially developed in low-resource settings (21), is one of the first publicly available and validated scales to measure the childbirth experiences of Black women and birthing people in the United States (12). Since its adaptation, the PCMC-US has been used to examine factors associated with person-centered care among Black women and birthing people in California (22). Prior research utilizing the PCMC-US scale contributes further insight into the maternity care experiences of Black women in the U.S.; however, study samples have been limited to Black women with predominantly privileged socioeconomic factors compared to all Black women and birthing people in California (12, 22).

Pregnancy-related deaths have continuously increased in Ohio, with 66% being deemed preventable in 2020 (23). As observed nationally, Black women in Ohio experienced the highest rates of mortality during and up to one year following pregnancy among all racial and ethnic groups (23). Mama Certified is a collaborative, community-led project initiated in response to a call from Black mothers of the greater Cincinnati area to improve their pregnancy and birthing care experiences. Mama Certified was co-designed by Black women in the community, in partnership with all local hospital networks, Cradle Cincinnati, and The Health Collaborative of the greater Cincinnati region, to meet the individual, hospital, and community-identified needs of Black women and birthing people in a collaborative, transparent, and reciprocal manner. As a result, the Mama Certified Birthing Experience Study was developed, with community input, to shift the focus from racial identity to racism as a risk factor for adverse maternal outcomes and care experiences among Black women and birthing people, thereby disrupting mother-blame narratives and the pathologization of Black bodies in care provision.

To address gaps in the existing literature regarding how maternity care experiences influence subsequent pregnancy and birthing intentions, we utilized data from the Mama Certified Birthing Experience Study to explore two research questions through a mixed methods approach: (1) What is the relationship between hospital-based maternity care experiences and subsequent pregnancy and birthing intentions among Black women in the greater Cincinnati area?, and (2) how do hospital-based maternity care experiences influence subsequent pregnancy and birthing intentions among Black women in the greater Cincinnati area?

Methods

The Mama Certified Birthing Experience Study research team employed an explanatory sequential mixed methods design with an integrated approach to instrument design. Quantitative data collection was initiated to identify the relationship between person-centered maternity care and subsequent pregnancy and birthing intentions, and to establish a subsample for qualitative data collection. Subsequently, qualitative data were collected through semi-structured interviews to elaborate on findings from the quantitative data. This mixed-methods design enabled a more nuanced understanding of participants' birthing intentions and expanded on the findings observed in the quantitative data. The Institutional Review Board at the University of California, Davis, and Cincinnati Children's Hospital and Medical Center reviewed our study protocol and granted an exemption from human subjects review with limited risk.

Study Population

Eligibility criteria for participation in the quantitative study included identifying as Black, being 18 years of age or older, and having given birth at one of five Cincinnati-area hospitals between April 2023 and September 2024 (i.e., within 1 year of their most recent birth). All participants were recruited via social media, community health workers, newsletters, the Mama Certified website, and recruitment materials given during postpartum hospital discharge. Prior to completing the survey questionnaire, potential participants completed a screening form via the Research Electronic Data Capture (REDCap) application to determine eligibility, uploaded a valid form of photo identification to verify their racial identity, and subsequently signed a consent form. This eligibility process for survey participation is modeled after Birthing Cultural Rigor's Verification Methodology (15). The research team verified each screening form to ensure it fulfilled the eligibility criteria. Participants who completed the survey questionnaire were randomly selected using Excel's randomization function to be recruited for the qualitative interview. The eligibility criteria for the qualitative study mirrored those for the quantitative study.

Quantitative Data Collection

The quantitative study included an electronic self-administered survey questionnaire administered through REDCap. We developed a survey questionnaire (Supplementary File 1) that included closed- and open-ended questions capturing demographics, pregnancy and birth characteristics, future pregnancy and birthing intentions, and maternity care experiences, measured using the PCMC-US scale. The sample size was based on a population of 3,306 live births to Black families in Hamilton County, Ohio, in 2021, with a 5% margin of error and a 95% confidence level, yielding a target sample size of 300. Quantitative data were collected for this study from May 2024 to September 2024. Each participant received a $50 e-gift card within two weeks of completing the survey.

Quantitative Measures

Quantitative methods aimed to measure the relationship between experiences during hospital-based maternity care and subsequent pregnancy and birthing intentions. The key independent variable was maternity care experiences, which was assessed using the 35-item PCMC-US scale. The PCMC-US includes a mix of subjective questions to capture perceptions (e.g., feeling respected) & objective questions (e.g., allowing a birth companion). Survey participants rated each item on a 0–3 scale (e.g., 0: No, never, 1: Yes, a few times, 2: Yes, most of the time, 3: Yes, all the time) and responses were summed for three subscale scores (*Dignity and Respect, Communication and Autonomy*, and *Responsive and Supportive Care*) as well as a total scale score. Subscale and total PCMC-US scores were calculated according to validated scoring guidelines. Scores are standardized to range from 0 to 100, with higher scores reflecting more person-centered care. The dependent variable was subsequent pregnancy and birthing setting intentions, assessed using a single-item survey question that asked participants: "Based on the care I received during my most recent birth,..." Response options included: (1) "I would give birth at the same hospital," (2) "I would give birth, but at a different hospital," (3) "I would give birth at home," (4) "I would not give birth again," and (5) "I would not give birth again for reasons unrelated to my most recent hospital birth experience". Covariates included age at time of birth, insurance status, primary provider, birth type, first birth, full-term birth, racial concordance, and doula support.

