IDENTITY AND PRIORITIES FOR SOCIAL CHANGE: AN EXPLORATION OF AFRICAN-AMERICAN WOMEN’S PERSPECTIVES ON THE CURRENT MATERNAL-CHILD HEALTH CRISIS

Cathleen J. Appelt, PhD & Jessica Devido, PhD, CPNP

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Abstract: The United States has experienced a marked uptick in rates of both maternal mortality and morbidity. African-American women and infants are disproportionately affected by this current health crisis. This community-engaged research represents a qualitative exploration of the varying perspectives, identities, and social relationships among African-American women in an inner-city neighborhood in Pittsburgh, Pennsylvania. Emergent themes from focus group discussions with 49 residents and leaders in the community suggest the existence of multiple identity-based “wisdoms” related to maternal-child health. Preliminary findings indicate the importance of identity in conceptualizations regarding the causes of and community-based solutions to this current health crisis. Understanding of plurality in identity, definition, and meanings associated with maternal-child health within the community could profoundly enhance the development of initiatives that are successful, empowering, and sustainable.

About the Authors: Dr. Cathleen Appelt is an Assistant Professor in the Department of Sociology at Duquesne University. Her areas of specialization include research methodologies (both qualitative and quantitative) and health inequality. She completed her doctoral degree in Sociology from the University of Pittsburgh in 2002 and a three-year, National Institute of Mental Health-funded Postdoctoral Research Fellowship in the Department of Psychiatry in the School of Medicine at the University of Pittsburgh. Her current work is focused on the roles of social interaction and identity in health processes. Shortly after coming to Duquesne, Dr. Appelt began collaborating with Jessica Devido, PhD, CPNP, from Duquesne’s School of Nursing. Their two community-engaged projects are focused on improving maternal-child health outcomes for African-American families in Pittsburgh. Their work has been supported by Duquesne’s Center for Community-Engaged Teaching and Research, The Center for Catholic Intellectual Tradition (Rice Fellows Award), and The McAnulty College and Graduate School of Liberal Arts.

THE CURRENT MATERNAL-CHILD HEALTH CRISIS
Maternal-Child Health (MCH) Crisis in U.S.

Maternal Mortality (per 100,000 live births)

MCH Crisis in U.S. (cont’d)

Rate of maternal mortality has drastically increased in U.S. in last 20 years

Increasing at the same rate as it is in Chad, Africa and in Afghanistan (think slope of a line representing rates through time), but for VERY different reasons

- Chad and Afghanistan – sepsis and hemorrhage
- U.S. reasons: poor general health of population (including even teen girls!); more than half of U.S. women who become pregnant are at higher than a healthy weight; access to care issues; and social inequality

MCH Crisis in U.S. (cont’d)

The U.S. Crisis – race-based inequities:
- U.S. African-Americans have worse rates than U.S. whites
- African-American women with diabetes are 4x more likely to die in child birth than white women
- Pregnant African-American women with hypertension are 10x more likely to die than their non-Hispanic, White counterparts

Figure 1: U.S. Maternal Mortality by Race, 2011
Source: Centers for Disease Control and Prevention, based on graphic by Tiffany Farrant-Gonzalez in Scientific American (2015)
MCH Crisis in Pittsburgh, PA

In the city of Pittsburgh, the race-based maternal-child health gap is even greater than that at the National level (all figures are per 1,000 live births)

- Infant mortality: AAs = 17.72 vs. 4.25 for whites
  
Pittsburgh AAs are fairing far worse than AAs at national level, while the opposite is true for Pittsburgh whites

- Preterm (early) birth: AAs = 15.8 vs. 9.2 for whites

- Low birth weight babies: AAs = 15.2 vs. 7.1
  
AAs women in Pittsburgh > 2x as likely, as white women, to have low birth weight babies

Source: Alleghany County Department of Health (2010)
Development of the Wise Women Study

Problem-Specific Research Questions:

1) Are there women in the African-American community who serve as key providers of guidance related to maternal-child health information?

2) What types of health-related information (e.g., conventional or alternative medicine-based information) are relayed and received by women in the community?

3) Are there additional informational, programming, or dissemination needs of the community with regard to maternal-child health?

