

Postpartum Experiences of Black Birthing People After Stillbirth: A Qualitative Study

Hamdi Abdi, PhD, Ruth Arévalo, MPH, Joann O’Leary, PhD

Despite improvements in obstetric care, stillbirth rates in the United States remain disproportionately high among Black birthing individuals, who experience losses at more than twice the rate of non-Hispanic White and Hispanic counterparts. This qualitative study explores the postpartum experiences of Black birthing people following stillbirth, with a focus on social support, emotional responses, and healthcare quality. Thematic analysis of focus group discussions revealed five central themes: the multifaceted nature of social support, complex emotional reactions, interactions with healthcare professionals, the impact of racial concordance in care, and challenges with postpartum follow-up. Participants described inconsistent or absent support, feelings of isolation, and interactions with providers that often lacked empathy and cultural understanding. When racial concordance was present, it enhanced communication and trust, but was rarely available. These findings highlight significant gaps in grief-informed and identity-affirming care, as well as the broader systemic

The authors have no conflicts of interest. Hamdi Abdi, PhD, MPH (ORCID: 0000-0002-1191-0726), is a public health researcher specializing in evidence-based research and systematic review methodology. Her research interests include stillbirth, postpartum care after perinatal loss, and support for individuals during the postpartum period. Her professional and personal experiences inform her dedication to improving bereavement care and advancing justice in maternal health policy and practice. Ruth Arévalo, MPH, RN, BSN, is a public health professional focused on integrating public health principles into community engagement. Her work emphasizes community well-being and the use of narrative and storytelling as tools for connection and empowerment. Joann O’Leary, PhD, MPH, MS, IM-ER(IV), is a researcher, writer, and consultant specializing in prenatal mental health, infant loss and the pregnancy that follows, and issues affecting siblings. Send correspondence to abdi0152@umn.edu.

inequities that shape care experiences. By centering the voices of Black birthing individuals, this study provides critical insights into the unique challenges faced after stillbirth. It underscores the need for targeted interventions and policy reforms to improve care quality and outcomes. Addressing these gaps is essential to promoting equity and healing for this underserved population.

Keywords: Black birthing people, stillbirth, postpartum care, social support, grief, racial disparities, racial concordance, healthcare experiences

Stillbirth, the loss of a baby before or during birth, affects approximately 24,000 families in the United States each year (Centers for Disease Control and Prevention [CDC], 2025). Black birthing people disproportionately experience stillbirth, with a mortality rate more than twice that of non-Hispanic White or Hispanic women (11.2 per 1,000 live births compared to 5.0 and 5.1, respectively) (Pruitt et al., 2020). Despite advancements in obstetric care (Peahl & Howell, 2021), racial inequities in stillbirth rates have remained unchanged since 2005 (MacDorman & Kirmeyer, 2009).

Structural racism, deeply embedded within systems, policies, and institutions, significantly shapes health outcomes for Black communities (Braveman et al., 2022). Mechanisms such as residential segregation, unequal access to healthcare, and biased clinical care contribute to persistent racial disparities in maternal outcomes, including stillbirth (Braveman et al., 2022; Gee & Ford, 2011; Hailu et al., 2022; Williams & Mohammed, 2013). Many Black birthing people report feeling unheard, stereotyped, or dismissed in clinical encounters, further contributing to mistrust and disengagement from healthcare (Barnett et al., 2022; Mehra et al., 2020; Murphy et al., 2022; OjiNjideka Hemphill et al., 2023; Spurlock & Pickler, 2024).

Although Black birthing people face the highest risk of stillbirth, their voices and lived experiences remain largely absent from the research literature (Lisy et al., 2016). The aftermath of stillbirth is often marked by profound grief, social isolation, and disenfranchised mourning, which may be further compounded by intersecting factors such as medical mistrust, implicit bias, and structural racism commonly faced by Black birthing people (Berry et al., 2021; Doka, 1999; Gillis et al., 2020; Kelley & Trinidad, 2012; Persson et al., 2023).

