2020

Minority Pregnant Women Perspective on Health Disparities and Health-Related Outcomes

Lorna Robinson
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Lorna Robinson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Donna Bailey, Committee Chairperson, Nursing Faculty
Dr. Kathleen Brewer, Committee Member, Nursing Faculty
Dr. Mary Catherine Garner, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Minority Pregnant Women Perspective on Health Disparities and Health-Related Outcomes

by

Lorna Robinson

MSN, Walden University, 2013

BSN, Montgomery University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health Policy

Walden University

April 2020

Abstract

Health agencies have recognized persistent health care disparities as the primary causes of mortality among minority populations. The emphasis of published studies on the health of minority women in the United States has revealed a knowledge gap in prioritizing prenatal care (PNC). The purpose of this narrative descriptive study was to explore access disparities in PNC and the effect the overall experience had on first-time pregnant minority women in receipt of PNC. The health services utilization framework provided the theoretical lens to analyze and interpret the findings of this study. The key research questions explored how the self-reported experiences of first-time pregnant minority women when seeking PNC affect the overall process to achieve positive pregnancy outcomes. Twelve first-time pregnant minority women living in the northeast metropolitan region of the United States participated in semistructured interview that generated data used in this study. NVivo 12 was used to manage data, enabling the use of thematic analysis to create the study findings. Key study findings revealed several interrelated themes such as racial/ethnic discrimination, health insurance status, and income status in the process of seeking care defined access disparities that negatively affect the PNC experiences. The positive social change implications from the results of this study include guidance for the implementation of targeted health care policy that includes public health professionals (PHPs) as stakeholders. A partnership between the PHPs and health care reform legislators could be the catalyst for improved outcomes, transparency, trust, accountability, and opportunities to create targeted approaches and sustainable interventions to influence positive pregnancy outcomes for these women.

Minority Pregnant Women Perspective on Health Disparities and Health-Related Outcomes

by

Lorna Robinson

MSN, Walden University, 2013

BSN, Montgomery University, 2004

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Public Health Policy

Walden University
April 2020

Dedication

I dedicate this dissertation to my family who have been instrumental and supportive in every aspect of this challenging and fulfilling process. I also dedicate the passion which provided the impetus to fulfil my long-term goal of being a lifelong learner and to create a positive social change by making a difference in this world.

Acknowledgments

First and foremost, I give thanks to God who has surrounded me with positive people who adds value to my life and challenge me to be a better person each day. My parents taught me that knowledge and wisdom go together; therefore, live my life so that I am teachable at any age and that my knowledge and wisdom will multiply if I am a lifelong leaner. I appreciate the constructive feedback by the Walden Faculty who provided insight during this process. The team of experts I was fortunate to have including Dr. Bailey, Dr. Brewer, and Dr. Garner who provided guidance and focus on this topic to affect social change for health access disparities that has the potential to affect social change and influence outcomes for those most vulnerable.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

Health disparities are significant health challenges experienced by minority pregnant women who are at a relative disadvantage in the United States. Minority populations, including African Americans and non-White Hispanics or Latinos, experience health disparities and adverse health outcomes when seeking access to health care services (Kirzinger, Hamel, Muñana, & Brodie, 2018). Healthy People 2020 (2015) reported that health disparities occur across many dimensions, including minority groups and socioeconomic status (SES), disproportionately affecting mothers and infants, and they emphasized that improving maternal and infant health outcomes is an essential public health goal for the United States. Researchers have recognized that the potential health benefits from health visiting practices of minority pregnant women are a facilitator for promoting health and improving maternal and infant mortality and quality of life (Cowley et al., 2015). Therefore, health visiting practices can provide from this lens the health of the next generation and predict the future challenges of the public health of women, infant, and the health care system.

Some subgroups in the United States are at a relative disadvantage and more likely to experience barriers to health care access, receive less quality of care, and report poorer health outcomes more often than other advantaged groups (Agency for Healthcare Research and Quality [AHRQ], 2016). The AHRQ (2016) reported that approximately 25.8% of African Americans, 34.9% of non-White Hispanics or Latinos, and 35.5% of the populations whose family incomes fall below the federal poverty level reported barriers to accessing the health care system. These barriers to accessing health services lead to unmet health care needs, delays in receiving appropriate care, and financial burdens (Healthy People 2020, 2015). African Americans and non-White Hispanics or Latinos receive worse health care than Whites do for 38% of all quality measures, and individuals with lower income receive more inadequate care than do those with higher income, defined by the AHRQ as family income four times the federal poverty level or higher, for 62% of all quality measures. Also, current literature showed that minority pregnant women are one of the medically underserved subgroups in the United States. Like other disadvantaged subgroups, minority pregnant women experience lower SES and are less likely to gain the timely use of personal health services or achieve the best health outcomes (Docherty & Johnston, 2015; Gabbe et al., 2017). Similarly, the U.S. Department of Health and Human Services (HHS) reported in April 2017 that, compared with Whites, racial-ethnic minority populations were less likely to receive the preventive care they need to remain healthy, less likely to gain access to quality health care, and more likely to suffer from severe diseases and report poorer health outcomes (Robert Wood Johnson Foundation [RWJF], 2018).

Evidence from research has shown that the implementation of an advanced community-based prenatal support programs results in significant improvements in maternal and infant health in disadvantaged neighborhoods at the local, state, and federal levels (Docherty & Johnston, 2015; Gabbe et al., 2017; Ramsey & Mayes, 2018). These support programs include PNC; evidenced-based education with specifically trained staff; Children’s Health Insurance Program (CHIP); Medicaid and Medicare, and Supplemental

Nutrition Program for Women, Infants, and Children (WIC); and other resources to target vulnerable and underserved populations. Evidence has suggested amid current healthcare reforms and rising immigration minority groups are at a disproportionate risk of being uninsured, lack access to care, have poor health status, and experience poorer health outcomes. The impact of uninsured on healthcare costs was nearly $185 billion in 2017 (Garfield, Damico, & Orgera, 2018). Further, the financial burden of uninsurance is as burdensome for uninsured individuals, with nearly 50% of personal bankruptcy filings being a result of medical expenses (Consumer Financial Protection Bureau [CFPB], 2017; Hamel et al., 2016).

Covered in this chapter is the background, the problem statement, the purpose of the study, the research questions (RQs), and the nature of the study. Additionally, Andersen and Newman’s Framework of Health Services Utilization (ANFHSU) is the theoretical foundation underpinning this study. Other areas highlighted in the remainder of this chapter include the nature of the study, definitions of key terms, assumptions, scope and delimitations, limitations, and significance.

Background to the Study

Less literature has given focus or voice to minority pregnant women’s perception of health disparity and health-related outcomes. Health disparity has been a longstanding issue in the United States mainly affecting racial/ethnic minorities and individuals of low SES. Coordinated efforts to address health disparities and achieve equity for all began in the 1990s with the publication of Healthy People 2020 initiatives (Douthit, Kiv, Dwolatzky, & Biswas, 2015). Twenty-eight years later, health disparities are even more complicated and remain an elusive victory facing arguably the most robust economy in the world, the United States. Other notable efforts to reduce health disparities involved the Institute of Medicine (IOM) 2002 report titled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” following the 1991 congressional request (IOM, 2002). The IOM report emphasized evidence of discrimination, exclusion, prejudice, and stereotyping by health care providers (HCPs) as contributing to disparities in care (IOM, 2002).