Novel framework – What are the points of strength in the community?
Wise Women Study (con’t)

The Rest of Our Community-Engaged Research Team

Jessica Devido, CPNP, PhD
School of Nursing
Project PI

Celeta Hickman
UJAMAA Collective
Community Partner

Rev. Paul Abernathy
FOCUS Pittsburgh
Community Partner

Terri Baltimore
Hill House Association
Community Partner

Honorary Community Partners:

Kristina Abernathy
FOCUS Pittsburgh

Deborah Germany
Divine Intervention Ministries
Evolution of My Sociological Question

- Original plan (proposal)
  - Combine social ecological approach (seeking community leverage points for change) with a social network approach

- Revised Sociological Approach (Year 2)
  - Based on time spent in the community during Year 1
    - Issues related to identity and stigmatization of young, unwed African-American mothers in maternal health could not be ignored
    - Some women seemed to be employing stigma navigation strategies
Interactionist Perspective

- Micro-level sociological perspective, conceptualizes ‘society’ as the product of situated interactions, focuses on individuals’ interpretations of events and construction of meaning.

- As indicated by Leon Anderson and David Snow (2001), the interactionist perspective offers a promising framework for understanding the:
  - manifestations and consequences of inequality in everyday lives
  - strategies that people employ to navigate status affronts.

My Research Questions

☐ In their everyday interactions, do young, African-American mothers (and mothers-to-be) experience stigma enactment and/or other more subtle status affronts?

☐ What are the consequences of these affronts (from the perspectives of the participants)?

☐ Do African-American women employ specific strategies for navigating these types of interactions?

☐ Are experiences, perceived consequences, and strategies for navigation consistent within a community?

☐ With regard to “Wise Women,” are there multiple wisdoms?
Methods: Overall Design

- **Prior to Application for Funds:** Established relationships with three community partners, developed project objectives and design, hammered out divergent disciplinary perspectives and priorities.

- **Year 1:** relationship building
  - Hosted “Meet and Greet Events” with six organizations (we provided refreshments, information, and $500 donation to each organization) attendance
  - Investigators attended other events and meetings in the community

- **Year 2:** Focus Group Data Collection (N=49)
  - **Community Leaders Groups (3):** the focus of this analysis
  - Women of the Community Groups (3)
  - “Wise Women” Groups (2)
Methods: Sampling & Recruitment

- All 49 participants recruited by referral
  - **Leader groups (3, N=22):** from our community partners
  - **Women of the community groups (3, N=22):** from leader groups
  - **“Wise Women” groups (2, N=6):** from leader and women of the community groups

- Recruited via flyers distributed to community partners and previous participants
Methods: Data Collection

- Informed consent, brief self administered questionnaires: sociodemographic and use of community’s services

- Focus Group
  - 10-min Video on MCH Crisis (all group types)
  - Discussion facilitated by Appelt and Devido
  - Brainstorm activities:
    - Leader Group (greatest MCH issues in community)
    - Women of Community (sources of MCH info)
    - “Wise Women” (no group activity)
Methods: Analysis

- Data from group discussions: transcripts coded and analyzed using grounded theory/constant comparative method
- Socio-demographic questionnaire data were entered and analyzed using IBM SPSS, Version 22.0
- MS Excel spreadsheets were used to evaluate data from the brainstorming and ranking of priorities activities

Note: This is an in-progress presentation and formal analyses have only been completed for the Leader groups (discussions, group activities, and socio-demographic data, but not utilization of community resources and businesses)
Outline of Findings

- Description of Each Leader Group
  - Relationship to/Role in the community (& organizational goals)
  - Position of group members relative to MCH issues
  - Individual characteristics of participants

- Emergent themes within each group
  - Identity and stigma: description and navigation

- Priorities/solutions for change within each group
Findings – General Group Description of the “Faith-Based, Social Entrepreneurs”

- **Group 1**: Ten individuals recruited by the leaders of two (closely integrated) “faith-based, social entrepreneurial organizations” operating inside the community:
  - Organization A: provides a wide-range of informal services: vocational training, job placement, clothing, household items, bus passes, food, weekend backpack food program for school-aged children, and one-room clinic (with volunteer docs), volunteers go to homes to check on community members (wake/feed children for school)
  - Organization B: provides instrumental supports, “ministry,” and referrals to individuals in the community who are re-entering society after incarceration

**MCH Involvement**: Most of the women were mothers/grandmothers, a couple have worked in health care (but not MCH care), most were not aware of maternal-child health crisis, relatively low, but direct involvement in MCH issues
Findings – General Group Description of the “Sisterhood”

- Group 2: Seven women recruited by one of the founders of an organization that supports the initiation of African-American woman-run businesses in this community and promotes entrepreneurial ventures among women artists and craftspersons on the African continent.

