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Black Pregnant Women "Get the Most Judgment": A Qualitative Study of the Experiences of Black Women at the Intersection of Race, Gender, and Pregnancy

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Abstract

Background: Pronounced racial disparities in maternal and infant health outcomes persist in the United States. Using an ecosocial and intersectionality framework and biopsychosocial model of health, we aimed to understand Black pregnant women's experiences of gendered racism during pregnancy.

Methods: We conducted semi-structured interviews with 24 Black pregnant women in New Haven, Connecticut. We asked women about their experience of being pregnant, experiences of gendered racism, and concerns related to pregnancy and parenting Black children. Transcripts were coded by three trained analysts using grounded theory techniques.

Results: Women experienced gendered racism during pregnancy—racialized pregnancy stigma —in the form of stereotypes stigmatizing Black motherhood that devalued Black pregnancies. Women reported encountering assumptions that they had low incomes, were single, and had multiple children, regardless of socioeconomic status, marital status, or parity. Women encountered racialized pregnancy stigma in everyday, healthcare, social services, and housing-

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CONFLICT OF INTEREST STATEMENT
The authors declare that they have no conflict of interest.

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related contexts, making it difficult to complete tasks without scrutiny. For many, racialized pregnancy stigma was a source of stress. To counteract these stereotypes, women used a variety of coping responses, including positive self-definition.

Discussion: Racialized pregnancy stigma may contribute to poorer maternal and infant outcomes by way of reduced access to quality healthcare; impediments to services, resources, and social support; and poorer psychological health. Interventions to address racialized pregnancy stigma and its adverse consequences include anti-bias training for healthcare and social service providers; screening for racialized pregnancy stigma and providing evidence-based coping strategies; creating pregnancy support groups; and developing a broader societal discourse that values Black women and their pregnancies.

INTRODUCTION

Contrary to global trends, rates of poor maternal and infant outcomes have increased in the US. Between 1990 and 2015, the maternal mortality ratio (maternal deaths/100,000 live births) increased from 16.9 to 26.4 (GBD 2015 Maternal Mortality Collaborators, 2016). In recent years, rates of preterm birth (<37 completed weeks of gestation) and low birth weight (<2,500 grams) have also increased (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018b). Of particular concern, racial disparities in poor birth outcomes have recently widened (Martin, Hamilton, Osterman, Driscoll, & Mathews, 2017; Martin, Hamilton, Osterman, Driscoll, & Drake, 2018a; Martin et al., 2018b; Xu, Murphy, Kochanek, Bastian, & Arias, 2018). Black women account for more than one-third of pregnancy-related deaths and have 3.2 times the risk of dying from pregnancy complications of White women (Creanga et al., 2015). Black infants have 2.5 times the infant mortality rate (deaths in the first year of life/1,000 live births) (Xu et al., 2018), 1.5 times the preterm birth rate, and two times the low birth weight rate of White infants (Martin et al., 2018b). Neither maternal factors such as socioeconomic status (SES), health behaviors, and prenatal care (Braveman et al., 2015; Goldenberg et al., 1996; Mohlman & Levy, 2016) nor macrosocial determinants of health disproportionately affecting marginalized populations, such as neighborhood poverty and unemployment (Morenoff, 2003; O'Campo, Xue, Wang, & Caughy, 1997; Pearl, Braveman, & Abrams, 2001), completely explain these disparities.

Research suggests the lived experiences of Black women in the US, in particular racism (Dominguez, 2011; Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008) and cumulative stress from racism over the life course (Lu & Halfon, 2003), are determinants of racial disparities in adverse birth outcomes. For example, risk of poorer birth outcomes is higher among US-born Black women than foreign-born Black women (Cabral, Fried, Levenson, Amaro, & Zuckerman, 1990; J. W. Collins, Jr., Soskolne, Rankin, & Bennett, 2013; David & Collins, 1997; Howard, Marshall, Kaufman, & Savitz, 2006; Oliver et al., 2018), and infant birth weight of descendants of foreign-born Black women approaches that of US-born Black women (J. W. Collins, Jr., Wu, & David, 2002).