This definition of health disparity by IOM (2002) provided more clarity and yet alarming attention:

> racial and ethnic disparities in health care exist even when insurance status, income, age, and severity of conditions are comparable, and because death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites, these disparities are unacceptable. (p. 666)

Healthy People 2020 (2014) defines health disparity as

> the difference in health because of the economic disadvantage including the lack of resources and opportunities that adversely affect groups of people based on their racial or ethnic group, SES and or geographic location and the subsequent inability to afford goods, services, and influence, or other “characteristics historically linked to discrimination or exclusion.” (p. 1)

These differences in health care occur in the broader context of historical and current social and economic inequality which is often a prevalent racial-ethnic discrimination of American life (IOM, 2002). Research literature has shown persistent and well-documented disparities in maternal–child health outcomes among childbearing women of low SES, women of color, adolescent women, and rural women and a parsed view showed that the social and economic toll of ill health among women and children is notably costly (Bloom, 2011; Smith, 2015). Moreover, racial/ethnic minority childbearing women experience cultural and interpersonal barriers when accessing services due to the hierarchical social structures resulting in the power dynamics of the patient-provider interaction (Zimmermann, Carnahan, Paulsey, & Molina, n.d.), resulting in inadequate care and less favorable outcomes for these women (Centers for Disease Control and Prevention [CDC] (2013).

There are structural measures of the presence or absence of specific resources that facilitate health care for racial/ethnic pregnant women, such as having health insurance or continued care, easy access to care, and the successful outcome received from much-needed services. Hall, Dalton, and Johnson (2014) research revealed that the poor and unequal reproductive health outcomes in the United States reflect the inadequate and differential delivery because of limited service use seen among low-income, unemployed, or uninsured women and women with less educational attainment than younger and more socioeconomically advantaged women. Beckham, Urrutia, Sahadeo, Corbie-Smith, and Nicholson’s (2015) research showed that socioecological conditions interfered with low-income, minority women’s capacity to engage in health-seeking behaviors postpartum. Moreover, when there is clinical uncertainty from the HCPs, these inequalities may contribute to racial-ethnic disparities (Chapman, Kaatz, & Carnes, 2013; IOM, 2002).

These factors have been detrimental to equally gain equitable care and successful outcomes for marginalized women.

Population health outcome indicators measure health care, health status, and quality of life (Health People 2020, 2015; World Health Organization [WHO], 2015). Improving health outcomes has been a top priority for health agencies and health research organizations (AHRQ, 2016; CDC, 2014; Healthy People 2020, 2014; WHO, 2015). Racial-ethnic minority status and socioeconomic factors are inarguably salient contributors to health disparities in minority pregnant women with limited health resources. These factors include sex, age, lack of healthcare, unemployment, and geographic location (Healthy People 2020, 2015). Lack of health care resources is a significant factor in how minorities and socioeconomic factors influence health disparities and health-related outcomes (Docherty & Johnston, 2015) toward successful receipt of health services. Unless there is adequate access to health care resources and transparency in underserved subgroups, the existence of these programs may not help promote equitable access and use toward successful outcomes.

Amidst the progress in policy and program interventions aimed at improving health care service at the local state and federal levels, not all are benefiting equally because of overarching factors such as SES or racial-ethnic designation preventing successful health outcome in reflecting the policy-driven and health-related objectives (Healthy People 2020, 2014). Addressing language and geographic barriers and increasing access to insurance are part of the coordinated efforts required to not just address but to reduce health disparities. Health disparities are a barrier to high-quality care in that, at all levels when seeking care, more impoverished individuals are less likely to seek preventive care and adhere to national screening and treatment guidelines (CDC, 2014). Gabbe et al. (2017) found that that first-time pregnancies and first-time clinic users demonstrated challenges in navigating the health care system and showed a strong association with delayed PNC and late pregnancy recognition. For minority pregnant women, having health care resources available and targeted to their needs at all stages of pregnancy is the intended outcome to avoid mortality of the mother and infant. Health disparities and variations in access to care experienced by minority pregnant women include (a) perinatal services, (b) prenatal and postnatal services, (c) newborn screening, (d) nutrition and breastfeeding access to antenatal and postnatal care, (e) hospital maternity beds postpartum, (f) insurance, and (g) well-baby visits.

There is existing literature on health disparities reflecting the inadequate and differential delivery in access, use, and health-related outcomes (Hall et al., 2014; Liddell, Burnette, Roh, & Lee, 2018). Researchers have argued that contributing factors such as race, ethnicity, SES, geographic location, and poverty are key causes of structural and systemic indifferences (Cowley et al., 2015; Zimmermann et al., n.d.). The key to removing health disparity and increasing successful health-related outcomes is obtaining health care services, hence the importance of the presence of specific resources that facilitate health care, including timely use of personal health services, attaining good access to care, finding providers who meet their needs, and continuing care (Guerra-Reyes & Hamilton, 2017; Selchau et al., 2017). Findings from Guerra-Reyes & Hamilton; Selchau et al study suggests that with the rising diversity and the projected growing immigration, there needs to be rigid advocacy for vulnerable populations and those less likely to access or use health care (Docherty & Johnston, 2015).

This qualitative, narrative descriptive study potentially provides a thorough understanding of minority pregnant women's unique experiences related to health disparity and health outcome (Smith, 2014) and barriers to accessing health care from the individual's point of view. The results of this study may influence positive social change by providing valuable insights about minority pregnant women's perspectives about their experiences of health disparities (Kennard, 2016), thus supporting their achievement in navigating the health care system to prevent delayed treatment and gaps in care. Minority pregnant women might be able to access the timely use of personal health services, attain good access to care and ongoing care, and find providers who meet their needs, which might reduce the health disparity gap (Vardeman-Winter, 2017).

Problem Statement

The United States benefits when everyone in the country is afforded the opportunity to live a long, healthy, and productive life, yet health disparities persist. For this to happen, the United States health care system needs interventions aimed at closing the health disparity gap. Evidence from the literature has shown that early-life interventions significantly influence health outcomes as adults, suggesting there is a need to implement effective policy and program interventions to target early-development health challenges (Bullock, 2015; Shonkoff, 2014). The central role of Healthy People 2020 is to ensure everyone is afforded the equal opportunity to be healthy regardless of their racial-ethnic background. The AHRQ (2016), Healthy People 2020 (2014), and

WHO (2014) support the growing discourse surrounding early-development interventions which strongly influence the health outcomes of the adult population. The AHRQ and Healthy People 2020, not surprisingly, have highlighted the need for improvement in health disparity and health-related outcomes.

Research has shown that there are persistent health disparities among minority subgroups (Cowley et al., 2015). There are differences in health because of the economic disadvantage, including the lack of resources and opportunities, that adversely affect groups of people based on their racial-ethnic identity, SES, and/or geographic location, which is historically linked to discrimination or exclusion (Healthy People 2020, 2014) and is responsible for contributing to poor health outcomes. The Kaiser Family Foundation (KFF; 2018) explained that the uninsured rates among the non-elderly population are 8.4%, and 2.9% among children, which accounts for 11% of Blacks, 18% of Hispanics, and 7% of Asians as of 2017 (Kirzinger et al., 2018), which contributes to widening the health disparity gap. Health disparities may underlie adverse outcomes for minority pregnant women and infants. When health disparity affects pregnant women, it creates distresses that may be compounded by existing family difficulties of being a new or single mother of color who is also uninsured or unemployed, resulting in more significant conflict and increased risk for adverse physical and psychosocial outcomes (Martinez, Chandra, Febo-Vazquez, & Mosher, 2013). However, the United States has yet to devise equal opportunity access to quality health care systems strategically focused on targeting communities at highest risk. Many health concerns disproportionately affect the minority population such as infant mortality and mental health (Center for Disease Control and Prevention, 2014).