However, most studies on stillbirth and postpartum care overlook racially minoritized perspectives, particularly those of Black birthing people.

Despite the recognized importance of postpartum care, attendance at postpartum visits (PPVs) remains suboptimal among many Black birthing people. Broadly, those who had a stillbirth are less likely to return for a PPV compared with those who had a live birth (Limenih et al., 2016). Existing research also suggests that participants who identify as Black are significantly less likely to attend a PPV compared with participants who identify as White (de Bocanegra et al., 2017). However, current literature has not explored how the experiences surrounding stillbirth, including grief, support, and quality of clinical care, may influence decisions about PPV attendance, particularly for Black birthing people.

To address these critical gaps, this study aimed to: (1) generate an in-depth qualitative understanding of social support, grief, and quality of care among Black birthing people who had a stillbirth and (2) explore whether these experiences may play a role in PPV attendance.

Methods

This qualitative study used a semi-structured interview guide with open-ended questions on grief, social support, and healthcare system factors, which were explored through focus group discussions (FGDs). The primary research question is: “What are Black birthing persons’ experiences with social support, grief, and quality of care during the postpartum period following a stillbirth?” A secondary question is: “Do these experiences of social support, grief, and quality of care play a role in PPV attendance?”

A non-probability purposive sampling approach was used. Recruitment took place from November 2023 through April 2024 via national and local stillbirth-related organizations (e.g., Star Legacy Foundation, Return to Zero, Push Pregnancy), Black-led community organizations in the Twin Cities (e.g., Faith’s Lodge, Chosen Vessels, Roots), and University of Minnesota-affiliated clinics. Flyers were distributed through social media, email listservs, clinic handouts, and in-person referrals. Interested individuals contacted the study team and participated in a 10–15-minute eligibility screening via Zoom. Eligible participants were invited to a 90–120-minute FGD, provided informed consent, and completed a brief demographic questionnaire. Each participant received a \$75 electronic gift card in appreciation of their time.

Participants were eligible if they self-identified as African American or Black, were 18 years or older, and had experienced a *stillbirth*, defined as fetal death at 20 weeks' gestation or later (CDC, 2025), within the past five years in the United States. The five-year limit was set to minimize recall bias and account for evolving obstetric care practices (McCool & Simeone, 2002). Individuals were excluded if they identified as White or another racial or ethnic group, were currently pregnant, or if the referenced loss was a miscarriage or elective abortion.

Two virtual FGDs were conducted via Zoom to gather qualitative data. FGDs were chosen over individual interviews due to their ability to foster shared reflection and comfort among participants when discussing sensitive topics such as stillbirth and postpartum care (Wellings et al., 2000). Each FGD included four participants, lasted approximately two hours, and was facilitated by the lead researcher. The semi-structured interview guide was structured around key domains, with questions focused on social support, grief, and quality of care, all of which were examined within the context of the postpartum period. The guide also included questions about postpartum visit attendance as the primary outcome of interest. It was piloted with two eligible participants and refined based on their feedback. Discussions were recorded and transcribed using Otter.ai for subsequent analysis (Otter.ai).

Data were analyzed by two researchers, both of whom bring lived experiences as parents, including experiences with miscarriage, stillbirth, live birth, and cesarean delivery due to complications. Dr. Abdi identifies as a Black woman and member of the Somali diaspora. Arévalo is a mixed-race, non-binary MPH graduate, registered nurse, and staff member at a community OBGYN clinic. Their positionality informed a reflexive and empathetic approach to data analysis and interpretation. Transcripts were analyzed using Braun and Clarke's six-step thematic analysis approach (Braun & Clarke, 2006). Deductive codes aligned with the conceptual model were combined with inductive codes developed during transcript review. Coding and theme development were carried out through an iterative, consensus-based process, with regular meetings to review coded excerpts. Data were managed using Dedoose (Version 9.0.107), and participant pseudonyms and illustrative quotes were used in reporting findings (Dedoose). A synthesized version of the results was shared with all participants to enhance transparency and trust. To ensure rigor and trustworthiness, Lincoln and Guba's evaluative criteria were applied: credibility, dependability, confirmability, and transferability (Lincoln & Guba,

2007). Strategies included piloting the interview guide, dual coding by independent researchers, regular team debriefs, a clear study protocol, and purposive sampling methods to ensure relevance and depth.