Rosenthal and Lobel contend that Black women are subject to a uniquely stressful experience in the US due to intersecting stigmatized and marginalized identities—woman and Black—and that stigmatization and marginalization of these identities increase Black

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women's risk of poor birth outcomes (Rosenthal & Lobel, 2011). The combination of sexism and racism is referred to as "gendered racism" (Essed, 1991), and theoretical frameworks of intersectionality describe how this intersectional experience of both forms of oppression is greater than their sum (Crenshaw, 1989). Intersectionality is a core tenet of the reproductive justice movement (Sister Song, n.d.), a framework developed by women of color that combines reproductive rights and social justice issues (e.g., economic injustice, welfare reform, housing, and environmental justice) to address intersecting oppressions (Price, 2010; Ross & Solinger, 2017). The framework focuses on the "lived, embodied reproductive and whole-life experiences within their communities of people who can become pregnant and give birth" (Ross & Solinger, 2017, page 12). We draw on the reproductive justice framework to situate women's experiences within a larger context that acknowledges how oppressive systems deny personhood to women based on their intersecting identities.

In the literature, gendered racism is operationalized as gendered racial microaggressions (Lewis, Williams, Peppers, & Gadson, 2017), events (Thomas, Witherspoon, & Speight, 2008), or stereotypes (P. H. Collins, 2000; Jerald, Cole, Ward, & Avery, 2017; Rosenthal & Lobel, 2018). Stereotypic perceptions of Black women combining sexist, racist, and classist images such as mammies (faithful, domestically servile), matriarchs (aggressive, unfeminine), welfare mothers (low-income, unwed), and Jezebels (sexually aggressive) (P. H. Collins, 2000) to stigmatize Black motherhood in particular, casting in a negative light not only gender and racial identity but also sexual identity. Negative stereotypic images of Black women in the US extend throughout history to justify economic exploitation and control of Black women's sexuality and fertility (P. H. Collins, 2000). Moreover, these stereotypes reflect and reinforce the concept of stratified reproduction, whereby reproduction is differentially experienced and valued across social hierarchies (Colen, 1995).

Theoretical pathways between gendered racism and poor birth outcomes are built upon Clark et al.'s biopsychosocial model of racism (Clark, Anderson, Clark, & Williams, 1999) and Lazarus and Folkman's stress and coping framework (Lazarus & Folkman, 1984). Racism is a perceived stressor that, depending on coping responses, results in negative psychological and physiological stress responses, and subsequently poor health outcomes (Clark et al., 1999). Sociodemographic, psychological, and behavioral factors moderate this pathway (Clark et al., 1999).

Empirical research on coping among Black women indicates that racism-specific coping responses include active and passive emotional and behavioral responses (McNeilly et al., 1996; Vines et al., 2001). Active responses include feeling angry, anxious, and sad (emotional) and working harder to prove others wrong and praying (behavioral). Passive responses include feeling powerless and hopeless (emotional) and ignoring, accepting, and not speaking up (behavioral) (Vines et al., 2001). In general, active coping responses may be more effective than passive or emotion-focused coping responses for decreasing the association between racism and health (Pascoe & Smart Richman, 2009). Among Black women, education but not income is associated with higher perceived racism, although there are few differences in coping responses by SES (Vines et al., 2006). Generally, psychological factors such as racial identity centrality may either buffer or exacerbate the

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racism-mental health association, whereas social support is more likely to buffer this association (Pascoe & Smart Richman, 2009).

The same mediators and moderators of the biopsychosocial model of racism may apply to a model of gendered racism. Africentric (Greer, 2007) and africultural (Utsey, Adams, & Bolden, 2000) frameworks of coping responses have been used to explore whether coping mediates the association between gendered racism and physical and mental health (Lewis et al., 2017; Thomas et al., 2008). In particular, the Africentric framework of coping responses includes four types of responses: interconnectedness, spirituality, problem-oriented coping, and disengagement (Greer, 2007). Recent empirical studies show gendered racism is directly associated with psychological distress (Lewis & Neville, 2015; Lewis et al., 2017; Thomas et al., 2008). This association is mediated by passive behavioral coping responses such as disengagement (Lewis et al., 2017) and avoidance (Lewis et al., 2017; Thomas et al., 2008), and moderated by lower levels of gendered racial identity centrality (Lewis et al., 2017).