Quantitative Analysis

Descriptive analyses summarized participant characteristics, birth intentions, and PCMC-US scores. PCMC-US Scores were categorized into 4 groups based on recommended cutoffs: Optimal (90–100); Good (75–89); Fair (50–74); and Poor (0–49) (24). For ease of interpretation and given the distributions, the PCMC-US score was further converted into a dichotomous variable, combining Optimal or Good scores as *"Optimal/Good PCMC"* and Fair or Poor scores as *"Fair/Poor PCMC"*. Similarly, we dichotomized the outcome variable of whether care influenced subsequent birth decision-making. Responses recorded as "I would give birth at the same hospital" or "I would not give birth again for reasons unrelated to my most recent hospital birth experience" were grouped as "*No Care-Related Change in Future Pregnancy or Birth Setting Intentions*" and those who responded that "I would give birth, but at a different hospital", "I would give birth at home", or "I would not give birth again" were labeled as "*Care-Related Change in Future Pregnancy or Birth Setting Intentions".* We conducted bivariate analyses to examine associations between PCMC and subsequent pregnancy or birthing setting intentions using both the continuous and categorical PCMC-US scores (total and subscales) and the different categories of subsequent birthing intentions. We used Pearson chi-square tests to assess statistical significance of the association between the dichotomized variables in bivariate analysis, and multivariable binary logistic regression to further evaluate the

association while controlling for relevant covariates. Any conceptually related covariates that showed a statistically significant relationship (P-value < 0.05) in the bivariate analysis were included in the adjusted model. Odds Ratos (ORs) and 95% confidence intervals (CIs) were calculated. Quantitative analyses were conducted using Stata/MP 17.0 and SPSS 31.0.1.0.

Qualitative Data Collection & Analysis

At the end of the online survey questionnaire, each participant was asked whether they were interested in sharing more information about their birthing experience. If they indicated interest, participants were compiled into a de-identified list for recruitment into the qualitative study and randomly selected for participation. To align with the quantitative study, we developed an interview guide based on the components of the PCMC-US that our community advisory board, comprised exclusively of Black women, identified as most critical to improving their birthing experiences. We also included a question towards the end of the interview related to their birthing intentions or subsequent pregnancies. Consistent with our research aims, we prioritized coding responses to this question: “How has your most recent hospital birth experience influenced your decision to become pregnant again, or where and with whom you would give birth for any other pregnancy?” Virtual interviews were conducted from September 2024 to November 2024 with two Black women, including the lead author and one of three community researchers, who observed and recorded field notes. Interviews were conducted and transcribed via Zoom. Interviews ranged from 11 minutes to 1 hour and 10 minutes, depending on the extent of the birth experiences shared, with an average of 22 minutes. Participants received a $50 e-gift card for completing the interview. To yield at least 10% of survey participants, we had a target sample size of 25. Data were analyzed using the reflexive thematic analysis (25) process to illustrate how experiences of maternity care influence Black women’s pregnancy and birthing intentions. First, transcripts and audio were reviewed multiple times for familiarization, and we generated initial codes inductively that were relevant to the research question. Codes were refined or combined to organize into initial themes. Further themes were refined and finalized through an iterative process.

Results

Quantitative Results

A total of 241 Black women participated in the survey, ranging in age from 17 to 44 years at the time of their birth. The majority had a vaginal birth (n = 155, 64.3%) and a full-term birth (n = 207, 85.9%). Approximately 36% (n = 86) had a cesarean birth, and nearly 60% of participants who indicated a cesarean birth reported it was unplanned (n = 51, 21.2%) rather than planned (n = 35,14.5%). Most (n = 204, 84.6%) births were facilitated by an OB/GYN physician as the primary provider, and fewer than 10% (n = 22, 9.1%) were supported by a Certified Nurse-Midwife. The majority of participants reported that they would give birth again at the same hospital (n = 159, 66.0%). Fewer participants indicated that they would prefer to give birth at a different hospital (n = 26, 10.8%), at home (n = 20, 8.3%), would not give birth again (n = 13, 5.4%), or would not give birth again for reasons unrelated to their care experience (n = 23, 9.5%). Further demographics and birth characteristics are presented in Table 1.

