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Centering Black Women's Voices: Illuminating Systemic Racism in Maternal Healthcare Experiences

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Abstract: The racial disparity in Black maternal healthcare outcomes in the U.S. reflects the devastating impact of systemic racism embedded within the healthcare system. This study addresses Black maternal health by centering Black women's perspectives to illuminate how systemic barriers, racism, and unequal care manifest in their maternal health experiences. We conducted six focus group discussions with 27 Black women in Harris County, Texas, an area with an alarmingly high Black maternal mortality rate. The analysis revealed three main themes: (1) institutional barriers to equitable maternal care, (2) inequitable clinical care and provider–patient interactions, and (3) navigating experiences of everyday interpersonal racism. The women's narratives provide insights into how systemic factors such as racism and unjust policies compromise the pursuit of optimal maternal care. By centering their situated knowledge, we can understand and develop solutions that emerge directly from the lived realities of this community.

Keywords: systemic racism; Black maternal health; maternal health disparities

1. Introduction

The stark disparity in maternal healthcare outcomes for Black women in the United States reflects a persistent and urgent healthcare crisis that requires both immediate attention and systemic reform. In 2021, the maternal mortality rate for Black women was 69.9 per 100,000 live births, nearly three times higher than the rate for White women [1,2]. This statistic reflects the deadly impact of systemic racism on the U.S. healthcare system, which has produced centuries of inequity in access to quality maternal care and poorer health outcomes for Black mothers. Systemic racism is a material, social, and ideological reality deeply entrenched in interconnected systems, such as political, economic, and social structures [3,4], and thus extends well beyond individual prejudice and bigotry. It operates through the day-to-day practices, policies, ideologies, and beliefs that shape the lived experiences of marginalized communities, such as Black women and their maternal health outcomes. Systemic racism significantly shapes the inequities Black women experience in maternal care today and is deeply rooted in a centuries-long history of oppression in healthcare settings such as the forced labor of medicalized chattel slavery, race-based pseudoscience, and reproductive oppression [5,6]. Historical medical practices, such as the experimental surgical operations that were performed on enslaved Black women by Dr. J. Marion Sims, highlight the unethical treatment of marginalized women. Sims conducted human operations without informed consent between 1845 and 1849, exploiting the institution of slavery to conduct ethically unacceptable human experiments [6,7]. The operations that Dr. J. Marion Sims conducted on enslaved Black women without anesthesia exemplified the dehumanizing medical treatment of Black women that was deeply embedded within the healthcare practices of that time [8]. Moreover, during the United States' eugenics era, from the late 19th century until the mid-20th century, the oppression of Black women was further compounded through state-sanctioned forced sterilization programs that sought to prevent the reproduction of those who were deemed "unfit" by the state [5,9].

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Forced sterilization "maintained racial hierarchies by controlling Black fertility" [5] more broadly, and had deeply rooted consequences for Black women's reproductive rights and maternal health outcomes.

The impacts of systemic racism on Black women's maternal health outcomes pervade throughout history. Contemporary research highlights the ongoing systemic factors contributing to disparities in maternal health. As Crear-Perry et al. [10] note, racism and implicit bias in healthcare directly contribute to suboptimal care and worse birth outcomes for Black women. These implicit biases are founded in unfounded beliefs about biological differences between races [11]. Research reveals that healthcare providers' implicit biases can lead to lower estimations of Black women's pain levels and therefore less treatment offered [11]. The implicit biases of healthcare providers have led to prolonged delays in care and diagnostic errors for Black women [12]. The use of race as a biological explanation in medical practice has resulted in discriminatory healthcare policies and racial inequities in maternal health. Further, the reliance on race-based medicine has resulted in medically, socioeconomically, and empirically unnecessary cesarean births as well as disparities in surgical treatments by race [13].