Given large and widening racial disparities in maternal and infant outcomes—not fully accounted for by risk factors identified in existing research—we sought to examine the ways gendered racism manifests in the everyday experiences of pregnant Black women and may contribute to poorer maternal and infant outcomes. While racism contributes to the deterioration of the health of Black women across the life course to affect pregnancy outcomes (Geronimus, 1992), distinct forms of gendered racism may also manifest during pregnancy, potentially having a larger impact on pregnancy outcomes. Using an ecosocial framing of discrimination as an oppressive phenomenon operating at multiple levels across the life course (Krieger, 2012), an intersectionality framework, and a biopsychosocial model of gendered racism and health, this paper examines the gendered pregnancy racism that women experience and the implications of these experiences for maternal and infant health.

MATERIALS AND METHODS

Study site and sample

Our study was conducted in New Haven, Connecticut. New Haven is the second largest city in the state, with a population of 130,884 (United States Census Bureau, 2017). The city has a racially and ethnically diverse population of which 31.5% is Black non-Hispanic, 30.4% is Hispanic, and 30.3% is White non-Hispanic (United States Census Bureau, 2017). Overall levels of unemployment (10.4% compared to 6.6% nationally) and poverty (25.6% compared to 14.6% nationally) are high (United States Census Bureau, 2017).

Pregnant women who were at least 18 years of age and self-identified as African American or Black (herein collectively referred to as Black) were eligible to participate. Within this eligibility, we diversified our sample to include both women whose primary source of financial support was public assistance benefits and those supported by employment (i.e., the participant, their partner, or a family member was employed). Because experiences of racism may vary across socioeconomic groups (Ertel et al., 2012; Paradies, 2006), this allowed us to examine the intersection of race, gender, and SES. Women were recruited via flyers in healthcare settings; public (i.e., libraries, churches) and private (i.e., grocery stores,

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laundromats) spaces; email distribution lists; and women's and African-American affinity groups (January 2017 to August 2018).

We provided participants with information on risks and benefits of the study and obtained verbal consent. We conducted individual, in-person, semi-structured interviews using an interview guide developed by the authors. We iteratively developed interview questions guided by ecosocial and intersectionality frameworks (see Table 1). Questions explored women's perceptions of things that either helped or hindered their ability to have a healthy pregnancy; experiences of interpersonal and structural racism; experiences of living in their neighborhood; neighborhood attributes that helped them to have a healthy pregnancy or make healthy decisions about their pregnancy; and concerns related to pregnancy and parenting Black children. A trained interviewer (RM) conducted the interviews, which were approximately 45-60 minutes in length. Interviews were recorded and transcribed verbatim. Ethical approval was received from the Yale University Institutional Review Boards (Human Subjects Committee).

Analysis

Three authors (RM, LB, and DK) trained and experienced in qualitative research methods followed an iterative and inductive coding approach adapted from grounded theory (Corbin & Strauss, 1998). We established coding reliability by iteratively selecting small samples of interviews to open code and double code to create and revise our code book. Coders met throughout the coding process and coding issues were resolved through consensus, assuring agreement on themes derived from the data and interview guide. The first author applied the final codebook to all transcripts using ATLAS.ti software (Version 8, Scientific Software Development GmhH, Germany, 2018). The authors used an abductive approach—a recursive and iterative process of fitting data and theories (Timmermans & Tavory, 2012)—to interpret data through the lens of intersectionality and the biopsychosocial model of gendered racism. To monitor biases, as backgrounds of the authors were different to those of Black pregnant women, we used field notes during data collection and memoing during data analysis. Additionally, we discussed our biases and various perspectives, and how to be sensitive and fair during author meetings. In completing the analysis presented here, the first author reviewed excerpts linked to relevant codes and read full transcripts to contextualize excerpts within participants' broader narratives.