Table 1

Descriptive Analysis of Demographics and Birth Characteristics

Variable	Frequency (N = 241)	Percentage (%)
PCMC-US Level (Mean = 81.7, SD = 16.3)		
Optimal/Good PCMC	178	73.9%
Optimal PCMC-US Scores	94	39.0%
Good PCMC-US Scores	84	34.9%
Fair/Poor PCMC	63	26.1%
Fair PCMC-US Scores	47	19.5%
Poor PCMC-US Scores	16	6.6%
Subsequent Pregnancy and Birthing Setting Intentions		
No Care-Related Change in Future Pregnancy or Birth Setting Intentions	182	75.5%
Same hospital	159	66.0%
Not give birth again for reasons unrelated to the care experience	23	9.5%
Care-Related Change in Future Pregnancy or Birth Setting Intentions	59	24.5%
Different hospital	26	10.8%
Home birth	20	8.3%
Not give birth again due to the care experience	13	5.4%
Age at Time of Birth		
17–24 years	67	27.8%
25–30 years	98	40.7%
31–36 years	51	21.2%
36+	25	10.4%
Insurance Status at Time of Birth		
Medicaid	180	74.7%
Private	52	21.6%
Other or Don’t Know	9	3.7%
Primary Provider		
OB/Gyn Physician	204	84.6%
Certified Nurse-Midwife	22	9.1%
Other or Don’t Know	15	6.2%
Birth Type		
Vaginal Birth	155	64.3%
Planned Cesarean Birth	35	14.5%
Unplanned Cesarean Birth	51	21.2%
First Birth		
Yes	95	39.4%
No	146	60.6%
Full Term Birth (> 37 weeks)		
Yes	207	85.9%
No	30	12.4%
Missing	4	1.7%
Patient-Provider Race		
Racial Concordance	57	23.7%

Variable	Frequency (N = 241)	Percentage (%)
Racial Discordance	184	76.3%
Doula Support		
Yes	39	16.2%
No	202	83.8%

The mean PCMC-US score for the sample was 81.7 out of 100 (standard deviation [SD] = 16.3) with scores ranging from 24.8 to 99.1. The majority of survey participants (n = 178, 73.9%) had PCMC-US scores between 75–100, categorized as Optimal/Good PCMC, and approximately 1 in 4 participants (n = 63, 26.1%) had scores between 0–75, categorized as Fair/Poor PCMC. PCMC-US subscale scores varied, with mean subscale scores of 86.7 out of 100 for *Dignity & Respect*, 80.0 for *Communication & Autonomy*, and 79.2 for *Responsive & Supportive Care*. The mean PCMC-US score among participants who would give birth at the same hospital was 92.1 compared to 71.7, 71.8, and 56.2 among participants who reported they would give birth at a different hospital, at home, or would not give birth again, respectively. The average PCMC-US score for those who reported they would not give birth again for unrelated reasons had a more comparable mean score than those who would give birth in the same hospital (87.0). A similar distribution was observed across the three PCMC-US subscales, with participants who intended to give birth at the same hospital or who would not give birth again for unrelated reasons consistently reporting PCMC-US subscale scores categorized as Optimal/Good. Consistently, those who indicated they would not give birth again due to their most recent care experience had the lowest average PCMC-US total and subscale scores within the Fair/Poor range (Fig. 1).

Figure 1.

Mean Total & Subscale PCMC-US Scores by Pregnancy and Birth Setting Intentions

Pearson's chi-square test revealed statistically significant differences in reported future pregnancy and birthing setting intentions by PCMC-US Level (i.e., Optimal/Good vs. Fair/Poor) ($p < 0.005$), while no statistically significant associations were observed among covariates. In the final unadjusted binary logistic regression model (Table 2), Black women who received fair or poor person-centered care had 11 times higher odds of reporting a care-related change in future pregnancy or birth setting intentions compared with those who received optimal or good person-centered care (OR = 11.36, CI: 5.76–22.43).

Table 2

Results of the final unadjusted binary logistic regression model for PCMC and Care Experience Influence on Subsequent Pregnancy or Birth Setting Intentions

Care-Related Change in Future Pregnancy or Birth Setting Intentions	
PCMC-US Level	Crude Odds Ratio [95% Confidence Interval]
Fair/Poor	11.364*** [5.758–22.427]
Optimal/Good	**Reference**
*p<.05. **p<.01. ***p<.001	

Qualitative Results

A total of 24 survey participants completed interviews to elaborate on their birthing experiences and intentions. Interview participants ranged in age from 22 to 43 at the time of birth, and nearly all births were facilitated by an OB/GYN provider. Among interview participants, PCMC-US Scores ranged from 24.8 to 97.1 out of 100, with a mean of 73.5, and the majority (n = 14) had scores categorized as Optimal or Good (n = 58.3%). Pregnancy and birth setting intentions varied; 9 interview participants indicated they would give birth at the same hospital, 5 at a different hospital, and 3 at home, while 4 reported they would not give birth again because of their care experiences, and 3 would not give birth again for reasons unrelated to their care. Further demographic and birth characteristics are presented in Table 3. We constructed themes to interpret the shared influence of Black women's care experiences on subsequent pregnancy and birthing intentions: (1) seeking autonomy in birth, (2) hypervigilance or fear of subsequent pregnancy, (3) reproductive decisions shaped by mistreatment. Additional illustrative quotes are presented in Table 4.