- The women all know each other well (and have “for years”).
- Refer to themselves as “sisters”.

- MCH Involvement: Nearly all were aware of maternal-health crisis, at least one of the women has worked as a doula and three of the women are involved in proposing a doula training program for teen girls, relatively high level of involvement in MCH issues.
Group 3: Five women came to this focus group through the Director of an organization (located in the community) that houses many organizations providing services to members of the community (and low-income persons residing outside of the community).

- Caseworkers
- Connect persons in need with existing services

MCH Involvement: Most were unaware of Maternal-health crisis, some reported working with teen girls/young women and noted need for services, discussants have a moderate level of involvement in MCH-related issues
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>“Faith-Based SEs”</th>
<th>“Sisterhood”</th>
<th>“Social Workers”</th>
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<tbody>
<tr>
<td>Number of Participants</td>
<td>10</td>
<td>7</td>
<td>5</td>
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<tr>
<td>Mean Age (Std. Dev.)</td>
<td>54.1 (13.9)</td>
<td>53.0 (15.0)</td>
<td>41.6 (11.9)</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
<td>9 (90)</td>
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<td>Male</td>
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<td>1 (14.3)</td>
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<td>Race, N (%)</td>
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<tr>
<td>African-American or Black</td>
<td>9 (90)</td>
<td>5 (71.4)</td>
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<td>Caucasian or White</td>
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<tr>
<td>Other: South African</td>
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<td>0 (0)</td>
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<tr>
<td>Other: White and Black</td>
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<td>--</td>
<td>1 (20%)</td>
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<tr>
<td>No response</td>
<td>0 (0)</td>
<td>1 (14.3)</td>
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### Educational Attainment, Household Income, and Location of Residence by Group

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>“Faith-Based SEs”</th>
<th>“Sisterhood”</th>
<th>“Social Workers”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Participants</strong></td>
<td>10</td>
<td>7</td>
<td>5</td>
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<tr>
<td><strong>Educational Attainment, N (%)</strong></td>
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<td>&lt;HS Diploma</td>
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<td>Some College</td>
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<td>Master’s or Higher</td>
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<td>2 (40)</td>
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<td><strong>Household Income, N (%)</strong></td>
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<td>Below $15,000</td>
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<td>$25,000-$49,000</td>
<td>3 (30)</td>
<td>2 (28.6)</td>
<td>2 (40)</td>
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<td>$50,000 and above</td>
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<td><strong>Home Residence, N (%)</strong></td>
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<tr>
<td>In Community</td>
<td>6 (60)</td>
<td>6 (85.7)</td>
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<td>Outside of Community</td>
<td>4 (40)</td>
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<td>5 (100)</td>
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<td>No response</td>
<td>0 (0)</td>
<td>1 (14.3)</td>
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Marginalization of African Americans by Medical Community

- Young AA females intimidated by going to doctor
  - Won’t ask questions/Don’t know what to ask
  - Providers do not “volunteer information” – you have to ask
- They assume “we are all drug addicts”
  - Practicing nurse, who was former patient of physician with whom she now works provided story in which she managed situation by assuming role of “educator” to her superior at work. To physician, she indicated:

  “I had, a surgical procedure, hysterectomy, no big secret, years ago...and you gave her pain medicine, but you told me I’ll be OK [...]... You give these, both of these Caucasian White ladies [pain medication]...but [when it’s me, you say,] ‘you'll be ok.’ [...] and this is why people don’t trust you, because they see things like this. [...] There are people that are drug addicts. There are a lot of nurses that are and all of them don’t look like this girl that is sitting in this chair.”
“Faith-Based Entrepreneurs” - Identity and Stigma-Related Themes

- Gender – girls labeled as “bad”
  - Teen/unwed, pregnant African-American females
    - Publicly judged in church (two separate stories)

  “[My friend’s daughter]… she was going to this non-denominational church. When she found out she was pregnant, she had to stand in front of the congregation and apologize for what had happened. I think sometimes we are so quick to just call them out publicly.”