Description of researchers' backgrounds

RM, a White and Asian female doctoral candidate, conducted the interviews. Three female authors (RM, LB, and DK) coded the data. LB is a White research scientist and DK is a White faculty member. Other members of the research team are White and included two faculty members (one female and one male) in the social and behavioral sciences department of a public health school, and one female maternal-fetal medicine specialist.

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RESULTS

Study sample

Twenty-four women ranging in age from 21 to 45 years (median 32 years) participated in the study (Table 2). Ten women (42%) received public assistance benefits as their primary source of financial support and 14 women (58%) were pregnant for the first time.

Findings

Participants in the study experienced gendered racism during pregnancy—a distinct form of intersectional stigma with potentially significant implications for women and their infants, that we hereafter refer to as racialized pregnancy stigma—in the form of stereotypes that stigmatized Black motherhood. Participants reported encountering judgments and negative assumptions in a multitude of contexts, including in their day-to-day lives, as well as in healthcare, social services, and housing-related contexts. Such racialized pregnancy stigma influenced their access to and quality of services and contributed to stress. Conversely, participants described individual coping responses and familial and community attributes that countered racialized pregnancy stigma.

Overall, an overarching sentiment Black pregnant women expressed was that they and their pregnancies were devalued by society. Participants felt judged based on negative assumptions about Black pregnant women, and for some, this judgment was a significant source of stress. Participant 11 succinctly captured this lived reality, "I do think pregnancy is harder for Black, African-American women, I really do. We get the most judgment… I notice that there be a lot more Black women stressed during their pregnancy, that I have witnessed."

Racialized pregnancy stigma in everyday contexts

Participants experienced harmful assumptions about Black pregnant women in multiple everyday contexts, which made it difficult to complete routine tasks without scrutiny. Regardless of SES, participants encountered the assumption that Black pregnant women had low incomes and the attendant implication that they were dependent on government resources. Participant 11, whose husband was employed, described an intrusive encounter in a grocery store, where, despite her economic means, she was assumed to have a low income and be in receipt of public assistance benefits. In response, she felt compelled to dispel these assumptions and defend the public assistance deservingness of Black women:

> [A Black woman] was like, "It's a shame that they can just have kids and, oh, live free." I turned around and was like, "Is there somethin' you want to say to me?" "No, I'm just, all these young Black girls have all these kids and get everything free." I said, "What do we get free?" I said, "Some people might get free medical, but there's a lot of Caucasians and White people on the state." I said, "If that's what you're talking about, and I'm not even paying with my groceries with food stamps. I'm with cash." And she was like, "Oh, I apologize. It's just, you know, some girls."

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Participants also encountered the assumption that Black pregnant women were single mothers, in conjunction with the assumption that this parenting structure was not conducive to providing a good home. For Participant 18, a single mother-to-be, encountering this assumption not only caused distress, but also hindered her enjoyment of her pregnancy: “I feel like it’s not fun … I could have the best life at home, and I could just be walking down the street pregnant and somebody will think that I'm alone and I don't have anybody because of what they know about African-American women. I don't like that at all. That’s just horrible. People can't think positive about you because what they already go off of.” Not only was this participant not seen for who she was, but these assumptions prevented her from being respected and celebrated as an expectant mother.

Participants also encountered the assumption that Black pregnant women have multiple children and perceived that large Black families were judged more harshly than large non-Black families. As Participant 11 recounted, “I witnessed it a lot of times at the doctor’s office, at WIC, downtown, anywhere, in the restaurant, grocery store. I’m like, soon as a Black girl come in pregnant, even if she got one kid, the looks you get, the mumbling under your breath. It’s just, I honestly don’t think it’s right. People are too judgmental.”

Some women who did not fit the assumption of hyperfertility—that is, older, childless Black women—encountered assumptions that they were lying or hiding children from others. As Participant 20, who was childless at the age of 34, articulated, “I have been questioned as to, you know, why would I hide how many kids I have. Like, I'm not, I don't have any, like that isn’t actually a fact. I would tell you had I birthed someone and at this point I have not.” This assumption seeks to invalidate women’s lives and experiences and imposes judgement on women's characters whether or not they have children. Moreover, racist assumptions about reproduction may have potentially significant implications for Black women’s well-being and pregnancy outcomes, even for women who do not fit the assumptions.