Table 3
Interview Participant Demographics and Birth Characteristics

Characteristic	
Age range in years at time of birth	22–43 years of age (mean = 30.5)
Birth Type	Vaginal Birth = 15 Planned Cesarean Birth = 3 Unplanned Cesarean Birth = 6
Primary Provider	OB/Gyn = 22 Certified Nurse-Midwife = 1 Other = 1
Racial Concordance	Racial Discordance = 21 Racial Concordance = 3
First Birth	Yes = 11 No = 13
Doula Support	Yes = 7 No = 17
PCMC-US Score Range	24.8–97.1 (mean = 73.5)
PCMC-US Score Level	Optimal or Good = 14 Fair or Poor = 10
Subsequent Pregnancy & Birth Setting Intentions	I would give birth at the same hospital = 9 I would give birth, but at a different hospital = 5 I would not give birth again = 4 I would not give birth again for reasons unrelated to my care = 3 I would give birth at home = 3

Seeking autonomy in birth

Some participants described a strong desire to avoid hospitals at all costs and seek alternatives beyond traditional obstetric care and medicalized birth through interest in home births, midwifery care, and doula support. This theme, “seeking autonomy in birth”, displays how, as a result of their most recent care experiences, Black women want to equip themselves with care professionals and environments that prioritize their preferences and provide more control over their birthing process. One participant expressed her desire to give birth in a community setting or with a midwife based on her birth experience:

“In general, I’m just…I'm shook with this experience, like I would just pray that my health is in good condition, and that I can afford one of the best doctors to do a home birth or yeah, just a home birth or midwife, or someone who's open to things. And just has more insight and won't judge me based off statistics. After this experience, I'm just shook. I can just see like…like I hear these stories, but now I see…I see how death is very common, if you just leave it up to these people.” (#516, Poor PCMC-US Score – 24.8, Would Not Give Birth Again)

Another participant described two instances during childbirth hospitalization where her concerns were ignored or denied, leading her to desire a home birth for a subsequent pregnancy.

I have rolling veins, so every time that they were trying to put the IV in my arm. It took like 6 or 7 people to do it, and I was telling them it hurt. It bothered me. No one was listening to me. I had a huge bruise on my left arm, ultimately, and then, when the baby was coming, you know, I was in the process of, you know, just going through it. And they kept saying, “No, he's not there yet,” and I'm like, “I can feel him coming out.” And so, soon as they did check, his head was right there coming out. So, I didn't like that part either, but I mean, still the same, all the same, though it wasn't as bad as previous experiences. But yeah, if I do have another kid, it would definitely just be completely at home. (#481, Fair PCMC-US Score – 64.8, Would Give Birth at Home)

Another Black woman shared her experience working with a doula as an added benefit to her birth experience; however, the services were offered free of cost, and she would not be able to afford doula support for a subsequent birth.

I mean, the doula was kind of like offered to me, so I didn't have to pay out of pocket. So, if I get the opportunity, I would definitely love to work with the doula again. But if it's something that I will have to pay out of pocket, unfortunately, we cannot afford. (#616, Good PCMC-US Score – 87.6, Birth at a Different Hospital)

Hypervigilance or fear of subsequent pregnancy

The second theme, “hypervigilance or fear in subsequent pregnancy,” captures the heightened anxiety linked to pregnancy experiences and risk as a Black woman. These racialized experiences emphasize the need to be hypervigilant for any anticipated challenges during the next pregnancy. Many participants described understanding statistics related to maternal health inequities in the U.S. and the dangers of birthing while Black.

One participant, among others, shared their discomfort giving birth without a doctor that they trust because of their fears surrounding potential complications and adverse outcomes related to pregnancy and childbirth for Black women.

I think just being a Black mom, I'm still nervous to have more children. Just because I know the statistics. And even though it was good this time, who knows what can happen the next time? Or if my doctor's out? So for me, I'm still on the fence, you know? Being pregnant is scary to me. (#513, Good PCMC-US Score – 83.8, Would Not Give Birth Again for Reasons Unrelated to Care Experiences)

Others explained spending a substantial amount of time conducting research to learn about ways they can protect and advocate for themselves during pregnancy, including equipping themselves with a doula.