This study was approved by the University of Minnesota Institutional Review Board (STUDY00020313), including consent procedures and all data collection instruments. All participants provided informed consent. The research was supported by two grants: the Graduate Student Research Development Grant (\$2,000) from the Minnesota Population Center and the Health Equity Working Group Grant (\$3,000).

Results

Eight African American participants who identified as cisgender women (mean age: 36) participated in the study. Most were married ($n = 5$), held an advanced degree ($n = 4$), and resided in the northeastern United States ($n = 4$). The average gestational age at loss was 29 weeks; most delivered singletons ($n = 7$), with one twin birth. One participant had a prior perinatal loss, and two had a previous live birth. An overview of the themes that emerged from the FGDs is presented in Table 1.

Table 1

Themes and Subthemes

Theme	Subtheme
1. Social Support/Support System	1.1 Sources of Support 1.2 Types of Social Support Received 1.3 Perceived Quality of Social Support 1.4 Lack of Support
2. Emotional Well-being/Grief Reactions	2.1 Emotional Responses 2.2 Behavioral Responses 2.3 Cognitive Responses
3. Interpersonal Interactions and Experiences with Healthcare Professionals	3.1 Positive Interactions 3.2 Negative Interactions
4. Racially Discordant and Concordant Care and Perceived Biases	4.1 Discordant 4.2 Concordant 4.3 Perceived Biases

Theme	Subtheme
5. Postpartum Follow-up Care and Beyond	5.1 Postpartum Visit Attendance 5.2 Type of Care 5.3 Navigating Subsequent Reproductive Care

Theme 1: Social Support

Participants described receiving varying forms of social support during and after their stillbirth experiences, which fell into three categories: emotional, informational, and instrumental. Support was primarily provided by healthcare professionals, especially nurses, and to a lesser extent by personal networks.

Emotional Support

Nurses were the most frequently cited source of emotional support, offering empathy, presence, and gestures that participants found deeply meaningful. Several participants described forming strong emotional bonds with their nursing teams. The mother of baby Giles shared "...one of them was like kind enough to, you know, give me a hug and kinda like tried to help me hold a [sic] piece together like what was happening" (Baby Giles), while Romiko's Mom remembered receiving "...a thinking of you card in the mail from a team of nurses who delivered my baby." Outside the hospital, nearly all participants emphasized the importance of peer support groups, which offered a space for honest expression and shared healing. Asiyah's mother expressed that "...when I tell you it has been, you know, very, very helpful for me just being in those groups and meeting other women who have experienced the same thing. ...it's been an amazing journey."

Informational Support

Nurses were also the primary source of informational support, providing guidance during hospitalization and postpartum care, including lactation management.

...I had a nurse who just yeah, she said cold cabbage. And so, I had my husband go buy cabbage. And sure enough, you know, again, two days after delivery, the milks [sic] started to come and so [I] had the cabbage prepared. (Mommy C3)

Most participants also received discharge packets from hospital social workers containing grief resources and local support group listings. Dee confirmed, “For me, I think that they, in that packet, like everyone mentioned, they give you just a free stuffed folder of stuff. There was a list of support groups, local support groups, and organizations.”

Only one participant reported receiving informational support from a family member; her brother helped her find a therapist after the loss.