Racialized pregnancy stigma and obtaining healthcare

Participants described how negative assumptions about Black pregnant women influenced access to and quality of healthcare and shaped their relationships with healthcare providers. Participant 22, who worked in the healthcare field, described the distress of being ignored at a pediatric clinic when she sought a pediatrician for her baby-to-be and storming out of the clinic after not getting the care she sought:

> I went to look for a doctor for a baby, for a pediatrician, and so I go in the office … I see that their backs are turned, okay, fine, whatever. I don’t know if I’m supposed to say hello, whatever. But this one lady, and she was White, she looked at me and then just walked away … I sat there for 10 minutes and no one acknowledged me. But when this other two [White] people come in and in the corner window the lady turn around and spoke to them. I’ve been sitting here for 10 minutes and you people didn’t say anything to me. And I, I just got up and stormed out. I said, “You know what? My baby won’t come here.”

Participant 11 conveyed how she felt judged when her healthcare provider recommended that she undergo a tubal ligation: “One of the midwives, it was basically they try to talk you into getting your tubes tied. ‘Oh, this is your third child’. That’s got nothin’ to do with it.”

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The midwife's implication that three children were enough and that the participant should use a permanent form of contraception to control her fertility devalues Black pregnancies and Black infants and denies Black women reproductive autonomy. Furthermore, the participant remarked that encountering such judgments made it difficult for her to have a healthy pregnancy.

Conversely, some participants reported building supportive relationships with healthcare providers who were "non-judgmental". Overall, participants reported complex medical and social histories that included mental health conditions and substance use. These issues can be difficult to discuss but are important for healthcare providers to be aware of, which is why having supportive relationships with healthcare providers is so important. Participant 4, who received public assistance benefits, expressed how having non-judgmental healthcare providers made her feel more comfortable in opening up and sharing important health information:

> My healthcare provider makes me feel comfortable. I have a male and a female. They answer all questions that I have, they're very patient with me, very understanding. They're non-judgmental and it helps me pursue a stronger relationship with them … Like, the questions that they ask me that I was concerned about, I was comfortable with telling the truth without feeling ashamed.

Racialized pregnancy stigma and obtaining services and resources

Participants described how assumptions about Black pregnant women negatively affected their access to resources intended to support healthy pregnancies. Several participants perceived social service providers to be judgmental and unwelcoming based on their attitudes and lines of questioning. Participant 17, who was financially supported by her partner but was unable to find employment while pregnant, described her interaction: "But [social services staff] stereotype you too, like basically, 'Why are you not married yet? Are you still with the father? What are you gonna do with another child?'" Interactions such as these made women feel as if they were required to justify their reproductive choices and prove they were worthy of services they are entitled to by law. Furthermore, women were burdened with refuting the assumptions they encountered in this setting and proving themselves as having the credentials to be treated with respect. Participant 13 described how her interaction with social services staff improved after she revealed her level of education: "And when I told her I have a four-year degree, that's when, kind of, like her body language and tone changed."

Participant 17 questioned whether difficulties in finding a new apartment were related to being Black and pregnant: "He told me he rented out the apartment. I'm like, how did you rent it out that fast? So, I figured, I guess, I don't know, maybe because I was pregnant or both … I'm African American, I don't know." Difficulties finding housing for growing families was reported as a stressor, particularly for women receiving public assistance benefits. Moreover, we found that women receiving public assistance benefits were highly residentially mobile, which may have exposed them to more experiences of housing discrimination, further impacting stress and pregnancy outcomes.

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Participants also noted challenges in obtaining social support in their surroundings and reported that a lack of this type of support was a source of psychological stress. To meet her needs of talking to supportive women, Participant 11 turned to an anonymous online pregnancy support group, where she was able to avoid judgmental posts:

> Cause like, I'm pretty sure that if one of the women, one of the Caucasian women or something, knew that they were talking to a 27-year old woman with 3 kids and she's Black, they wouldn't really give me the type of respect cause we are all anonymous on that app. You can't upload no pictures … and you're anonymous and I think that's good cause there's no judgments going on up there, even if the stories is wild.