So I really wanted a birth doula, because I didn't have any family locally. And so, and then on top of that, doing like all the research that I did, seeing about the maternal mortality rate, especially of Black women, I was just kind of like I do not want to go into this arena alone. (#536, Optimal PCMC-US Score – 94.3, Would Give Birth at the Same Hospital)

Another Black woman shared the sentiments of other participants. Still, the lingering impact of her birth experience left this participant hesitant about the possibility of future pregnancies, shaping her decision about whether to have more children or to try again with midwives and doulas on her care team as protection.

I think I was pretty apprehensive about having kids in America as a Black woman before I had my first child. And just because, again, the statistics are not great. I think I still feel that way. So, as far as like kid #2, I think just physically, I'm a little older, so I'm physically apprehensive. But then I also think again, just because of the labor delivery experience and making sure I could get the right care, and like I don't want to do a C- section again. Those factors that did occur with my first birth do weigh on my decision to have kids again. So I'm not a hundred percent on having another kid because of the whole process, like my pregnancy itself was smooth, but just like those last few weeks of the last trimester. And then also just how my birthing experience went, not something I want to recreate. So, I was looking into doulas and stuff before. And I do think maybe this time around or next time around, if I decide to have a kid, like looking more into midwives and that kind of thing. So, I do think it has impacted my decision to have more kids and how. (#530, Fair PCMC-US Score – 64.8, Would Give Birth at Home)

Reproductive decisions shaped by mistreatment

The final theme, “reproductive decisions shaped by mistreatment”, illustrates how participants’ experiences of mistreatment during care not only caused them physical and emotional harm but also shaped healthcare-seeking behaviors and reproductive choices. For some, harm enacted by healthcare providers led them to never want to experience childbirth again, reflecting the lasting impact of dehumanizing care.

One participant explained her desire for sterilization, but due to provider distrust, she did not complete the procedure. This ultimately led to a subsequent pregnancy at the time of the interview, where she wants to avoid hospital-based care and have doula support.

So I am currently 7 months pregnant. It was not planned at all. I was supposed to have a tubal ligation before I left, but I wasn't comfortable with Dr. [redacted] touching me like she wasn't an honest person, so that didn't happen. So I'm pregnant right now. But I told myself that I would probably do a home birth, reach out to some doulas. I am being seen at [redacted hospital] right now. I'm comfortable with the care that I'm receiving right now, but I don't know if I would want to deliver in a hospital again. I don't know.” (#505, Poor PCMC-US Score – 36.2, Would Give Birth Again at a Different Hospital)

Another participant, who gave birth at a different hospital, shared similar sentiments. The mistreatment experienced during maternity care led her to desire sterilization, but she did not go through with the procedure as a result of broken trust in providers during childbirth.

Well, they have made me not want to go get pregnant, because what if I go through the same situation, and I have to go back there? I don't want to deal with them, so I don't want to have no more kids. They made me want to tie my tubes. And I didn't want them to do it, so I didn't even get my tubes tied there. I don't want them to touch me no more. I feel like I probably wake up with something inside of me that they done tied up in me, messing with my tubes, or cut too much, or cut too…I don't know, I don't trust them. And that just made me not want to go there. It made me not want to give birth no more. It made me not even…they asked, can they tie my tubes. They told me to come back. Nope, I'm not. Don't touch me. I don’t want nothing to do with y'all. (#499, Fair PCMC-US Score – 56.2, Would Give Birth at a Different Hospital)

Lastly, many participants expressed never wanting to step foot in their birthing hospital again based on the care received during birth. One Black woman shared she would rather not receive the care she needed than to go back to her birthing hospital, which ultimately led her not to want to reproduce in the future.

Like God knows if something happened and someone had to take me to [redacted hospital], I would tell them to just leave me, because that's just not a place I want to go for maternity care again. And once I left, I would tell people I just didn't want to have another kid. Like my first daughter, she would be the first and last. If she wanted a sibling, she'd have to get like an animal or something, because I just didn't want to go through that experience again. (#621, Fair PCMC-US Score – 66.7, Would Not Give Birth Again)

Table 4
Additional Illustrative Quotes by Theme

Theme	Illustrative Quote
Seeking autonomy in birth	"You know, that was my 4th baby, and I feel like what it did was make me for sure know that I'm going to have an at home birth if I do have any more kids. Because I think I was just afraid to do it this last time. But that the last experience was validating to me, that I want to have it at home because I wanted it my way" (#481, Fair PCMC-US Score – 64.8, Would Give Birth at Home)
Hypervigilance or fear in subsequent pregnancy	I would never, ever, ever have a baby at [redacted hospital] again. I would do a home birth or I will probably try to find.. I will do my research on the Doc that I pick before I just up and go with a hospital, because that's what somebody recommended. (#528, Fair PCMC-US Score – 57.14, Would Give Birth at Home)
Reproductive decisions shaped by mistreatment	Well, it's kind of both. But you know, I don't know if I'm gonna have kids again because of that experience. And then, you know, as far as the hospital, I just didn't like that at all, and I just I don't think I have another baby there. I had, like I said, I went to them the first time, because I was with [redacted hospital] before, and you know, I kept telling them, "I'm in pain, I'm in pain, I'm in pain", every time I would go to a prenatal visit. And that was my first time being pregnant. And you know, when I finally kept going, they just kept telling me ain't nothing wrong, but everybody kept telling me you should not be experiencing pain like that. I couldn't walk. I was extremely huge, and they kept telling me it's just normal. But when I went to [redacted hospital], they discovered I had preeclampsia, and they wanted to, you know, induce me immediately…And that's what made me go back. But after this, because of how I was, you know, treated, I wouldn't go back. (#529, Fair PCMC-US Score – 66.7, Birth at a Different Hospital)