Instrumental Support

Instrumental support included tangible actions such as memory-making activities or logistical help. Again, nurses played a central role in facilitating these efforts. “She [nurse] took pictures of me and my partner and mom. . . .they dressed him [son] up in little donated premature outfits. They did his handprints, and his feet prints for me” (Romiko’s Mom). Musa’s Mommy shared, “My midwife called my doula, and she also called my mom, and one of the nurses took me home.” From personal networks, one participant described a community-organized meal train: “I think my main social support came from the community that we’re in, you know, they organized meal trains. It was, it was so beautiful” (Mother to Asiyah).

Perceived Quality of Support and Lack of Support

Participants overwhelmingly praised the emotional and practical care provided by nurses, often describing them as “compassionate,” “spectacular,” and “sincere.” However, many expressed dissatisfaction with physicians, characterizing their presence as brief and emotionally detached. Baby Giles’ mother felt like “the doctors tried to distance themselves.” Several participants also reported a lack of meaningful support from family and friends, noting that relationships often became strained or distant: “Like I said, I’m not even one year, but there are some friendships that have already gone by the wayside. Because they don’t know how to handle someone who’s had something like this. And that’s hard, but it’s reality” (Mommy C3).

Theme 2: Emotional Well-being and Grief Reactions

Participants described complex grief reactions following stillbirth, encompassing emotional, behavioral, and cognitive dimensions. These

responses were organized into three subthemes: emotional, behavioral, and cognitive.

Emotional Responses

Emotional reactions were varied and intense, with sadness, guilt, and anger being most prominent. Over half of the participants reported persistent anger during the postpartum period. Bereaved parents shared, “I think my postpartum experience was really emotionally devastating, and I had various emotions, sadness, regret, guilt, and all that” (JD and KD). Musa’s Mommy expressed, “I started seeing a therapist like maybe seven months later, because I knew that I was, I was getting worried because I was angry. I was angry all the time” (Musa’s Mommy).

Behavioral Responses

Social withdrawal was widespread, as participants isolated themselves from family and friends. One participant noted, “I just cut people off because they were irritating me” (Sunshine). Another participant, Romiko’s Mom, shared the profound impact of stillbirth: “I did the self-isolation. It took me a month to even announce to the world that my son was no longer here, that I wasn’t pregnant...”

Simultaneously, nearly all participants actively sought support from others with similar experiences, often through support groups and targeted resources:

...but I ended up doing my own deep dive, you know, kind of research on Google, trying to figure out like, what resources would be helpful to me since I have a baby, you know, it wasn’t like I had a child that died. So that kind of took me to finding like Star Legacy and other different resources that were more focused on infant loss and miscarriage. (Baby Giles)

Other behavioral responses included self-care practices and deliberate avoidance of loss-related triggers.

Cognitive Responses

Though mentioned infrequently, one participant described how she often found herself spending a significant amount of time “ruminating” and reflecting on the loss. This rumination typically centered around thoughts of “how things could have been different” and dwelling on aspects that were “missed.”

Theme 3: Interactions and Experiences with Healthcare Professionals

Participants' experiences with healthcare professionals during and after their stillbirth were divided into two subthemes: positive and negative interactions.

Positive Interactions

Many participants described receiving compassionate, collaborative care during labor and delivery. Supportive communication from nurses, midwives, doulas, and social workers was a key feature, often including emotional support, shared decision-making, and access to grief resources. Participant Dee shared that “the emergency room team and the labor and delivery team were very kind and they were so socially engaged and gentle with me...”. Another participant detailed:

You know, she [doula] told me what to expect, you know, like she told me what my choices were, as far as having a C-section or delivering, and since I had a doula, I knew I was gonna have a solid support system at the hospital. ... The midwife that was at the hospital who was going to deliver me, like you know, we, you know, everything was just take a breath, you know, like this is going to be really, really difficult, but we're here to support you. (Musa's Mommy)

Participants appreciated being involved in care decisions and noted when professionals took time to support their families. For example, JD and KD affirmed, “The good thing about this [was] we were involved in decision making. I feel the family was adequately involved in decision making during the whole process...” Another participant shared her experience, stating:

So, they did you know, there was a woman [social worker] you know, she did take her time to really go through how to she took her time with me to talk to me about how to help my kids cope with the grief. (Mother to Asiyah)

Negative Interactions

Conversely, participants also recounted distressing interactions across the continuum of care during pregnancy, labor, and postpartum. Nearly half

described unsupportive or dismissive communication, often feeling gaslit or unheard.