Evidence from research has revealed that African American women are marginalized in multiple domains of life and live in a context of reproductive disadvantage leading to racial inequalities in health (Beckham et al., 2015; Guerra-Reyes & Hamilton, 2017; Liddell et al., 2018). In another article on health disparity among minority pregnant women, Zimmermann et al. (n.d.) discussed some of that evidence experienced by marginalized groups. Second, socioeconomic disadvantage has exposed how unique challenges interfered with low-income, minority women's capacity to engage in health-seeking behaviors and health service use across the reproductive life course (Scherman, Tolosa, & McEvoy, 2018). The right to health quality indicates shared responsibility to be healthy not only in medical care but in health-promoting physical and social environments in homes, community, and workplace. Findings from the abovementioned research support the claim that health disparity exists and the need for additional research into understanding how to mitigate the disparity. Hence, this study helped fill a gap in the research by focusing specifically on the examination of self-rated health disparities and health-related outcomes by first-time use of a clinic among pregnant minority women, which cannot be fulfilled unless there is improved access linking coordinated resources to comprehensive care regardless of ability to pay.

Purpose of the Study

The purpose of this study is to identify (a) what SES, provider's perception of their race-ethnicity, knowledge, and care-seeking factors influenced first-time pregnant minority women’s access and use of health care, and (b) what first-time pregnancy health disparity may be unique to this population. Minority childbearing women experiencing their first pregnancy face a unique set of challenges as they navigate the health care system without resources, with little or no insurance, resulting in health disparities and uncertain health outcomes to avoid adverse pregnancy outcomes. To address this gap, for this study I used a qualitative paradigm, conducting interviews to develop an understanding of minority pregnant women’s perspectives on their unique challenges in accessing health care.

Research Questions

Narrative descriptive studies subsume a group of approaches that rely on the spoken words or visual representation of participants. These approaches typically focus on the lesson learned from the experiences of individuals as told through their own stories. Narrative approaches are considered real-world measures when real-life problems are investigated. Narrative research is guided by the validation of the audience (Creswell, 2009). Narrative description facilitates the identification of events directly from the context of and lessons experienced by these women (see Creswell, 2009). With these constructs in mind, I framed three narrative descriptive study questions. These RQs were used to obtain the responses needed to identify (a) what SES, provider’s perception of their race-ethnicity, knowledge, and care-seeking factors influenced first time pregnant minority women’s access and use of health care, and (b) what first time pregnancy health disparity may be unique to this population.

RQ1: How do the experiences of women, minority and underserved, of childbearing age, as they seek health care, affect their ability to achieve positive pregnancy outcomes (defined as term vaginal delivery, appropriate birth weight for infant and pregnancy weights for mother, and to avoid postpartum depression and infant mortality)?

RQ2: What are the self-reported health disparities in first-time pregnant minority women as they seek health care for the first time?

RQ3: How have the experiences of health disparity affected the health-related outcomes in first-time pregnant minority women as they sought health care for the first time?

Theoretical Framework

The theoretical underpinning for my study was the ANFHSU (Andersen, 1968). Andersen developed the original model in 1968 and extended it through numerous iterations to adopt health outcomes. Andersen developed the model to (a) to facilitate the understanding of why individuals use health services, (b) describe and measure equitable access to health care, and (c) contribute to the development of policy interventions for promoting equal access to health care, thus suggesting the need to explore factors that enable or inhibit access to health care. In this model, the use of health services is determined by three dynamics which are predisposing factors, enabling factors, and perceived and actual need (Andersen, 1968).

The ANFHSU has been used extensively in numerous studies to investigate the use of health services (Babitsch, Gohl, & von Lengerke, 2012) and was the most appropriate choice for this study. The ANFHSU is not only relevant to my study, but it is the most commonly used framework for studies focused on obtaining the individual's perception of their experiences as they access and use health care services (Aday & Andersen, 1974; Han & Redlich, 2018). In this study, I sought to understand health disparity and health outcomes experienced by minority pregnant women.

Nature of the Study

The nature of my study used a qualitative approach. Qualitative research is consistent with understanding health disparity and health-related outcomes experienced by minority pregnant women (Smith, 2014) and the unique barriers and challenges to accessing care. Keeping the focus on how health disparity and health behaviors in minority pregnant women exist is relevant to the ANFHSU. The results of my study may provide findings that will help understand health disparity from pregnant minority women experiencing the disparities, using qualitative narrative descriptive methods to address the local patterns of health care that are provided to these women. Narrative description is recommended because it facilitates the identification of events directly from the context of and lessons experienced by these women. A narrative descriptive approach includes in-depth interviews and journaling, which was optimal for collecting data on pregnant minority women personal histories, perspectives, and experiences, and when sensitive topics are being explored. It is also ethical to allow participants to review their data and the interpretations and offer their views regarding them (Creswell, 2009), allowing them "an opportunity to provide context and an alternative interpretation"

(Patton, 2002, p. 561) and adding their own perspectives to provide insight into their motivations which addressed the issues of quality and rigor.

I used purposive selection to ensure study participants included only pregnant Black/African Americans or non-White Hispanics or Latinos who experienced the phenomenon of health disparities when seeking health care and are willing to articulate their unique experiences to participate in the study. I collected data through one-on-one, face-to-face interviews conducted in a private room to ensure privacy and confidentiality of each study participant. Face-to-face interviews allowed direct interaction to explore experiences, perception, and perspectives of participants, which established the foundation for understanding the phenomenon under study through the lens of each participant, as emphasized by (Patton, 2002).

I used Braun and Clarke's (2006) six-phase guide thematic analysis technique as used by (Beng et al., 2014) and explained by Braun and Clarke, to become familiar with the data, generate initial codes, search for themes, review themes, define themes, and write-up the data collected. I used NVivo, a computer-assisted qualitative data analysis software (CAQDAS) system for organizing and storing the data collected and aid the analysis process (Woods, Paulus, Atkins, & Macklin, 2016). Braun and Clarke's six-phase guide thematic analysis technique allowed me to produce an exhaustive description of the phenomenon under inquiry.

Definitions

In this section, I define the meaning of recurrent key terms and phrases used in this study.

Health care access: Healthy People 2020 (2014) argued that access to comprehensive and quality health care services means achieving equitable health care services to preserve or improve health for populations health outcomes. Measuring health care access encompasses three key components including coverage, services, and timeliness. In my study, access to health care refers to the timely use of personal health service and visiting practices to achieve the best health outcomes.