Despite quantitative evidence highlighting maternal health disparities [14], there continues to be a research gap in highlighting Black women's lived experiences and voices [15]. This oversight necessitates that research accounts for the unique challenges faced by Black women, whose lives are intricately shaped by their intersecting identities [16]. Black women's experiences make them experts on navigating the maternal healthcare system. This distinct standpoint shapes a situated knowledge [17–19] that is invaluable for illuminating the complexities of Black maternal health disparities as well as developing solutions centered on the needs and realities of Black women. Maternal health research must amplify Black women's voices to uncover the complex ways in which systems of power and oppression impact their lives [17]. By centering Black women's voices on maternal health, researchers can gain a more in-depth understanding on the experiences before, during, and after childbirth, as well as potential solutions and resources needed to create healthier birthing experiences.

The current study examined Black maternal health disparities by centering the perspectives of Black women in Harris County, Texas. Harris County has an alarmingly high Black maternal mortality rate of 106.01 deaths per 100,000 live births, surpassing the national average [20]. Using qualitative methods, we gained rich context-specific insights into the lived maternal health experiences of Black women in this high-risk area. The study revealed several major themes that illuminate how systemic racism shapes Black women's encounters with and navigation of the maternal healthcare system. These findings provide a nuanced understanding of the complex factors that contribute to adverse maternal health outcomes for Black women in Harris County and beyond.

2. Materials and Methods

Focus groups are used in this study's qualitative methodology to investigate the healthcare experiences of Black women during pregnancy and childbirth. A team made up of Black women, including public health sociologists, a community health consultant, and a physician, led these focus groups. They created a space that was both culturally sensitive and conducive to the participants' sharing their stories because of their collective expertise in comprehending the healthcare experiences and social structures Black women experience. The team had a thorough understanding of the various cultural, social, and health-related factors affecting the Black women. To ensure the participants' comfort and dignity, we implemented various strategies. Comfort measures included offering refreshments during the focus groups and setting up a welcoming environment with comfortable seating. In case any of the participants found a topic to be upsetting, a local mental health counselor was available to offer support to the participants.

In order to maintain the integrity and objectivity of the research, reflexivity was incorporated throughout the entire research process, with ongoing discussions about

potential biases and responses to the data that had been collected [21]. Participants for this study were actively recruited from the Third and Fifth Wards of Houston, Texas, through collaborations with local Black churches and community organizations. The recruitment phase spanned from late October 2022 to December 2022, during which various outreach strategies were employed to ensure a large and diverse sample of Black women. Invitation emails were sent to faculty members, Black church leaders, community health clinics, and local community and organizational leaders. Flyers were widely distributed, and personal phone calls were made to ensure the inclusion of Black mothers from diverse socioeconomic backgrounds. This grassroots approach was essential to ensure the participation of a wide range of Black mothers. Out of the 45 women who expressed interest, 27 Black mothers ultimately participated in the focus groups. The participating mothers received a $50 incentive. The participants ranged between the ages of 19 and 40. Twelve of the women had Bachelor's degrees or higher. Fourteen postpartum women gave birth vaginally, either with or without medication (see Table 1).

Table 1. Respondent demographics.

Characteristic	Respondents (n=27)
Age Range	
	19–40
Education	
Less than high school diploma	1
High school or GED	6
Some college	5
Associate degree	3
Bachelor's degree	6
Graduate	6
Number of Weeks Pregnant	
27–40	6
14–26	4
13 or less	3
Post-pregnancy	14
Chronic Health Conditions	
Yes	4
No	23
Doula	
Yes	2
No	25
Midwife	
Yes	7
No	20
Type of Birth (All pregnancies)	
Vaginal with medication	6
Vaginal without medication	8
C-Section	11
Both	1
Not yet delivered	1

The study employed six focus group discussions, providing the participants with a convenient and comfortable setting to share their perspectives. Each focus group discussion lasted approximately 90 min and followed a discussion guide featuring open-ended questions to facilitate an in-depth exploration of the topics. The information gathered through these focus group discussions formed the basis of the study's findings. The participants were asked the following questions:

1. What, if any, difficulties did you experience or are you experiencing during your pregnancy?
2. How did you feel about the care you received or are currently receiving from your health practitioner?