My OBGYN who I felt like this accident could have been prevented, because there were some questions that I had asked her prior to the occurrence of his passing that I believe could have been lifesaving. And yeah, I wasn't listened to. (Mommy C3)

Some shared traumatic or retraumatizing encounters, including being congratulated on a baby who had died or being met with confusion during follow-up care. Dee explained, "I felt like more than just the labor and delivery and postpartum experience. My entire pregnancy and just my interactions with OBGYN were incredibly traumatizing the entire time." She later described her interactions with nurse assistants during routine follow-up care.

Every time I went back in the nurse assistants were asking so you had a pregnancy, you're pregnant, where's your, you had a baby, you have a baby, how many babies do you have? And it's just very it's just like retraumatizing every time. (Dee)

Similarly, another participant said, "I got a bunch of congratulations, but it wasn't a congratulations because I knew I was going to be going in pregnant believing [sic] without a baby..." (Romiko's Mom). Many participants also felt their care was rushed or impersonal, particularly after the delivery. One participant noted, "...but in regard to my health care provider, I think it was just like, this is what we do. And then bye, your here's your stuff, and that was it" (Mommy C3). Dee shared a similar sentiment, stating, "I felt like once he was delivered, I was just another person in the way... they [medical doctor and hospital staff] were just trying to figure out how to get me out of the unit."

Theme 4: Racially Discordant and Concordant Care, and Perceived Biases

Participants reflected on how race and perceived biases influenced their reproductive healthcare experiences. This theme is divided into two subthemes: 1) racially concordant and discordant care, and 2) perceived biases.

Discordant and Concordant Care

Half of the participants mentioned that the racial identity of their healthcare providers was a significant factor in their care experience. Several shared that

racially concordant providers, those who shared their racial or cultural background, were more likely to communicate in relatable, accessible ways. In contrast, discordance often created a disconnect.

But I feel like medical professionals, who can see themselves in their patients, can figure out a way to paraphrase complex terms in a way that's relatable. And, I feel often times that I because I don't have medical professionals who can see themselves in me, I am not afforded the opportunity to have things broken down in a relatable, layman's term way. ... And, that's where that disconnect with white medical professionals comes into play. (Dee)

Some participants actively sought out providers of color, particularly Black women, though they acknowledged these providers were often difficult to find:

You know, there's sometimes there's something to that so I always attempted at the very least to try to find a woman doctor, African American tend to get harder. Not so much because they weren't around. ... So and then always I would try to go to a woman of color next. (Baby Giles)

Others expressed fear of discrimination impacting the quality of their care: "Somehow I had fears that I would be maybe discriminated because of my race and all that, and I would not receive a good care after delivery and all that" (JD and KD).

Perceived Biases

Several participants described interactions they interpreted as biased or dismissive. One participant felt her birth options were presented in a way that discouraged genuine choice:

When I got to the hospital, they laid out all of my options on the table, but I don't feel like the options were given to me. Like, what would you like to do? I feel like they were biased or like they were trying to persuade me to one option versus the other. (Romiko's Mom)

Others felt they were being gaslit or blamed, potentially due to their race, age, or appearance:

...I was given so much like reassurance, if that makes sense. Like, it was like, you're okay. You're fine. Like gaslighting in a sense of making me

feel like I don't know if it was because of my age or for whatever the reason, maybe hijab, not sure, color of the skin. I don't know that my ethnicity. (Mother to Asiyah)

Theme 5: Postpartum Follow-up Care and Beyond

This theme explored participants' experiences with postpartum follow-up care and their navigation of reproductive healthcare after stillbirth. Subthemes included: (1) postpartum visit attendance, (2) type of postpartum care received, and (3) navigating subsequent reproductive care.