Countering racialized pregnancy stigma

Consistent with Clark et al.'s (1999) biopsychosocial model of racism, encountering racialized pregnancy stigma was a source of psychological stress for many participants. And as Participant 8 declared, "Stress is one of the main things you don't need in a pregnancy."

In response to racialized pregnancy stigma, participants reported using all four types of coping in the Africentric framework of coping responses: interconnectedness, spirituality, problem-oriented coping, and disengagement (Greer, 2007). For example, participants sought emotional support from family members, used prayer, challenged those who expressed the abovementioned assumptions, or ignored the encounter.

For some participants, employment helped them distance themselves from these assumptions by enabling them to live in or move to neighborhoods that signaled that they did not have low incomes or were not receiving public assistance benefits. For others, relationship status signified that they did not fit these assumptions. Participant 13, who was employed and married, confirmed that she did not fit these assumptions, stating:

> I don't have any insecurities when it comes to being Black and pregnant, I think because I'm probably not your stereotypical Black and pregnant and single. I am married, I am Black, and I am pregnant. So that probably helps me feel even more secure, I don't know it that lets people like make people look different at me. I'm not sure, maybe. Me being Black and pregnant, I love it. I'm comfortable, I'm secure.

Women embedded in families and communities that validated their personhood and their pregnancy had experiences that celebrated their motherhood and were buffered from experiences of racialized pregnancy stigma. Participant 4 expressed the joy of being pregnant in her supportive community: "It's exciting because everybody's like supportive and they rub my stomach and say, 'Hey little boy, how you doing today?' They call me mom. 'Hey mom, how you feeling today?' So, it's very exciting. It's a lot of supportive people in that area."

However, ultimately participants expressed a desire to change how Black pregnant women were defined in society. Participant 14 articulated, "I think that it's important they know there is a lot of us out there who really just want to work and grind and do what we have to

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do for our new baby." Participants countered these assumptions by defining themselves as hard working, financially independent, and good providers for their families. Furthermore, participants described their aspirations for their children's economic success, including planning to send or having already sent their children to college and desiring that they obtain good jobs. Some participants, particularly those receiving public assistance benefits, also countered negative assumptions by defining themselves as good mothers. Participant 9 asserted, "I am a hardworking mother. I'm very dedicated to being a mother."

Participants described how their families helped them define themselves. Participant 14 explained that her upbringing helped her respond to discrimination: "I've been blessed because the African Americans that I'm around, in the family that I have, we're all very proud. We're proud of who we are and where we're from." In turn, participants described how they were going to bring up their children to conquer negative assumptions. Participant 22 shared, "I'm gonna explain to her like, you know, there are gonna be some people who might look at you a certain type of way. Don't let it get to you. Don't let no one talk you down." Or as Participant 13 expressed, "I would definitely tell my child to be confident, to be proud; definitely those two things. Be secure with your Blackness. Cause I think that's what got me through." This highlights not only how interconnectedness works as a potential coping mechanism, but also the intergenerational consequences of discrimination. This underlines the importance of understanding and addressing racialized pregnancy stigma: these experiences impact not only women, but also their children.

DISCUSSION

Experiences of racism are common among Black women (Ertel et al., 2012; Vines et al., 2006): as many as one-quarter of higher SES women report racist experiences in medical settings (Krieger & Sidney, 1996; Peters, Benkert, Templin, & Cassidy-Bushrow, 2014; Vines et al., 2006). Furthermore, experiences of racism are associated with preterm birth (Bower, Geller, Perrin, & Alhusen, 2018) and may contribute to racial disparities in infant outcomes. Women burdened by the consequences of gendered racism and other forms of stress may be at increased risk for poor pregnancy outcomes (Jackson et al., 2001). In particular, Black pregnant women report feeling judged by society because of their circumstances and this judgment is a source of stress that they consider to be a risk factor for preterm birth (Giurgescu et al., 2013).