3. What barriers prevented you from receiving the quality of healthcare that you wanted when you were pregnant or after you delivered your baby?

Focus group meetings were audio recorded and transcribed with an automated transcription program. Then, qualitative program NVivo was used to aid in the organization and analysis of the data. The authors employed Braun and Clarke's [22] six-step thematic analysis methodology. This method entails becoming familiar with the data, creating preliminary codes, looking for themes, reviewing, defining, and naming them, as well as creating a report. In order to become familiar with the data, the research team first read and reread the transcripts. The transcripts were then independently coded, with pertinent words, phrases, or passages being highlighted. To enhance the rigor and trustworthiness of our analysis, we also engaged an external qualitative researcher to independently review a subset of the data. This external researcher coded the data without knowledge of the codes and themes generated by the research team. After receiving the external researcher's independent analysis, the research team compared it to our own codes and themes. We found there was strong alignment between the external researcher's codes and our own, which increased our confidence in the validity of our findings. There was a small number of discrepancies, which we resolved through discussion between the research team members until we reached full agreement. The few inconsistencies were minor and did not impact the overall themes and conclusions. The authors got together to compare codes, talk about inconsistencies, and come to an agreement. These codes were then assembled into potential themes and subthemes, reviewed frequently, and improved to accurately reflect the dataset.

The Texas Southern University's Institutional Review Board (IRB) approved the study. In order to participate, the women read and signed a written informed consent form, which included a full disclosure of the study's details and a guarantee that their participation would be kept confidential. The study participants were also made aware that they could withdraw at any time without suffering any negative consequences.

3. Results and Discussion

This study sought to explore the experiences of Black women in Harris County, Houston, Texas, during pregnancy and childbirth and in the postpartum period. The findings from the six focus group discussions with 27 participants revealed the significant issues that constricted these women's access to high-quality maternity care. Our analysis resulted in the identification of three main themes: institutional barriers to equitable maternal care, inequitable clinical care and provider–patient interactions, and navigating experiences of everyday, interpersonal racism. These themes advanced a nuanced understanding of the multiple factors specific to Black women that interact to shape their prenatal and postpartum healthcare experiences (see Table 2 for an overview of the themes and subthemes from the data). In the sections that follow, we explain these themes, including representative quotes from our participants.

Table 2. Themes and subthemes.

Themes	Subthemes	Number of Participants
1. Institutional barriers to equitable maternal care: Systemic obstacles limiting Black women's access to quality maternal healthcare.		
	Lack of diversity among healthcare providers	6
	Insurance and financial barriers	8
	Lack of hospital resources and staff	5
	Total	**19**

Table 2. *Cont.*

Themes	Subthemes	Number of Participants
2. Inequitable clinical care and provider-patient interactions: Disparities in care quality and communication between providers and Black women.		
	Inadequate pain management	4
	Disregard for patient autonomy	4
	Communication breakdowns	7
	Provider absence and unavailability	1
	Total	**16**
3. Navigating experiences of everyday, interpersonal racism: The pervasive impact of racism on Black women's daily lives and healthcare experiences.		
	Medical mistrust, neglect, and exploitation	6
	Weathering and chronic stress	2
	Distressing and dismissive interactions with providers	3
	Total	**11**

3.1. Institutional Barriers to Equitable Maternal Care

The first theme to emerge from the focus group discussions centered on institutional barriers. Our findings illustrate how these institutional barriers constrained Black women's access to quality maternal care [23]. A central issue for the Black women in our study was that of health insurance. One woman explained, "I don't feel like my insurance allowed me to really pick where I wanted to go and stuff like that. Um, I've had a lot of insurance issues, which is kind of stressing me out." This quote reveals how insurance can operate in ways that compromise choice, create stress, and possibly yield negative maternal health outcomes. Another participant explained how such barriers transpire:

> I was going to women's hospital, and they accepted my insurance and then all of a sudden my doctor... switched over to a different hospital... they didn't accept my insurance and... I had to go back to Harris Health.