Health disparities: Health disparities have been used in multiple contexts; there is consensus on the meaning. Although the term *health care* is often used to define racial-ethnic minority disparities (Healthy People 2020, 2015), in my study, *health disparities* refer to the definition by the National Institutes of Health (NIH, 2015) stating, "Health Disparities are gaps in quality of health and health care that mirror differences in SES, racial and ethnic background, and education level" (p. 1). Also, NIH added that the differences in health occur because of the economic disadvantage including the lack of resources and opportunities experienced by minorities or racial-ethnic disadvantage groups.

Maternal, infant, and child health: Maternal health encompasses the health care dimension of women of childbearing age from pre-pregnancy, during pregnancy, labor and delivery, and the postpregnancy period and infant and child health. The WHO (2015) referred to maternal health as the health of women during pregnancy, delivery, and the postdelivery period, whereas infant health refers to infant health and infant care, including promoting infant health before birth, newborn screening, basics of infant health, feeding, and immunization (WHO, 2015). Child health refers to physical, mental and emotional well-being in the absence of disease (WHO, 2015). Healthy People 2020 (2015) explains that the well-being of mothers, infants, and children determines the health of the next generation and helps to predict public health challenges in the future for families, communities, and the health care system. Moreover, healthy birth outcomes can identify early treatment of health conditions among infants, prevent mortality and ensures children reach their full potential.

Minorities or minority population: The terms minorities and minority populations are used interchangeably to represent the vulnerable, disadvantaged, and underserved populations. In my study, minorities refer to populations living in the United States with inadequate access to health care services and barriers to receiving essential care and receive lower-quality treatments compared to members of a privileged social group. The HHS states explicitly that self-identifying or the designation as a minority include one or more attributes such as living at or below the poverty level; being uninsured; has a language barrier; has knowledge deficit of the health care system, difficulty accessing health care, and/or provider perceived unmet needs (RWJF, 2018).

Socioeconomic status: SES is the combined measure of the economic, sociological, and work experience of the person, individual, or family in relation to others. The CDC (2014) stated that SES is a broad concept that includes economic, social position, and work measured by wealth, education, and income respectively. In my study, SES refers to the measurement of an individual's economic and social position in relation to others based on income, occupation, geographic location, education, and access to care. SES groups can be grouped into three categories such as the upper, lower, and middle class (Markus & Conner, 2013). My study focused on the lower social level of the socioeconomic hierarchy. In the next section, I highlight assumptions which form the foundation of my study.

Assumptions

Underlying my study was the assumption that the availability of scientific evidence about health disparities experienced by pregnant minority women in the United States would enable the understanding of maternal and neonatal-life health needs and health outcomes of this population. I assumed that study participants voluntarily would share their unique experiences of health disparities as they seek health care through providing honest answers to all interview questions. Another assumption was that the available literature on the phenomenon being investigated could help inform policy and the implementation of effective program interventions to confront the root causes of health disparities, particularly socioeconomic inequalities. If these interventions were effective, they would improve equity in health care access and use, which would result in tremendous improvements in the health and well-being and quality of life for all Americans. I also assumed that the knowledge deficit of the nature and outcome of barriers to access essential health care was a result of poor health outcomes among minority pregnant women.

Many available kinds of literature have supported the overwhelming findings that programs supporting family planning and maternal health helped to reduce poor health outcomes for mother and infant (Black et al., 2017; Creanga et al., 2014; Johnson et al., 2006; S. Lee et al., 2016). I assume that disseminating the findings from my study would highlight the areas of urgency and health disparities for the pregnant minority women more transparent to prioritize the government's policy agenda. In creating this awareness, HCPs at the forefront of policymaking and policymakers would not only address the urgency but advance the agenda of health disparities. My study is assumed to be in line with United States health agencies agenda and national priority in reducing health disparities in essential health care access to promote quality health among individuals, groups, communities, and populations in the United States.

These assumptions were necessary to facilitate how I saw the population I explored and what I hope would happen as a result of my study. The main reason I did this study was to fill the gap in the literature related to the minority pregnant women's perception of health disparity and inequality. Many available kinds of literature have contributed and supported the overwhelming findings that programs supporting family planning and maternal health help to reduce poor health outcomes for the mother and infant.

Scope and Delimitations

My study was limited to understanding the details of health care access experienced by minority pregnant women in the United States. The focus of my study advanced from findings indicating that minority pregnant women were one of the medically underserved populations in the United States. Regardless of growing efforts to address health disparities among different subgroup populations in the United States, study findings have indicated that minority pregnant women experience more challenges in accessing ongoing health care and report poorer health outcomes compared to those in more privileged social status (Caldwell et al., 2016; J. Chen, Vargas-Bustamante, Mortensen, & Ortega, 2016). In my search of the literature, I found no qualitative study focused on understanding first-time pregnant minority women accessing health care for the first time. The lack of details about first-time health care access experienced by first-time pregnant minority women in available literature was the primary rationale for my study.

My study was conducted in a large metropolitan area (MA) in the Northeast region of the United States, one of the largest in MA and one of the most populous areas for minorities (World Population Review, 2018). The U.S. Census Bureau (2017) has shown since 2018, the population of MA is estimated at 622,000, and the racial and ethnic breakdown of the city include Blacks at 63.7% and Hispanics, Latinos, or Spanish of any race at 4.2%. I do not live in this area or interact with the population which is the focus of my study. I included self-identified Blacks/African Americans and non-White Hispanics or Latinos who are first-time pregnant women and first-time accessing health care. Focusing my study on first-time pregnant Black and non-White Hispanic or Latino women who are also first-time accessing health care excludes other racial-ethnic pregnant women and multiparity women.

The screening process for participants in my study excluded mothers, other racial-ethnic pregnant women, or other illegal or undocumented pregnant women. My rationale for the exclusion is keeping in line with the population focus of my study and that multiparity women may be intensely emotional and may not respond accurately or comfortably from their recollection. Furthermore, eliciting information from pregnant undocumented women in the United States could jeopardize those who may be visitors who overstayed, and excluding this population ensured that all participants included in my study are eligible for care. Understandably, the exclusion is necessary to ensure it would not undermine my study.

Another illustration is to avoid acculturation on the area being studied of health disparities in first-time pregnant minority women seeking health care for the first time. The purpose of my research was to understand that minority women experiencing their first pregnancy face a unique set of challenges in navigating the health care system without adequate resources. Therefore, it was assumed that including acculturated first-time pregnant minority women in my study could undermine the potential to understand the experience of health disparity by first-time health care seekers.

The characteristics of the recruited participants I used in my narrative descriptive study might be challenging for transferability to other settings or similar groups or populations. The participants were from the northeast area MA, a state that has offered health and supplemental insurance and has included the Affordable Care Act (ACA) since 2010. Findings from my study may not be transferable to first-time pregnant minority women or in other states with different insurance policies or states that did not adopt the ACA. Furthermore, from a cultural standpoint, health-seeking behaviors may differ between cultures and may not inform the general population of first-time pregnant minority women experiences of health disparity when seeking health care for the first time across communities in the United States.

Limitations

Limitation from the study may include the recruiting of participant criteria of my narrative descriptive study. Study participants purposively selected may not represent adequately the general experience of health disparities seeking health care for the first time among first-time pregnant minority women in the United States. My central role in the recruiting selection and being the primary study instrument may become a problem for biases or distortion of research outcomes in my study. However, considering the implications of the potential problems of biases in my qualitative research, I used reflexivity and reflexive journal as one effort to address the potential distortions or preconceptions I might unwittingly introduce into my qualitative designs. Reflexivity is a significant concept directed at the greatest underlying threat to the trustworthiness of qualitative research outcomes (Patton, 2002), specifically, the social interaction component of the interviewer-interviewee relationship. Therefore, to understand my role as the interviewer and the interview context to establish trustworthiness, utilizing the technique of “mutual collaboration” helped enhance transparency and accountability (Shelton, Smith, & Mort, 2014).