Our research explored the experiences of Black pregnant women that may contribute to the considerable disparities in birth outcomes they confront. We found that Black pregnant women encountered gendered racism specific to pregnancy—which we refer to as racialized pregnancy stigma—in a multitude of contexts and that these encounters contributed to the sentiment that their pregnancies were devalued in society. Racialized pregnancy stigma may contribute to poorer maternal and infant outcomes through increased stress and reduced access to quality healthcare, services, resources, and social support, which may in turn lead to delays in health seeking behavior, financial and material hardship—inadequate food, housing, and medical care (Mayer & Jencks, 1989)—and reduced stress buffering.

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In addition to Black women in this study reporting experiences of racism throughout their life course, they reported experiencing racialized pregnancy stigma. Women described encountering assumptions consistent with the stereotype of welfare mothers, or, more insidiously, welfare queens. Ronald Reagan is attributed with coining the term "welfare queen" (Hancock, 2004) while campaigning for president in the 1970s (Mooney, 2012). This public identity has two main dimensions in the political and media discourse—laziness and hyperfertility—which, as Hancock asserts, defines Black women as devalued mothers (Hancock, 2004). Rather than Black women with low incomes being perceived as worthy of public assistance benefits they are entitled to receive (P. H. Collins, 2000), we found that many encountered assumptions that they were burdening society.

Furthermore, we found that participants encountered assumptions about single parenting rooted in a historical discourse that blames the disintegration of family structure for perpetuating the cycle of poverty and disadvantage in Black families (United States Department of Labor Office of Policy Planning and Research, 1965), rather than the structural challenges that Black communities confront (i.e., unemployment, wage disparities, barriers to education, residential segregation, concentrated neighborhood poverty, and incarceration) (Acs et al., 2013). As this and previous qualitative studies show (Giurgescu, Banks, Dancy, & Norr, 2013; Harris-Perry, 2011; Murrell, Smith, Gill, & Oxley, 1996; Nuru-Jeter et al., 2009), the use of the welfare queen stereotype persists, often regardless of a woman's age, education, income, insurance coverage, marital status, or parity (number of births). Thus, the discourse of devaluing Black pregnant women persists.

We found that encountering racialized pregnancy stigma in healthcare settings may lead to reduced access to quality healthcare and unsatisfactory healthcare interactions. Encounters where healthcare providers recommend tubal ligations by default perpetuate the historical control of Black women's fertility through permanent contraceptive procedures—from the negative eugenics of forced sterilization of Black women with low incomes labeled as "sexually indiscriminate and as bad mothers who were constrained by biology to give birth to defective children" (Washington, 2006), to the coerced sterilization of Black women enrolled in Medicaid as a solution to poverty (Roberts, 1997). Research shows single Black women perceive their healthcare to be poorer in quality than that of married White women (McLemore et al., 2018). Medicaid-insured women perceive that judgmental attitudes and stereotypes affect healthcare interactions around contraception, particularly forced contraception (Roman et al., 2017). Furthermore, prejudicial experiences, including gendered racial stereotypes, in the healthcare setting can overshadow good treatment (Benkert & Peters, 2005).

Conversely, we found that women who have non-judgmental interactions with their healthcare providers may feel more comfortable sharing important health information, which may include risk factors for poor maternal and infant outcomes. Moreover, positive healthcare experiences are linked to long-term relationships with healthcare providers (Benkert & Peters, 2005). Having continued access to supportive healthcare may improve the prevention, detection, and management of complex medical and social conditions, which may in turn reduce disparities in pregnancy outcomes.

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Encountering racialized pregnancy stigma in other contexts may reduce a woman's ability to address important social determinants of health. Women who experience judgmental social service interactions may not enroll in government programs (Stuber, Meyer, & Link, 2008). Women who are denied housing may experience homelessness or housing instability. Women who experience racialized pregnancy stigma in one grocery store may devote additional time and resources to finding a new grocery store. For women who rely on public transportation, this situation may present more of a challenge in obtaining basic necessities.