Postpartum Visit Attendance

About half of the participants attended their PPV within the recommended timeframe, while others either skipped it or followed up later through other means.

Type of Postpartum Care Received

Participants primarily received clinical care focused on physical recovery, often prompted by postpartum complications. "I had a follow-up, I think six days, like within a week or two after I gave birth to my son, because I had excessive bleeding, and I was concerned about it..." remembered Romiko's Mom. The mother of Baby Giles "was in and out of the hospital for follow-up procedures for the full six weeks of [her] postpartum period." Some also received informational support, such as explanations of autopsy results or referrals to resources. "And then I ended up going back because I really needed the MFM to explain to me the autopsy report," participant we have coded as Baby Giles shared. Repeated stillbirths could mean more attention. "I was given additional resources because of the first [sic] and experiencing loss earlier with [sic] with your first pregnancy" (JD and KD).

Navigating Subsequent Reproductive Care

Several participants expressed a profound loss of trust in the healthcare system and hesitance to engage with OBGYN care in the future.

...it still wreaks havoc on my medical care, like how I interact with, especially OBGYN, just because for other like menstrual care and things

like that, I just don't trust that they will believe when I tell them something, because they never showed that they believed me in the first place. (Dee)

...it's so hard to trust anyone after that, like even my OB now. Like we're always just going like it's so hard to like the whole the healthcare like it's just, it puts you in such like this terrible mindset where it's like these people don't know what they're talking about, like, like we don't even know what we're talking about like there's it's so hard to trust someone in the health care now... (Mother to Asiyah)

Some attempted to re-engage previous providers. In one case, a participant was denied continued care without explanation:

...but I did end up getting pregnant a few months later. And I tried to go back to that woman that I was getting my prenatal care from because I don't feel like any of it was her fault. Or you know, I feel like it was out of her control. She didn't do anything wrong, but that clinic was still very close and I still had that idea that positive idea of her being everyone's doctor and she kind of refused service from me. So that kind of all will always stick in my mind as well. And I'm like why she couldn't give me a medical reason. Why so that kind of hurt my feelings as well. (Romiko's Mom)

More than half opted to change providers and in some cases, their entire healthcare setup to regain a sense of control and safety. "It was a completely different company, a completely different location, a completely different city. I even got a new medical insurance..." shared Romiko's Mom. Mommy C3 was unsure of how to approach neducan care going forward: "So, for me all the medical like I don't even know if I'll see a doctor next time. Maybe I'll just do a midwife..." (Mommy C3).

Discussion

This qualitative study explored the postpartum care experiences of Black birthing people following stillbirth, with a focus on social support, grief, and quality of care, and examined whether these experiences influenced PPV attendance. Participants reported limited sources of postpartum support, with nurses and midwives often serving as the primary providers of emotional, informational, and practical support. These findings mirror prior research indicating that nurses play a critical role in compassionate care following stillbirth, particularly for Black birthing people (Fenstermacher & Hupcey,

2019). This theme also underscored that time with medical doctors was generally brief and usually occurred only when a medical diagnosis was involved. For the birthing parent, this often created the impression that doctors were detached and distant, and appeared to lack empathy for the situation. Support groups were described as a crucial outlet, providing emotional validation, reducing isolation, and fostering a sense of community. This aligns with previous studies noting that support groups help bereaved parents navigate grief by sharing experiences with others who understand perinatal loss (Cacciatore, 2007). A recent feasibility study also emphasized the importance of culturally specific online support groups for people of color, highlighting the need for tailored bereavement support (Gold et al., 2022).