Significance of the Study

This qualitative study is essential because it filled a gap in understanding by focusing specifically on health disparities and health outcomes from the perspectives of first-time pregnant minority women and their first time accessing a clinic in an urban neighborhood. My project is unique in that it addressed an under-researched area, views from the women themselves, surrounding their unique experiences related to health care access, health disparity, and barriers to care related to socioeconomic factors and minority groups (see Ganle, 2016; Vardeman-Winter, 2017). The results of my study may provide valuable insights about minority childbearing pregnant women's perspectives about their experiences of health disparities (Kennard, 2016), thus supporting their achievement in navigating the health care system to prevent delayed treatment and gaps in care. These potential findings could foster positive change in nursing practice. As a practice discipline, nursing may benefit from this research because it could provide nurses with insight into some of the barriers these women face in accessing and navigating healthcare and healthcare services. Being able to create care environments that welcome pregnant women and encourage them to ask questions and share their concerns could increase the patient's compliance with their treatment plan because they perceive they are a part of the team. Looking at the study findings from new perspectives could lead to positive social change beyond nursing.

Walden University defines positive social change as, "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies" (About Us, para 1, 2018). Identifying the perspectives of women experiencing health disparities related to socioeconomic factors and ethnicity/race could engage women to partner in their development of their own health and that of their unborn child. Their ideas and approaches to accessing healthcare under difficult circumstances could help providers mitigate factors that create those difficulties as well as to develop services that foster more accessible navigation of those services. Facilitating the developing family's access to healthcare and information could benefit communities by enabling the family members to become more engaged and involved in their local communities. Growing communities depend on their citizens for stability and growth that is fostered by healthy citizens, involved organizations, and diverse perspectives.

Summary

Health disparities are the difference in health because of the economic disadvantage including the lack of resources and opportunities that adversely affect groups of people (Semega, Fontenot, & Kollar, 2017), such as pregnant minority women, SES and/or geographic location. Minority pregnant women are one of the medically underserved populations in the United States (Cohen, Zammitti, & Martinez, 2017). Women from racial-ethnic minority groups and low-income communities have limited and fragmented access to quality maternity care services and experience disparities in access and adverse outcomes of maternity care in the United States. Although there are policy interventions at the local, state, and national levels to mitigate health disparities, research has indicated evidence of persistent challenges in disparities in health care access and health-related outcomes between minority pregnant women than more privileged pregnant women (Bloom, 2011).

This narrative descriptive study provided study participants with an opportunity to identify events directly from the context of and lessons experienced when seeking access to PNC. Chapter 1 provided a synopsis and background of the challenges of health disparities, the problem statement, the purpose of the study, the nature of the study, and the RQs. Additionally, Chapter 1 emphasized how the ANFHSU underpinned this study of the events from their experiences and lessons learned from the challenges of health disparities. Finally, recurrent key terms were defined followed by the scope of the study, assumptions, limitations and delimitations, and the significance.

In Chapter 2, provided additional detail from the literature to support why this study was needed, what we currently know, how we have usually explored the area of health disparities empirically, and why narrative descriptive design is an effective approach to understanding this area. I also describe the research that has used the ANFHSU to illustrate its utility in framing my RQs. Chapter 3 presented details of the chosen methodology for my study, Chapter 4 presented the results of my study, and in Chapter 5, I discussed the findings of my study and provided conclusions and recommendations.

Chapter 2: Literature Review

Introduction

Health care access disparities are among the primary health challenges experienced by minority pregnant women in the United States. Minority groups including Black/African Americans and non-White Hispanics/Latinos experience worse health outcomes attributed to health disparities when seeking health care services in the United States (Parekh, Jarlenski, & Kelley, 2018; Roman et al., 2017; Sacks, Greene, Burke, & Owen, 2015). Policy interventions noted by researchers (Lorch, 2017; Meghea, Raffo, VanderMeulen, & Roman, 2014; Roman et al, 2009; Tschudy, Toomey, & Cheng, 2013) are implemented to mitigate disparities related to health care focused on the highest risks and social determinants of health (SDH), specifically SES (Durkin et al., 2015; Kothari, Romph, Bautista & Lenz, 2017). Studies remain sparse on the effect of health disparities and health outcomes on first-time pregnant minority women seeking health care services for the first time, such as Black/African Americans and non-White Hispanics or Latinos. Minority populations, such as Black/African American and Hispanic American women, face unique social and cultural stressors that are different than those faced by their privileged counterparts, and these differences have significant consequences for the physical and mental health of pregnant women which contribute to the burden of perinatal health inequalities (D’Anna-Hernandez & Rivera, 2014).

Black/African Americans’ and Hispanic/Latino Americans’ poor health outcomes are attributed mainly to this population’s lower SES (Durkin et al., 2015; Kothari et al., 2017). Also, few researchers have explored the health needs among first-time pregnant minority women focusing on opportunities for access to reliable information and opportunities for essential perinatal care. Lack of relevant literature challenges efforts to advance effective, evidence-based policy to facilitate care access tailored to meet the health needs among low-income pregnant women.

Minority Americans experience harsher health circumstances and disparities in access to care compared to privileged Americans. Racial/ethnic diversity in this country is increasing, and an estimation by the U.S. Census Bureau (2015) reports that by 2045 the minorities will represent 51% of the United States population. There is an urgent need to address how barriers to quality health care influence short- and long-term effects for pregnant minority women, such as stressors, depression, morbidity, and mortality. Delays and gaps in essential health care needs adversely affect health outcomes and are linked to self-reported physical stressors and psychological states (Berkowitz, Traore, Singer, & Atlas, 2015), and a strong need to recognize health challenges experienced by pregnant minority women and health risks of the unborn infant exists.

Current research on health care disparities has indicated that inequalities refer to differences in access and utilization of healthcare services, especially the quality of services provided among population groups (Boslaugh, 2019). These include Black/African Americans and Hispanic/Latino Americans who are less likely than White Americans to have a reliable source of health care. The IOM report, in 2002, found that ethnic disparities in health care grossly affect members of minority groups in the United States who tend to receive lower quality care than non-minorities. The IOM reports further suggested that these inequalities were rooted in social and cultural factors such as stereotypes, language and geographic barriers, and attitudes toward the healthcare system (Barr, 2014; Boslaugh, 2019; LaVeist & Isaac, 2013). Particularly, Boslaugh (2019) notes that more indigent children are less likely than higher-income children to visit a dentist annually. There is a strong need for comprehensive health policy interventions tailored to satisfy the complex health care needs of minority population exists.