Consistent with previous research, we found that Black pregnant women used a variety of coping responses (Benkert & Peters, 2005; Lewis, Mendenhall, Harwood, & Browne Huntt, 2013; Shorter-Gooden, 2004), which may be the most effective way to minimize stress (Everett, Hall, & Hamilton-Mason, 2010). However, avoidant coping responses may not be an effective strategy for gendered racism (Thomas et al., 2008). Valuing oneself by cultivating a positive self-image and supporting personal development may be a way to resist negative stereotypes (Shorter-Gooden, 2004). Black women traditionally cope with oppression through family networks and Black community institutions (P. H. Collins, 2000), and within the context of family and community, the conceptualization of self is found (P. H. Collins, 2000). Cultivating family and community networks may help Black pregnant women define themselves.

An additional form of gendered racism that may negatively impact pregnancy is the assumption that Black boys and men are dangerous (Jackson, Phillips, Hogue, & Curry-Owens, 2001). Women reported that anticipating that their sons would encounter this assumption, particularly by police, was an additional source of psychological stress. The burden of protecting children from gendered racism before and during pregnancy may increase the risk of poor pregnancy outcomes (Jackson et al., 2001). Nuru-Jeter and colleagues recommend the development of a more comprehensive racism measure that assesses the anticipation of future discrimination for women and their children (Nuru-Jeter et al., 2009).

The strengths of this study include using purposeful sampling to gain perspectives from women of different socioeconomic groups, as many studies have only included women of higher SES, and enrolling numerous women to explore all relevant codes and themes. However, using primary source of financial support as a measure of SES may not be as comparable as other measures such as income or education. Additionally, our findings may be unique to New Haven and not transferable to other settings.

IMPLICATIONS FOR PRACTICE AND/OR POLICY

Participants reported encountering harmful racist assumptions and discriminatory treatment in both healthcare and community settings, and that supportive families and communities helped buffer them from experiences of racialized pregnancy stigma. Racism is deeply entrenched in virtually every aspect of society in the US. However, we may be able to reduce the way racialized pregnancy stigma manifests in specific settings that are relevant to pregnancy outcomes by instituting bias training for healthcare and social service providers; screening for racialized pregnancy stigma in healthcare settings and providing evidence-

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based coping strategies; and creating pregnancy support groups in healthcare and community settings. Broader interventions in the community and society include developing a discourse that values Black women and their pregnancies and addressing the structural challenges that Black communities confront.

CONCLUSION

This study contributes to a growing body of evidence for the need to achieve reproductive justice to address racial inequities in health. Racialized pregnancy stigma influences Black pregnant women's access to and quality of healthcare, social services, resources, and social support; contributes to stress; and may contribute to poorer maternal and infant outcomes. Understanding and addressing racialized pregnancy stigma may reduce intergenerational consequences of discrimination. Further research on racialized pregnancy stigma and maternal and infant health is warranted.

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Table 1.

Sample questions on semi-structured interview guide

Domains	Sample questions
Things that either helped or hindered their ability to have a healthy pregnancy	In general, what are the things that help you have a healthy pregnancy? In general, what are the things that make it hard to have a healthy pregnancy?
Experiences of interpersonal and structural racism	What is it like to be Black and pregnant? Can you tell me a time when you felt discriminated against? Why did you choose to live in your neighborhood? What is it like to be pregnant in your neighborhood?
Experiences of living in their neighborhood	Can you tell me what it's like to live in your neighborhood?
Neighborhood attributes that helped them to have a healthy pregnancy or make healthy decisions about their pregnancy	What are the healthy/unhealthy aspects of your neighborhood? How does your neighborhood help you have a healthy pregnancy?
Concerns related to pregnancy and parenting Black children	Are there things that are stressful (or make you worry) during your pregnancy? As a future parent, are there things that you are worried about for your infant? What are you going to tell your child about being Black/growing up Black in this neighborhood (the talk)?

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Table 2.

Characteristics of 24 participants

Characteristic	Descriptive summary
Demographics	
Age, median (range)	32 (21-45)
Primary source of financial support	
Public assistance benefits	10 (42%)
Employment (participant, partner, or family member)	14 (58%)
Relationship status	
Married	7 (29%)
Living with/has a partner	6 (25%)
Single	5 (21%)
Unknown	6 (25%)
Pregnancy and reproductive history	
Gestational age in weeks, median (range)	22.5 (5-38)
Nulliparity (no previous births)	14 (58%)