Participants described a range of grief responses, including sadness, guilt, anger, and social withdrawal, which are well-documented in the broader stillbirth literature (Persson et al., 2023). Consistent with prior qualitative research involving Black birthing people, this study confirms that emotional and behavioral reactions to stillbirth are multifaceted and often intense (Evans et al., 2023; Kavanaugh & Hershberger, 2005; Van, 2001; Van & Meleis, 2003). While the study did not introduce new grief typologies, it adds depth to the limited body of literature specific to Black birthing people's emotional responses after stillbirth.

Participants generally reported positive interactions. This positivity often stemmed from the social support provided by the nursing staff, whether it was emotional, informational, or practical assistance. These findings also align with the limited qualitative research that indicates interactions with nursing staff are generally positive for Black birthing people who have experienced perinatal loss (Fenstermacher & Hupcey, 2019). However, negative encounters with other healthcare professionals were frequently described. Participants recounted experiences of being gaslighted, dismissed, or retraumatized, especially when medical staff congratulated them at follow-up visits without reviewing their charts. Findings from this study are consistent with other research that broadly examines the obstetric experiences of Black birthing people, though not specifically in the context of stillbirth. Previous studies suggest that many Black birthing people frequently encounter poor communication, feel overlooked with their concerns disregarded, and often report a lack of empathy from healthcare providers regarding their obstetric care (Barnett et al., 2022; Mehra et al., 2020; OjiNjideka Hemphill et al., 2023).

These findings suggest that Black birthing people who have experienced stillbirth encounter similar challenges in care.

Many participants emphasized the value of racially concordant providers and described how racially discordant care compromised communication, comfort, and cultural understanding. These findings align with a growing body of research showing that racial concordance improves trust, patient-provider communication, and perceived quality of care among Black patients (Shen et al., 2018). Participants in this study reported greater comfort and openness with racially concordant providers, confirming findings from earlier work indicating that such concordance fosters safer, more affirming care environments (Altman et al., 2020; Deichen Hansen et al., 2021). This study extends that literature by highlighting how the desire for racially concordant care is especially salient in the context of stillbirth.

While half of the participants attended a PPV, their primary motivation was medical necessity, typically due to complications during pregnancy. Emotional care was often absent from these visits, and prior negative experiences with the healthcare system eroded trust, prompting some to seek new providers. These findings are consistent with the literature, indicating that chronic health conditions increase the likelihood of PPV attendance in live birth populations (Bennett et al., 2014; Levine et al., 2016; Schwarz et al., 2017), suggesting this may extend to those experiencing stillbirth. However, participants did not explicitly link their experiences of social support, grief, or care quality to their decision to attend a PPV, limiting the ability to draw conclusions about these relationships. This highlights a gap in the existing literature, while prior studies have suggested that social support may influence PPV attendance (Cardona Cordero et al., 2021), no known studies have examined grief or quality of care as predictors of PPV following stillbirth.

Strengths and Limitations

This study has several notable strengths. It addresses a significant gap by centering the lived experiences of Black birthing people following stillbirth, a population that faces disproportionate risk yet remains underrepresented in the literature. Grounded in Black Feminist Thought, the study offers a culturally attuned lens that enhances its relevance and depth. A further strength is that participants were given a synthesized summary of the findings, promoting transparency and trust. However, the study also has limitations. The small

sample size and use of only two focus group discussions limited the ability to explore contextual diversity (e.g., geographic location, place of birth, socioeconomic status). All participants had sought support groups, which may have influenced their experiences and limited the variability in their responses. The inductive analytic approach, while appropriate, relies heavily on the researcher's interpretation, which may differ from that of other analyses.

Conclusion

This study contributes to a growing but still limited body of research exploring postpartum experiences of Black birthing people who have experienced stillbirth. It is among the first to qualitatively examine how social support, grief, and care quality may influence PPV attendance in this population. While no direct link was established, these findings underscore the importance of emotionally attuned, culturally responsive care and highlight the need for further research on systemic barriers to post-loss support and follow-up. Given the disproportionately high rates of stillbirth among Black birthing people, addressing existing gaps in the literature is crucial, particularly around key elements of care, such as care quality, that warrant further examination to better support this population.

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