The respondent illuminates how changes within the insurance companies can derail the continuum of care, affirming research that underscores the importance of a stable, long term healthcare professional–patient relationship to achieve better health outcomes [24].

Consistent with research which has identified staffing deficits as a critical issue in maternal health [25], our study also found a paucity of hospital personnel and resources as another critical institutional obstacle. For example, a respondent disclosed, "I had to be in the waiting room because there were no beds and no nurses at work... a lot of nurses was quitting... when COVID started." This account accentuates the pivotal role of adequate staffing in the provision of maternal healthcare and underscores the additional strain of the COVID-19 pandemic on healthcare providers.

Our findings also highlight that the participants were concerned with the absence of Black healthcare professionals, speaking to a representation issue as the participants often expressed a desire for more Black doctors and nurses. The participants contended

that Black healthcare professionals could create an enhanced experience because they were more likely to be understanding and empathetic of Black patients. One respondent talked about how a Black nurse led her to listen to the nurse's advice because she felt comfortable with her:

> ...When my daughter, um, when I was being triaged, I don't know if the nurse that I had was, uh, I had one Black lady nurse and I was cussing. I was, cuz I was in pain, <laugh>. And I still remember to this day that she told me, "Oh, no, no, no, no cussing," you know, but she was really sweet in her approach. And, and that was my first baby and, you know, [I] didn't know what to expect. I listened to her and I calmed down. Well, this other [White] nurse came in, she was really handling me. She was rough. Like, I don't know if she was ready to get off of work or I'm sure she was, but I told her, I said, "You are being too rough with me, ma'am, can you like, you know, just go a little easier?"

The respondents' preference for more Black healthcare professionals highlights a significant gap in the current healthcare system, notably the lack of demographic alignment between providers and patients. This issue can be analyzed through the lens of subcultural capital, which are social assets such as knowledge, skillset, appearance, and ways of being important and authentic to particular cultures [26,27]. Within the healthcare sector, subcultural capital can manifest as a shared understanding of cultural norms, experiences, and competencies. When providers and patients share a similar cultural background, it validates the patient's cultural capital, enhancing the quality of care through mutual respect and understanding. Thus, the demand for increased demographic representation in healthcare is not merely a call for diversity but an essential step toward addressing systemic inequities. For example, a respondent described an experience of working with a Black doctor for several months, but when it was time for her to deliver, she had to work with a White doctor that she was unfamiliar with:

> ...And then when I finally went in, I went at like three o'clock in the morning. I stayed up one night and they say, "Oh, can you come in?" I said, "Okay, I can be there." And then the [Black] doctor that I had all this time, who knew me, who I developed a relationship, wasn't there to deliver the baby. And I, I, selected a Black physician just because of, you know, just, you know, cuz you need a Black physician. But when I got there, I had a White lady telling me I had to have a C-section.

This finding suggests that an inability to access a Black physician can affect the development of trust and comfortability, which adds stress, uncertainty, and distrust during pregnancy and delivery. This finding corroborates existing research on patients feeling more at ease with providers who share their racial or ethnic background [28]. Several of our respondents also found it difficult to even access a Black doctor. One respondent stated:

> ...I wanted to um, get a doctor, a Black doctor who could, who I'll feel more comfortable with during my, uh, appointments. But it was kind of difficult for, for one [to be] assigned [to] me. So that was one of the major things I, I think I had a problem with.

Overall, the findings in this theme emphasize the crucial role systemic and institutional factors play in determining how Black women experience healthcare, emphasizing the need for policy-level interventions to address these structural problems. Lack of accessible insurance options, sufficient staff, and a lack of diversity among healthcare professionals are not just inconveniences; they are essential factors that can exacerbate health disparities and prolong cycles of injustice. These findings highlight the need for comprehensive, systemic reforms that go beyond superficial changes and fundamentally alter the design of healthcare delivery.