Although previous researchers examined the health outcomes of minority women in the United States, most of have been on larger ethnic populations such as non-Hispanic Whites, Asians, and Europeans, but less on Black/African American and Hispanic/Latino American pregnant women. A gap exists in knowledge focusing specifically on the examination of self-reported health disparities and health-related outcomes by first-time use of prenatal services among first-time pregnant minority women. Despite the growing number of children born to Black/African Americans and Hispanic/Latino Americans, no consistent research reflects understanding minority pregnant women experiences when seeking PNC. Although there is an acute awareness of the effect of early-age development on the adult population health outcomes (Bullock, 2015; Campbell et al., 2014; Shonkoff, 2014; WHO, 2015), little consideration is applied to the efficacy of researching minority pregnant women. In my review of the literature, I have not found one study that specifically addressed first-time pregnant minority women’s perspective on their experiences of health disparity seeking PNC services for the first time. The absence of adequate science-based evidence about first-time pregnant minority women’s unfulfilled health care needs generates a gap in developing and implementing actual policy interventions to fulfill these requirements. This narrative descriptive study allowed me to gather necessary data about health disparities in accessing health care experienced by minority pregnant women to close the knowledge gap.

The purpose of this narrative descriptive qualitative study is to (a) identify what SES, provider's perception of their race-ethnicity, knowledge and care-seeking factors influenced first time pregnant minority women's access and use of health care, (b) discover what first-time pregnancy health disparity may be unique to this population, and (c) learn how health disparities affect the overall experience and perceptions of first-time pregnant minority women toward seeking health care services for the first time. The detailed description of health disparity from childbearing women experiencing the disparities augments the current literature gap on the topic. The results of my study may provide findings that will help understand health disparity from minority pregnant women experiencing the disparities to address the local patterns of health care that are afforded to these women. Such an understanding could facilitate the development and implementation of evidence-based and sustainable policy interventions tailored to meet the needs of the study participants. Hence, this research could enhance positive social change and improve the health outcomes of minority pregnant women and their offspring.

This literature review drew on major studies surrounding health disparities, health-related outcomes, and minority pregnant women in the United States. Studies have indicated ongoing challenges in health care access in the United States, mainly among minority groups (Borders et al., 2015; Scherman et al., 2018), and the adverse effects health disparities have on their offspring when compared with their non-minority counterparts (Durkin et al., 2015; Kothari et al., 2017; Nurius & Logan-Green, 2012). The frequently reported health disparities in the review of the literature in my study include (a) prenatal and postnatal; (b) breastfeeding; (c) nutrition and breastfeeding prenatal, perinatal and postnatal; (d) weight gain during pregnancy; (e) well-baby/postpartum check-up; and (f) insured (Caldwell et al., 2016; Lorch & Enlow, 2016; Taylor & Nies, 2013). Health disparities were reported in minority pregnant women outcomes, such as differences in maternal and infant mortalities based on racial-ethnic and income status and among minority and non-minority newborn (Creanga et al., 2014; S. Lee et al, 2015; Lu, Highsmith, de la Cruz, & Atrash, 2015; Semega et al., 2017). I gave particular attention to demonstrating the current disparities in health and health care access among different subgroups, as well as the urgent need to address these disparities, regardless of ability to pay.

First, evidence from research reveals that Black/African American women are marginalized in multiple domains of life and live in a context of reproductive disadvantage leading to racial inequalities in health (Beckham et al., 2015; Guerra-Reyes & Hamilton, 2017; Liddell et al., 2018). Another article showing health disparity among racial-ethnic childbearing women (Zimmermann et al., n.d.) discussed some of that evidence experienced by marginalized groups. Second, socioeconomic disadvantage exposed how unique challenges interfered with low-income, minority women’s capacity to engage in health-seeking behaviors and health service use across the reproductive life course (Scherman et al., 2018). The right to health quality indicates shared responsibility to be healthy not only in medical care but in health-promoting physical and social environments in homes, community, and workplace. To fill a gap in the literature by focusing specifically on the examination of self-rated health disparities, I explored the health-related outcomes of first-time use of a clinic among minority pregnant women.

Findings from the research support the overwhelming evidence that health disparity exists within minority groups, yet fewer studies have focused on first-time health-seeking behaviors and health-related outcomes by first-time pregnant minority women. Thus far, no single study explored health disparity for first-time pregnant minority women as they seek health care services for the first time. Also, studies have indicated that socioeconomic disadvantage among minority pregnant women becomes challenges influencing poorer health outcomes across the reproductive life course (Beckham et al., 2015; Scherman et al., 2018).

Literature Search Strategy

I searched, collected, and reviewed literature published within 5 years of the completion of this dissertation and relevant to the study problem of health disparity and the significance of health care access in the racial-ethnic minority communities especially among minority pregnant women, and are described here. I reviewed peer-reviewed journal articles and other publications, information from government agencies, official websites, including conference papers using keywords searched on health disparities, access disparities, and minority women. Academic databases used to locate literature relevant to this study include Academic Search Complete, CINAHL Plus, ProQuest Nursing and Allied Health Source, ProQuest Central, ProQuest Health and Medical Complete, Complementary Index, MEDLINE with full text, PsycINFO, PubMed, Social

Sciences Citation Index, and Thoreau multi-database search. I also searched relevant journals including American Journal of Psychiatry, American Journal of Public Health, Annals of Epidemiology, Family Community Health, Health Communication, Health Service Resource, International Journal of Nursing Studies, Journal of American Medical Association of Pediatrics, Journal of Global Health, Journal of Health Care for the Poor and Underserved, Journal of Women's Health, Maternal and Child Health Journal, Maternal and Child Nutrition, Maternal Child Health Journal, Medical Care, Science, Morbidity and Mortality Weekly Report, Nursing, Nursing Research, Public Health, and, Women and Birth. I also included search engines such as Google Scholar. Lastly, I searched government and health agency websites including those of the AHRQ, MA Department of Health, CDC, HHS, Healthy People 2020, NIH, and WHO.

I restricted my search to materials published within the last five years to ensure they were current and relevant, with exceptions to historical events, statistics, and theoretical methods foundations. Older sources were used as references to emphasize the extent of health disparities and that it is not a new topic in American history on the health care delivery system. Because of the limited research on first-time pregnant women seeking health care for the first time, I primarily reviewed studies on health and health care access disparities among racial-ethnic minorities and minority subgroups.

To limit my research results and increase access to current and relevant and literature pertaining to my study, I used combined keywords and search terms such as *health disparity, access disparity, health care disparities, health equity, health outcomes, health services accessibility, health inequalities, maternal health, income inequalities,* *minority disparities, minority pregnant women, PNC, perinatal care, minority health, maternal health, maternal child health, maternity and infant mortality, SES, status disparities,* and *underserved population*. I also used phrases to expand my search including *barriers to health care access, barriers and influences of SES,* and *health disparities among minority and non-minority pregnant women*.

Theoretical Foundation

Theoretical or conceptual frameworks and models underpin the method design to support the researcher in grounding their studies. The theoretical framework is the general representation of tested theories that embody how phenomena occur and the conceptual framework is the researcher's idea on how to explore the research problem (Bradbury-Jones, Taylor, & Herber, 2014; Green, 2014). Theoretical framework describes a broader relationship, and conceptual framework is more specific in defining the relationship; however, both frame the design of the research to explain the outcomes (Green, 2014). In qualitative studies, researchers use theoretical and conceptual frameworks to support their research arguments, determine their RQs, give direction to focus discussion and interviews, and justify the methodology choice (Green, 2014).