Integration of Findings

Both quantitative and qualitative findings demonstrate that Fair/Poor PCMC or aspects of care that deny respect, dignity, communication, autonomy, and responsive care influence the decision to birth in the future or in a hospital-based environment. Additionally, despite varying levels of PCMC-US scores among interview participants, the care experiences of Black women led to hypervigilance regarding subsequent pregnancies. For those open to subsequent pregnancies, they desire more autonomy, home births, midwifery models of care, and doula support to ensure dignity, safety, and survival.

Discussion

This mixed methods study examined the relationship between person-centered maternity care and Black women's intentions for future pregnancies. In doing so, we aimed to better understand how Black women's interactions with healthcare providers and hospital systems during childbirth influence reproductive decision-making, particularly within the context of persistent racial and structural inequities in maternal care. Quantitative findings reveal a significant relationship between person-centered care and its influence on Black women's future pregnancy and birth setting intentions, with Black women receiving fair/poor person-centered care having significantly higher odds of wanting to give birth in a different hospital, at home, or not give birth again at all.

The mean PCMC-US score for our sample of Black women was lower than scores reported in previous studies with majority or exclusively Black women (12, 20, 22). A previous study using the PCMC-US scale to measure the care experiences of Black women in California reported a mean score of 91.6 out of 100, compared to our mean score of 81.7 (12). Our lowest PCMC-US subscale scores were reported in *Communication & Autonomy* (80.0) and *Responsive & Supportive Care* (79.2), as reflected in interview responses regarding care. In comparison, during the adaptation of the PCMC-US scale, the lowest subscale score was 87.0 in *Communication & Autonomy*, and the highest score was reflected in *Dignity & Respect* (92.0) (12). For our sample, lower responsive and supportive care scores reflect neglectful practices, including feeling unheard, a lack of pain management, and receiving less support for birth companions, such as doulas. Lower communication and autonomy scores illuminate power imbalances, including gaps in information exchange, and a lack of shared decision-making.

Prior research on the development of the PCMC-US demonstrated its effectiveness in using scores to understand patient satisfaction and aspects of quality care, including their desire to give birth in the same facility (12, 24, 26). Prior findings revealed that more person-centered care are associated with the intent to give birth at the same hospital; however, the analysis did not include other birth settings (e.g., home birth) or the desire not to give birth at all based on the care they received during their most recent birthing experience (12). Our study includes qualitative findings that provide an in-depth understanding of how these care experiences influence Black women's future pregnancy and birthing intentions. Person-centered care is crucial for improving patient experience and health outcomes.

As an extension of our quantitative findings, our qualitative findings demonstrate that a lack of person-centered care produces not only immediate physical and emotional harm but also lasting distrust in hospital systems that influence reproductive decision-making and intentions. Within our findings and aligning with prior research, distrust in hospital systems and providers due to direct and vicarious harmful birthing experiences and the awareness of maternal health inequities contribute to heightened vigilance and fear surrounding pregnancy (27, 28). In response, many Black women in our sample desired more autonomous care with the support of midwives and doulas because they did not trust hospital-based obstetric care practices. Others sought to resist medicalized birth completely and give birth at home. Collectively, the quantitative and qualitative findings demonstrate how negative care experiences both constrain and reshape reproductive choices, while simultaneously fueling resistance toward more empowering forms of care.

Our findings and the previous literature collectively demonstrate Black women's motivations for alternative care models, community birth settings, and doula support (2, 28–30).

In one study, similar to our participants, Black pregnant women who sought doula care were in need of support, aware of mistreatment in birthing hospitals, as well as maternal and infant health inequities faced by the Black community (31). Doulas relieve the burden of Black women having to self-advocate, particularly when there is a deviation from their birth plan, and ultimately provide a more positive birth experience and outcomes(31–36). Black women also employ doulas as an act of racial reconnaissance, protecting them from anticipated or actualized experiences of obstetric racism(2, 28). A study, utilizing the PREM-OB Scale™ suite, found that the presence of a community support person, such as a doula and midwives, reduced instances of obstetric racism among Black women and birthing people within hospitals across the nation(37). In comparison, Black birthing people who lacked support from anyone

unaffiliated with their birthing hospital were more likely to receive less autonomous, more isolating, and more degrading care than those with support (37). Despite the need and desire to seek doula support, affordability poses a threat. As observed in a prior study exploring Black women's pregnancy and birthing experiences in the U.S., our study participants expressed costs as a barrier to seeking doula support (2).