3.2. Inequitable Clinical Care and Provider–Patient Interactions

The challenges that Black women in maternal healthcare settings face are intricate and multilayered, and they are encapsulated by the theme of inequitable clinical care and provider–patient interactions. The respondent who vividly recalled the lack of anesthesia during her delivery serves as an example of how inadequate pain management is a significant problem. She stated:

> Um, they said that there wasn't enough time... but as soon as I got there, ... the first thing that I said is, "I want an epidural, so whatever you do, as long as I get... an epidural... this is what I want..." Because I hadn't dilated or was only dilated maybe a half a centimeter; they just said, "Oh, you know, well, we need to see if we're going to even admit you." And since it was my second baby, I was like, "Well, I don't dilate until I have the baby... I dilate that day and then I have the baby that day, so I've already done this..." They're like, "We'll check you in an hour," and an hour came, and they're like, "Oh my God, you're six centimeters dilated." I was like, "Well, yeah..." And so then they had to get... the order from the nurse... she's gonna come down. And they checked me again. They're like, "Oh, okay, well... you're eight centimeters, we gotta take you upstairs." By the time I get upstairs, they're just like, "You're 10 [centimeters], I'm sorry, it's too late [for an epidural]." And that was it.

The respondent's experience highlights the value of prompt and attentive medical care, especially in the context of labor and delivery where conditions can change quickly. Her story raises questions about whether medical professionals are equipped to accommodate varying physiological responses of Black women during labor. The lack of an epidural despite the patient's explicit request and explanation of her particular dilation pattern points to a systemic problem that goes beyond individual negligence. It highlights a broader, more alarming pattern where healthcare professionals prioritize their clinical training while minimizing or dismissing the worries and life experience of Black women. The experiences of this respondent also shed light on the racial biases present in pain assessment and treatment [11,29].

Another major concern is the unavailability of providers and their disregard for patient autonomy. A systemic failure to deliver prompt care was highlighted by one respondent who stated, "I went to the hospital like four times and she [the doctor] never showed up." In addition, some participants felt their independence was in jeopardy. A respondent stated, "I went to one doctor, and once she found out about my history, by me having two cesareans, she just automatically opted me into having another cesarean." This participant believed that her healthcare provider made decisions on her behalf without taking into account her wish to try a vaginal birth after a cesarean (VBAC). Another respondent complained that a doctor tried to push her to make decisions insensitively and forcefully. She recounted, "I didn't like his [doctor's] bedside manner, and I didn't like how... forceful he was about trying to make me do certain things... So I just knew he wasn't gonna be a good fit for me." This experience led her to switch to a midwife, adding to the growing body of literature advocating for alternative, patient-centered models of care [30]. The experiences of these women highlight the significance of patient autonomy and informed consent in healthcare decisions, which is essential for effective maternal healthcare [31] and a significant problem for Black women [32].

Respondents were also concerned about effective communication with healthcare providers. According to one respondent, for instance, "I did start off with a White doctor, and it was just difficult because she didn't know anything. She used incorrect language throughout." She eventually decided to transition to a Black doctor. Some respondents were also concerned that their healthcare providers did not provide them, as expectant mothers, with sufficient education, one respondent stated, "I feel like when it comes down to... you know, paying attention and like educating the, the new mothers about it, they don't do a good job." Existing research corroborates that subpar communication can adversely

affect health outcomes due to inadequate counseling and a lack of open dialogue between patients and providers [33,34].

This theme elucidates the way in which communication barriers and educational neglect serve to amplify the existing health disparities, while concurrently eroding the fundamental trust between patients and healthcare providers [35]. The concerns voiced by respondents also highlight the need for improvements in healthcare provider training programs that place emphasis on effective communication rooted in cultural competency and adequate patient-centered education [36]. Inequitable clinical care and provider–patient interactions serve as a critical lens to examine the systemic racism that manifests in Black maternal healthcare. These findings corroborate and expand upon the existing research that underscores the need for systemic transformations in how healthcare providers interact with Black women [37,38].