In qualitative research, theoretical or conceptual contexts are used to frame the design or explain the outcomes of the research (Green, 2014). Green (2014) argues that the term *theoretical framework* should be used when one theory is used to underpin the study and that *conceptual framework* draws on concepts from the theories and findings to guide research. Bradbury-Jones et al. (2014) argued that theory is the chain connecting different parts of the study (e.g., problem statement, the purpose of the study, research questions, literature review, methodology, and findings) to establish consistency and coherence.

Andersen and Newman Framework of Health Services Utilization

The ANFHSU (Aday & Andersen, 1974; Aday & Andersen, 1981; Andersen 1995; Andersen & Newman, 1973) was the theoretical framework used in my study. Andersen developed the model in the 1960s, which has gone through four phases to (a) facilitate the understanding of why individuals use health services, (b) describe and measure equitable access to health care, and (c) contribute to the development of policy interventions for promoting equitable access to health care (Andersen, 1968, 1995; Andersen & Newman, 1973, 2005; Rigg et al., 2014). The ANFHSU was designed to determine circumstances that either facilitate or impede the utilization of health care services (Andersen, 1995). Andersen characterized the individual's access to and use of health services into three functional categories predisposing factors, enabling factors and needs factors (Andersen, 1995). Andersen's original model expanded through several iterations with the most recent encompassing health services utilization to health outcomes, including feedback loops (Andersen, 1995). Hence, Andersen's fourth phase of the health services utilization represents the integration of the health care system, an individual's belief in the health system and decision to seek health care and the health-related outcomes.

Andersen's (1995) describes predisposing factor as the socio-cultural characteristics including the social structure of how a person's culture or education may influence their coping skills in the face of an illness and how the attitude and value they place on the health care system may influence their access to and use of health services in their time of need. Predisposing factors described by C. Brown, Barner, Bohman, and Richards (2009) include demographic characteristics as age and gender and social structure as race-ethnicity, educational attainment, occupation, and social interaction. Health belief is concerned with attitudes and knowledge individuals have towards the health care system and access to and use of health services based on their demographic characteristics and social structure (Coley et al. 2018). Andersen's framework assumes that the individual's perceived benefits influence their health-seeking behavior; therefore, exploring the predisposing factors of health beliefs can facilitate the understanding of the minority pregnant women access to and use of health services. Hence, the ANFHSU may be used to explain minority pregnant women health behaviors in the presence of health disparities to accessing health care services.

Enabling factors are factors such as resources and the knowledge to access health services, earn enough income, acquire and sustain health insurance, and the availability of health care providers and facilities (Andersen, 1995; Andersen & Newman, 1973, 2005). The paradigm of enabling resources assumes that individuals and families experience in accessing health care is determined by potential availability and opportunities to access health care. Here is an example, a minority pregnant women's ability to afford health insurance, income sufficiently provides for the family, and the availability of maternal child health professionals could define the nature of health disparity within this population when seeking essential access to health care services.

Need factors, as described by Andersen (1995), involves both perceived and evaluated need. Andersen defines perceived need as the immediate cause that generates one's need for health service use. Whereas evaluated need is the professional decision about an individual's health in determining their health status and need for medical attention. Moreover, perceived needs are the attitudes, values, and knowledge individuals place on the health care system that influence their perception of their need for health service use. Hence, the perceived essential health care needs of minority pregnant women could affect the perceived inequalities this population experience as they seek health care services.

Figure 1 provides a distinct framework of Andersen and Newman's proposed relationship among variables.

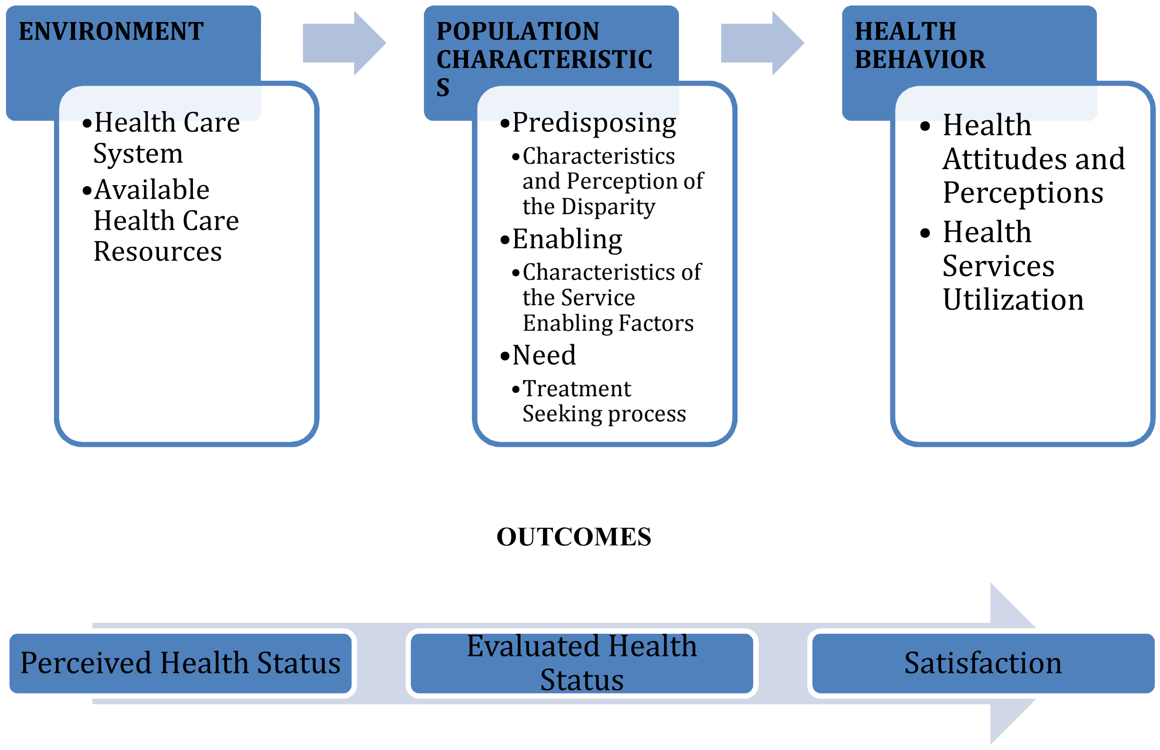


Figure 1. Andersen and Newman Framework of Health Service Utilization. The purpose of this framework is to discover conditions that either facilitate or impede utilization. This model is based on extensive and well-elaborated literature revision.

To further illustrate how these factors, influence health care service use among individuals, Andersen and Newman (1995) revisited the model and introduced the concept of mutability. The idea is that if a concept has more mutability, it can be easily changed to promote access equality to health care services, perhaps resulting in behavior modification. For instance, an increase in enabling resources, equitable access, adequate income, or sustainable health insurance, would increase health service use. Rather than a factor with less mutability, such as characteristics which fall under demographics, age or sex, are impossible to change (Andersen & Newman, 1995). Hence, factors influencing health disparities experienced by minority pregnant women can be explored using ANFHSU to determine mutability to mitigate changeable inequalities as oppose to those with low mutability. Classifications of causes of health disparities among minority pregnant women may lead to the development of policy interventions targeting health care access inequalities within this population.