In addition to doula support, our sample shared their desires for midwifery models of care and community births (i.e., at home or a freestanding birth center). Similarly to our study participants, a qualitative pilot study with Black pregnant and recently pregnant women in Florida identified resistance to medicalized birth, particularly epidurals, longer labor, and unnecessary cesarean births as a motivation for seeking midwives and doulas(38). They also identified community births as settings with greater autonomy and a sense of control than a hospital setting. Prior studies have assessed the impact of home births in the U.S. on maternal outcomes and experiences and found associations with receiving less mistreatment, having a full-term birth, and a vaginal birth following a cesarean birth (VBACs)(1, 39). Additionally, a recent study exploring the care experiences of Black women who had a home birth and a race-concordant midwife found that motivation to seek this model of care often involved a previous negative hospital birth experience (40), a care experience opposite to their home birth, which they described as more liberating, personalized, autonomous, high-quality, and supportive.

Strengths & Limitations

As with all research, this study has some limitations. The quantitative sample was relatively small and confined to a single geographic area, which limits generalizability. Further data collection in additional sites may validate and expand upon these results. Additionally, all births occurred in hospital settings, and there were no freestanding birth centers in the metropolitan area at the time of data collection, limiting birthing options in a community setting for our participants. Furthermore, we found that interview participants' survey responses did not always align with their interview responses regarding future pregnancy and birthing intentions (e.g., Participant #499). This could be due to survey fatigue, as the birthing intentions analysis question was at the end of the questionnaire or the influence of more time and reflection, with interview participants unpacking their birthing experience in ways they had not considered before, leading them to have a different perspective on their intentions for a subsequent pregnancy. For example, Participant #505 indicated on the survey that she would give birth at a different hospital; however, at the time of the interview, she revealed she was currently pregnant and was highly considering a home birth based on her previous care experience.

Despite these limitations, this study exhibits several strengths. Our sample identified exclusively as Black, a community burdened by infant and maternal health inequities, who frequently report less person-centered maternity care, mistreatment, and experiences of obstetric racism. Most studies utilizing the PCMC-US are conducted in California, a state that has some of the lowest maternal mortality rates among Black women. The Mama Certified Birthing Experience study took place in the greater Cincinnati area, a metropolitan area of Southwest Ohio, a city and state with stark infant and maternal mortality rates and a deep history of anti-Black racism given its location on the banks of the Ohio River, which served as a hallmark of freedom and refuge for enslaved people during the antebellum era. Therefore, findings may be relevant to other areas of the U.S., with similar disproportionate outcomes and rooted histories (41–44). Furthermore, we used a validated scale specifically adapted for Black women and birthing people in the United States. Lastly, we used a mixed methods approach to add depth and breadth to the examination of maternity care experiences; the first study to integrate both quantitative and qualitative data to explore Black women's future pregnancy and birthing intentions based on their most recent medical encounter during a childbirth hospitalization. Among all racialized communities, Black women are most significantly declining in U.S. births (4), and although complex, the awareness of maternal health disparities and harmful maternity care experiences may be a contributing factor. Future qualitative research should explore medical and non-medical (e.g., social) drivers that shape Black women's decisions not to birth. Although every woman or pregnant-capable person has a right not to have children, there is a need to address the health system's role in negatively shaping this decision.

Conclusion

In conclusion, the Mama Certified Birthing Experience Study addresses a critical gap by examining how care experiences influence future pregnancy and birthing decisions among Black women, an area largely overlooked in existing research. Grounded in a reproductive justice framework and a community-led research approach, this mixed methods study demonstrates how Black women's care experiences influence trust, perceptions of safety, and willingness to re-engage with hospital systems following pregnancy. We urge scholars and practitioners to move beyond documenting harm alone and instead integrate validated measures with the narratives of Black women and birthing people to provide actionable evidence to inform practice, policy, accountability models, and patient-centered reforms. Ultimately, this work contributes to ongoing efforts to ensure that Black women and birthing people not only survive childbirth but experience care that does not impede their right to quality, respectful, and autonomous care that is free of racism and harm.

Abbreviations

CI
Confidence Interval
OR
Odds Ratio
PCMC
Person–centered maternity care
PCMC
US–Person–Centered Maternity Care Scale–United States
PCPC
Person–centered prenatal care
PREM

OB Scale™–Patient Reported Experience Measure of Obstetric Racism Scale
REDCap
Research Electronic Data Capture Application
SD
Standard deviation
U.S.
United States
VBAC
Vaginal birth after cesarean

Declarations

Human ethics approval and consent to participate – This study was conducted in accordance with the Declaration of Helsinki. Participation in this study was voluntary, and written informed consent was provided by each participant prior to data collection. Ethics approval was provided by the Institutional Review Boards at the University of California, Davis, and Cincinnati Children's Hospital and Medical Center.