  - Stigma navigation strategy: avoid church (some for several generations of women)

  “My mother in law is eighty-something years old. Still doesn’t want to go to church because that happened. Because they made her go up in front of the church or put her out of the church when she got pregnant with her oldest child and she still feels the same way about the church. She won’t even go to church.”
“Faith-Based Entrepreneurs” - Identity and Stigma-Related Themes

- **Gender – “Trope of the Strong Black Woman”**
  - Don’t ask for help
  - Have to do it all alone

One respondent reflecting on her own teen motherhood experience, and how she parented her own daughters:

“I still carried that trope of the ‘Strong Black Woman.’ And I raised my daughters to prepare to be mothers, not wives. So, they never knew how to ask for help. They never knew how to navigate systems to look up information, to reach out, to connect with communities, and to be able to be vulnerable enough to say, ‘I need help!’“

- **Consequences of the ‘Strong Black Woman’ sited by participants:**
  - stress
  - poor health
  - isolation
“Sisterhood” -
Identity and Stigma-Related Themes

- Identity as “mother” among young, African-American girls/women
  - Underestimating the impact of motherhood on one’s life

  “I can’t get through to my daughter. You must sacrifice! This little person has changed the algebra in your life. They are a variable in every equation now. Look, even taking a shower and shaving your legs... You have a kid and want to do that? Do the algebra!”

  - View infant/child as separate from them and as “an interruption” – one respondent indicated that “Western” [White] parenting culture” and commercialism is responsible for this.

  “When New Futures came about, after the Mayor’s Commission on Families, the big giveaway was strollers...and the big giveaway - a baby carriage. And the big giveaways were things that kept you from your child!”
“Sisterhood” - Identity and Stigma-Related Themes

- “Identity Problem” among young mothers (cont’d)
  - “Oversexualization” of African-American girls and women
    - Current Hip Hop music/culture

  “When I was coming along and hip hop was on the scene, there were beautiful songs about one love, one love, one lucky ...just nice hip hop. […] But now, if a hip hop song does not make it through the strip club [scene] in Atlanta, Houston and Miami, its not getting on the radio. They got to make it bounce. Gotta’ have that right thing for the strip club. So, that shows how our culture is just intricately linked up with unhealthy concepts about women, about sex, about your reproductive organs, about your body.”

- Same respondents attributes low rates of breastfeeding in the African-American community to stronger identification of the breast as “sexual rather than nutritional”
African Culture – reconnecting with ancestral culture to navigate stigma?

Highest reverence for the “matriarchal principle” and can help a woman:

- “When her confidence as a woman with child is challenged or interrogated [by Western, male doctors]”
- “in maintaining her identity’ up until the birth of her child”

“It [my faith] was all the empowerment that I had. It was the only tool that was available to me in that particular situation. I never had a caesarean before […] and when I was in that OR I begged [two Gods] to come help me. ‘Cause that was all I had and it was a disruption to the OR. I started chanting, my husband started chanting with me, and the more the pain, the more intense the pain was, the louder the chanting got. I had to bring Africa into that room because it was all I had, I tell you. And had I not started chanting and asking for that help, I would have passed out. I wouldn’t have made it. […] Well, we ask those forces to come be with us when your being assessed, your being tested, interrogated in some regards and you have to have, you have to maintain your sense of self and your identity up until the birth itself.”
“Sisterhood” - Identity and Stigma-Related Themes

- African Culture – reconnecting with ancestral culture to navigate stigma? (cont’d)
  - Nigeria – there are “midwife societies”
    - “Midwifes are viewed as most revered and sacred citizens”
    - Songs, dances, and rituals dedicated to “baby catchers”

- General concepts from African culture shared by this group
  - Natural is better: breastfeeding over bottle
  - Keep the baby close – wear the baby by using wrap or sling
  - Children are taught to think beyond themselves – consequences of one’s actions
50+ years ago motherhood was different

Did not have choice to breast feed

“I’m listening…I mean, it was so long ago for me! I’m 77 years old and my son, my oldest, is 60. And my youngest, he, is in his 40s. [...] I was just 15 when I had my first child and so I couldn’t breast feed. No way. ‘Cause nothing was there and it was painful for me. So automatically over here at [name removed] Hospital, they put you on formula. So, with all five of my sons, I never did breast feed anyway. Yep.”