3.3. Navigating Experiences of Everyday Interpersonal Racism

Experiences of everyday interpersonal racism emerged as a salient theme in the narratives of the respondents, accentuating the imperative to confront and ameliorate racial disparities in maternal healthcare. It is well-known that racism has a negative impact on Black women's health outcomes in the United States. The racism experienced by the respondents manifests in many different ways, including unequal treatment and restricted access to basic services, which exacerbates the already-existing disparities. One respondent encapsulated the pervasive nature of racial experiences in her daily life stating, "I feel like race impacts me every day." Experiences of racism have been linked to stress and adverse health outcomes in a wide range of research [39–42]. Studies indicate that chronic stress stemming from frequent encounters with racism is associated with low-grade inflammation and bodily dysregulation, potentially elevating the risk for various health conditions such as heart disease [43,44]. The constant high-effort coping required for Black women to navigate everyday racism can contribute to accelerated physiological deterioration, a process known as "weathering" [45]. Weathering postulates that the cumulative impact of economic and social adversities caused by systemic racism produces a wearing down of Black women's physical and mental health over the life course [45]. Black women's experiences with everyday interpersonal racism can cause them to distrust medical institutions and put off seeking treatment, thus widening health disparities [46].

A respondent described her experience of placental interruption and the dismissive treatment she received from her healthcare providers, stating, "If I wasn't African American, they probably would have looked into it more rather than just hitting me on the hand." This observation emphasizes the widespread issue of medical mistrust and neglect Black women contend with, which is a symptom of a larger issue of racial bias in healthcare and frequently results in delayed or inadequate care [47]. Experiences of medical neglect and mistreatment harm Black women's health, and only serve to exacerbate their high maternal mortality rates [48,49]. Similarly, another respondent described the upsetting experience of learning that her baby had died. She reflected, "I feel like if it was her, I don't know. I don't wanna look at it negative." Despite her reluctance to cast the situation in a negative light, she could not shake the feeling that her race might have influenced the manner in which her doctor delivered the devastating news. This incident exacerbated the emotional turmoil she was already experiencing [50]. The respondent then referred to the historical case of Henrietta Lacks, stating, "Because I'm always greeted well... It is always a pleasant visit, but Henrietta Lacks had a pleasant visit as well, and they lied to her and told her there was something wrong just to run experiments on her blood."

The mention of Henrietta Lacks serves as a poignant reminder of the structural injustices that Black women have historically experienced in healthcare settings. Henrietta Lacks, whose cells were used for medical research without her informed consent, serves as a symbol of the medical exploitation and deceit that have exacerbated Black women's long-standing mistrust of the healthcare system. This historical backdrop amplifies the respondent's own experiences and worries, underscoring the pressing need to address racial biases and foster trust in

healthcare interactions [51,52]. The medical mistrust stemming from historical injustices is further compounded by contemporary experiences of neglect and inadequate education from healthcare providers. One participant, a first-time mother, shared:

> . . .Oh. Um, like this is my first, this is my first child. So like, I feel like with me, I don't feel like they gave me a lot of education on what to do and what not to do with a child because it's certain stuff that like, they would tell me and then like I would ask other mothers and they'll be like, that's not what you're supposed to do. Um, and I just feel like, I don't know, I feel like the hospitals are really like, bad when it comes to pregnant women because they don't, I feel like we are kind of like a last in choice to, like, watch over or they'll put us in somewhere and then, like, they'll feel, like, forget about us.

This quote underscores how a lack of comprehensive patient education and attentive care can leave Black women feeling neglected and forgotten by healthcare providers. Such experiences erode trust in the medical system and exacerbate the challenges Black women face in accessing quality maternal care.