Clinical Trial number: Not applicable

Consent for publication – The authors provide consent for the publication of the data detailed above.

Availability of data and materials – To protect participant privacy, survey data and interview transcripts are only available from the corresponding author upon a reasonable request.

Competing interests – The authors declare no competing interests.

Funding – Not Applicable

Authors' contributions – DSO, DW, JJ, LP, BDCB - Contributed to the design of the study; DSO, KC, JJ, DW - Collected & analyzed data; DSO, KC, JJ, PA - Interpreted the data; DSO, KC, JJ, TH – Manuscript writing; DSO, BS, LE, PA, BDCB, JT, LP, MS – Manuscript editing. All authors reviewed and approved the final manuscript.

Acknowledgments – We'd like to thank our three community researchers, Dr. Mika Karkari, Mia Crockett, and Brandi Colvin, for their contributions to the qualitative research of this study and their commitment to Mama Certified. We'd also like to acknowledge Celeste Laing for her support with the coding process.

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Figures

Figure 1.

Mean Total & Subscale PCMC-US Scores by Pregnancy and Birth Setting Intentions

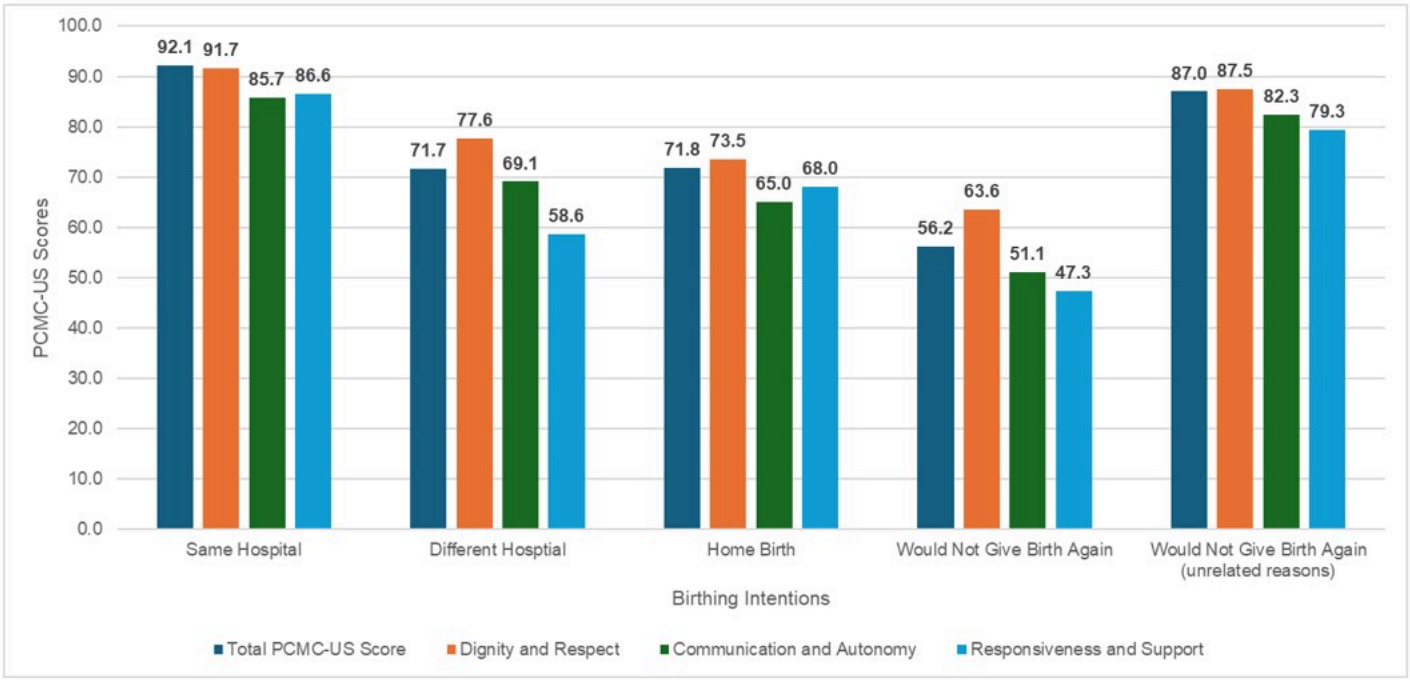


Figure 1

Mean Total & Subscale PCMC-US Scores by Pregnancy and Birth Setting Intentions

Supplementary Files

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- SuppFile1MamaCertifiedBESurveyQuestionnaire09Jan2024.docx