Motherhood was about cooking and keeping a nice house

“What you all are talking about is really Greek to me. I never even, I didn’t know about the how many babies had died, cause that was never in my area. Mine was more like, housekeeping. That’s where everything is for me. Keeping a nice home, cook, that’s what we did.”

Regarding motherhood identity in older age, same participant said,

“[Now,] I am the matriarch. I am the matriarch of this family and you don’t do this and you don’t do that. They all look at each other. They know don’t say nothing. ‘Cause I am the matriarch and supposed to tell them. That is my job.”
“Stepping In” – taking over the role of mother to one’s siblings

- Of one of the women who “stepped in at an early age,” other respondents indicated that she “was always so serious.” The other young women rarely asked her go out with them, “We didn’t even approach her with that.”
- One respondent noted that “stepping in” has its roots in African tradition and is good for fostering responsibility.
- The respondent who ‘stepped in’ at early age noted how stressful it was, especially when she was in college after her mother passed away:

  “Even at [name of University], the nuns and the support system that I had [there] was phenomenal, I always felt like I had to had this scowl. [I had to] adhere to this thing or my life would fall apart. It’s only until recently that if something goes down in the family, I’m like, ‘OK, what alternatives do we have?’ My sibling is like, you smile now. You laugh at jokes now. Because [before] I had to be so responsible.”
Many “personalized” the information from the video - expressing greatest (compared to other groups) concern related to the inability of education to ameliorate the effects of race on MCH outcomes

- Most attributed race-based MCH disparities to mental health issues
  - Mental and emotional stress associated with becoming a mother living in poverty
  - Unresolved trauma-related issues
  - Young women/teens more susceptible to postpartum depression, because they are less likely to have resolved prior trauma issues and their minds are not fully developed

- Seeking mental health care and possibly prenatal (or other MCH) care is highly stigmatized in the African-American community
  - “There are certain things that you don’t share about your life and so to go potentially to a white provider with that voice in your head [talking]about [how]you don’t share what goes on in your house with somebody who may not understand your life experience, is a challenge as well.”
  - May apply to MCH care, because “no one [in the community] is speaking out on it.”
The “Social Workers” group members had mixed thoughts about African traditions

- One respondent was strongly opposed to this:

  “That tradition stuff is out the window. I know... I need... just for someone who has had a baby, and had a baby at a young age, I can’t have JoJo across the street coming over and all of that. I need to be at a hospital, where [there is] somebody that went through training and [is] educated to do that.”

- Some took a middle of the road position

  - It would be OK for women with uncomplicated pregnancies, but that it is not for everyone and/or it is OK in compliment to Western medical care

- Positive reactions took various forms:

  - MCH techniques could reduce maternal stress (that group had listed as cause of poor MCH)
  - It could be positive if it involved training and led to entrepreneurial ventures for women
  - It would be beneficial to have people from the community involved in MCH care
Selected quotes related to traditional African approaches to MCH

Could help women to deal with stress associated with race and poverty stigmatization

“Personally, my best friend is pregnant right now and she is choosing to have a midwife and a complete natural birth. [...] I have a whole new respect for it. [...] She just asked me to download some stuff for her that her midwife gave her and it’s relaxation techniques. Like that stuff all ties back to some of the issues that African-American people face with trauma. If you’re dealing with someone who has trauma and poverty issues, things like that, racial issues, that type of meditation can help you center yourself.”