The narratives in this section illuminate how experiences of and perceived racism permeate society and have a negative impact on Black women's mental, emotional, and physical health, exacerbating maternal health disparities. Targeted interventions that aim to dismantle racial biases permeating the healthcare system are urgently needed. Examining and reforming current healthcare policies, practices, and cultural norms are crucial if we are to address these deeply ingrained problems effectively. Healthcare professionals and institutions have a real opportunity to improve the standard of care and health outcomes for Black women in maternal healthcare settings by acknowledging and proactively addressing racism.

Overall, our findings corroborate and build upon the existing research highlighting the pervasive impact of racism and systemic barriers on Black women's maternal health experiences and outcomes [42,47,48]. The institutional barriers, inequitable care, and everyday racism described by our participants echo the experiences of discrimination, neglect, and mistreatment documented in prior studies [37,49]. Our results underscore the importance of racial diversity and representation in the healthcare workforce for promoting positive interactions and experiences with healthcare professionals, aligning with evidence on the benefits of race concordance [28,51]. A key strength of this study is the community-engaged qualitative methodology which privileged the lived experiences and expertise of Black women in Harris County. By centering the voices of those most directly impacted by maternal health disparities, we were able to generate nuanced insights into the complex ways systemic racism permeates Black women's encounters with and navigation of the healthcare system during pregnancy and childbirth. This approach aligns with calls to ground maternal health research and interventions in the experiential knowledge of marginalized communities [15,17].

Although this study provides valuable insights, it is essential to note its limitations. It was conducted only in Harris County, Texas, where Black women have extremely high maternal mortality rates. Therefore, these conclusions may not apply to other regions or demographics. Hence, caution should be exercised when generalizing these results to broader contexts. Secondly, the study utilized qualitative research methods, which, while providing detailed insights, have inherent constraints, such as difficulties verifying data reliability and validity [53]. Our research team tried to address these problems by being reflective, documenting thoroughly, and analyzing data rigorously. Although the researchers were vigilant in ensuring the participants' comfort and respectful handling, the power dynamics between the researchers and the participants could have affected the participants' responses. As researchers, it is essential to remain cognizant that our backgrounds and positions of power can influence the research process and outcomes [54]. Additionally, this study captures the experiences and opinions of the participants at a specific point in time. Over time, healthcare experiences, practices, and challenges can evolve, so it is worth noting that these findings present a specific moment.

4. Conclusions

The goal of this study was to examine the factors that contribute to Black women's poor healthcare experiences during pregnancy, delivery, and up to one year post pregnancy. Through the qualitative analysis of the focus group discussions with women from Harris County, Texas, we identified three key themes: institutional barriers to equitable maternal care, inequitable clinical care and provider–patient interactions, and navigating experiences of everyday interpersonal racism. The narratives the women articulated in this study detail the multifaceted challenges and adversities they encountered during pregnancy and childbirth. The experiences of these women accentuate the urgent requirement for modifications at every tier of the healthcare system. Strategies addressing these issues must be multifaceted, encapsulating a multilayered approach that considers systemic hurdles, care quality, patient–practitioner interactions, and racial biases within healthcare. These findings may guide policymakers, healthcare providers, and researchers striving to ameliorate disparate maternal health outcomes for Black women.

Future research should strive to expand the geographic scope of studies to encompass other regions in the United States, particularly those areas with large populations of Black women with high maternal mortality and morbidity incidences. Bailey et al. [39] suggest that studying Black women's experiences in different regions would provide a clearer understanding of their universal and unique aspects. Future research could also benefit from including other relevant stakeholders in the healthcare system, such as healthcare providers and administrators, to gain a multi-perspective understanding of the issue. Their perspectives could provide valuable insights into institutional barriers, policies, and systemic issues contributing to the disparities in maternal healthcare. Quantitative research can also complement qualitative findings, offering statistical data to substantiate those findings. Such data can provide a more comprehensive picture of the healthcare experiences of Black women [55]. Finally, future research studies should continue to explore effective strategies for enhancing the maternal healthcare experiences of Black women, emphasizing intervention research. Given that the issues identified in this study are complex and multifaceted, solutions must be similarly comprehensive and must center the standpoint of Black women.

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