Not taking care of oneself can be an outcome of stigma and that connecting with African traditions may help to promote better health:

“So here is this mid-wife teaching my friend to do this to deliver her baby. So, it’s possible that there are those techniques in that [that] would help unify and maybe break that whole stigma that [name of other participant] brought up that is in the community. There is a stigma of how African Americans or black people are living that can sometimes prevent you from taking care of yourself. But if you’re going to somebody who is living and fighting against those things...stigmas., but in her heart is to take care of you and to help you become a better person, I would definitely consider it.”
“Faith-Based, Social Entrepreneurs” Group - Priorities for Change Related to MCH

Narrowed brainstorming to 4 priorities, individuals picked their own top 3:

- Education specific to MCH and parenting
  - 1st or 2nd choice for 7 (70%) of participants
- More low income housing
  - 1st or 2nd choice for 6 (60%) of participants
- Clinic, located in community with African-American providers, who won’t “judge” pregnant girls/women and who will provide verbal validation (“You are not a Jezebel”): 1st or 2nd choice for 4 (40%) of participants
- Transportation: 1st or 2nd choice for 3 (30%) of participants

Recall that main themes for this group included: marginalization by medical community, shaming of unwed pregnant girls/women, view of girls as “bad,” and the Trope of the Strong Black Woman

- The community-based clinic, as conceptualized: addresses, potentially, the first three
- The educational programming: may be helpful to women afraid to ask for help support and/or inform them of available community resources
“Sisterhood” Group - Priorities for Change Related to MCH

Narrowed brainstorming to 5 priorities, individuals picked their own top 3 (Note: 7 priorities are listed here, because one participant cast a ballot that included 2 previously eliminated priorities; 2 participants did not participate in this exercise):

- No healthy food/people don’t know how to cook - 1st or 2nd choice for 3 (60%)
- Education pertaining to community problems - 1st or 2nd choice for 2 (40%)
- Affordable, stable housing: - 1st or 2nd choice for 2 (40%)
- Women w/ children need info. re: what to do in a crisis - 1st or 2nd choice for 1 (20%)
- Oversexualization of girls/women: 1st or 2nd choice for 1 (20%)
- Girls/young women lack self-respect: 1st or 2nd choice for 1 (20%)
- Lack of communication within community: no 1st or second choices (3rd for 1 (20%)

Recall that main themes for this group included: identity problems among young mothers, shifting their own identities to align with traditional African conceptions of motherhood, changes in definition of motherhood (used to be ‘domestic capacity’), older women as matriarchs, and the stress of “stepping in”

- Concern over healthy food and knowing how to cook: resonates with the holistic conceptions of maternal-child health and the domestic dimensions of motherhood mentioned
- Education related to community problems: this priority for change seems potentially related to traditional, African teachings regarding the need to look beyond oneself
Narrowed brainstorming to 4 priorities, individuals picked their own top 3

- Alleviate poverty- 1\textsuperscript{st} or 2\textsuperscript{nd} choice for 4 (80%)
- Medical Insurance- 1\textsuperscript{st} or 2\textsuperscript{nd} choice for 3 out of 5 (60%)
- Affordable, stable housing: -1\textsuperscript{st} or 2\textsuperscript{nd} choice for 1 (20%)
- Unresolved trauma-related issues- 1\textsuperscript{st} or 2\textsuperscript{nd} choice for 1 (20%)
- Access to healthy food: 1\textsuperscript{st} or 2\textsuperscript{nd} choice for 1 (20%)

Recall that main themes for this group included: attributing MCH issues to mental health and stress, stigma associated with receiving mental health care and possibly MCH care, and group members had a variety of perspectives regarding the utility of identification with African culture/traditions and MCH.

- Poverty: given that this is a group of caseworkers (who live outside of the community) — not surprising
- Medical Insurance: much of the conversation surrounded concern with stigma associated with accessing health care, specifically, that of mental health services. While the group discussed the impacts of stress frequently, the group seems to attribute this, at least in part, to an access to mental health care issue.
Conclusion

With regard to my research questions…
Yes, African-American women experience status affronts related to maternity (ex: medial marginalization, pregnancy shaming)

Yes, these status affronts have potentially meaningful MCH-related consequences (ex: delayed prenatal care, lack of health care, lack of social support)

Yes, African-American women employ strategies for navigating stigma and related status affronts (ex: avoidance, taking on role of educating white people, redefining their identity)

Experiences and strategies related to stigma varied across the groups with whom we spoke.
Thank You!

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