The initial model was not without criticism because of attempts to study why a family uses health care services (Guendelman, 1991; Portes, Kyle, Eaton, 1992), because of the heterogeneity of family members, the study shifted from the family to individuals. The sixth iteration of Andersen's framework focused more on the individual of vulnerable populations going beyond health care use and adopting health outcomes (Andersen, Davidson, Baumeister, 2015). The use of a feedback loop to illustrate health outcomes could affect characteristics such as health beliefs and need (True et al., 1997). The reconceptualization of the model makes a distinction between potential and realized access. Andersen also reiterated that the model functions to predict and explain health services use. The model builds upon health status to include health outcomes, consumer satisfaction, personal health practices and emphasizes more of a public health approach of prevention, as advocated by (Andersen, 1995; Evans & Stoddart,1990). The numerous iterations of ANFHSU addressed many concerns and criticisms and through the many years of refinement, making it the most appropriate model for studying health care access and use.

Though there are other approaches for studying health care access and services use including sociocultural and sociodemographic (Blanas et al., 2015; Fortin, Cao & Fleury, 2018; Lo, Parkinson, Cunich, & Byles, 2016; Strain, 1990), ANFHSU was ideal for my study. The ANFHSU was not only applicable to the conceptualization of the phenomenon under research but it was considered one of the most commonly used frameworks in studies focused on understanding individual's access to and use of health care services (Andersen, 2015; Lix, 2015; Tomiak, Berthelot, Guimond & Mustard, 2005). My study aims to understand health disparities experienced by minority pregnant women seeking essential health care services. Andersen's constructs predisposing, enabling and need factors are most appropriate because it facilitates the identification of events directly from the context of and lessons experienced by minority pregnant women and their perspective on unique challenges in accessing health care. The constructs of the ANFHSU model make a distinction between potential and realized (actual) access (Andersen & Newman, 1995), which informs barriers and facilitators influencing health disparities experienced by minority pregnant women.

Health Disparities in Health Care Access

Quality health care services in the broader context of equitable access are the catalyst for better care and health outcomes achievable by all populations. The broader literature indicates prioritizing early-life development programs results in reduce health risks among populations and promotes better health outcomes for communities when interventions aimed at goals are effective (Bellis, Hughes, Leckenby, Hughes, & Harrison, 2014; Bellis et al., 2015; Manning, Homel, & Smith, 2010; Osler, Avlund, & Mortensen, 2013). The U.S health care system supports the early-life development and (AHRQ, 2017; Healthy People 2020, 2015; WHO, 2015) identified improvements on all aspects of health care to establish enhanced health outcomes for all populations. Studies showed that with income policies and decades of economic growth and despite considerable investments in the public health infrastructure and extensions of Medicaid coverage for the underserved, health disparities remain critical goals that requires prioritizing equitable access for racial-ethnic minority populations (Adams, Gavin, & Benedict, 2005; Bloom, 2011; Parekh et al., 2018; Roman et al., 2017). In confronting the challenges of the persistent and pervasive threat of health disparities in the U.S, requires understanding the multiple layers of health disparities experienced by various populations and necessitates peeling back those layers.

The literature indicates health disparities continue to exist in populations such as minority pregnant women in low-income communities and the socioeconomic context establishes that characteristics of race, location, and low-income status affect health outcomes by those experiencing the disparities (Bloom, 2011; Durkin et al., 2015; Parekh et al., 2018; Roman et al., 2017). The pervasiveness of health disparities in the United States include variations in (a) perinatal services, (b) prenatal and postnatal services, (c) newborn screening, (d) nutrition and breastfeeding access to antenatal and postnatal care, (e) maternity beds postpartum, (f) insurance, and (g) well-baby visits (Caldwell et al., 2016; Lorch & Enlow, 2016). Health disparities suggestively influence the quality of health outcomes, including gestational weight gain, infant growth, birth weights, neurodevelopment outcomes, maternal and infant mortality (CDC, 2014; Taylor & Nies, 2013). The NIH (2015) has emphasized that one of the most public health research challenges is "unraveling the underlying reasons for ethnic variations in low birth weight and preterm delivery" (para 12). Considering the significance of the persistence of health disparities, it is crucial to understand these variations of the underlying ecological mechanisms that are responsible.

The direct economic burden of health care on the society of an unhealthy population because of health disparities and health care access disparities create both short-term and long-term financial stress on society. Health disparities are inconsistent with the values of society and are a significant threat to the national asset and social investment of future generations essential for the health of the next home, community and work life (Bloom, 2011). Given the significance of early-life experience influence on population health outcomes and the economic burden of health disparities in early-life development, the US health care system should place more emphasis on programs benefiting maternal health. The WHO proposes a defined conceptual framework to assess interventions to address SDH and reduce health disparities and improve health outcomes among minority pregnant women in the United States (Lorch & Enlow, 2016). The role of social determinants in illuminating racial-ethnic disparities in minority pregnant women outcome requires a robust intervention approach to understand the underlying influence leading to adverse outcomes. Consideration given to implementing policy interventions to enhance minority pregnant women outcomes requires understanding the limitations in understanding the SDH care access experienced by the target population (Bloom, 2011; Hall et al., 2014). For example, maternal age, education, and insurance status, as well as individual-level or community-level SDH, should be explored. A collaborative approach integrating evidence-based intervention policies and programs may facilitate the understanding and provide useful solutions to improve care access to and use of essential health services.

Racial-ethnic minority groups in the United States represent the fastest growing population, with literature remaining sparse on health outcomes. There is growing evidence from the literature suggesting obstetric complications are sensitive to the quality of care provided during pregnancy and at delivery (Louis-Jacques, Deubel, Taylor & Stuebe, n.d), as a result of the disparities gap stemming from inadequate or gaps in essential care during pregnancy. Minority infants are at a disadvantage from not receiving essential parental care during the critical developmental stage, receiving suboptimal breastfeeding (Bartick et al., n.d), necessary for growth and development and adult health outcome. Children, born to minority women, face specific challenges and rarely can grow up in the care of their parents and spend more time in daycare (Bloom, 2011). Contributing factor suggests minority mothers of low SES tend to work more than one job to support their family, hence, limiting the time spent as a family unit compared to high-income families. Improving the health care access experience of minority pregnant women, key considerations addressing SDH disparities such as the burden of disease in populations, the adverse impact of economic consequences of poor health, and enhancing quality access to essential care services can significantly improve the health outcomes of United States populations (CDC, 2014; E. Howell & Zeitlin, 2017; KFF, 2018).

Researchers suggest that minority pregnant women in the United States are indeed a part of the vulnerable population (Docherty & Johnston, 2015; E. Howell & Zeitlin, 2017). Minority pregnant women are at a higher risk of experiencing harsher socioeconomic circumstances related to the microeconomic level of low household's incomes and impoverished neighborhoods. Similarly, minority pregnant women experience disproportionate adverse obstetric and perinatal outcomes because of gaps in essential care because they are less likely to gain access to quality health care compared to non-minority or privileged counterparts (Bartick et al., n.d; Bromley, Nunes, Phipps, 2012; E. Howell & Zeitlin, 2017). Disparity gaps are responsible for variations in socioeconomic circumstances experienced by different groups seeking access to and use of health care in the U.S (Caldwell et al., 2016; E. Howell, Egorova, Balbierz, Zeitlin, & Hebert, 2016: E. Howell & Zeitlin, 2017). Racial-ethnic minorities experience a disproportionate number of adverse outcomes, and the national data documented Black/African American women showed a pregnancy-related mortality rate of three to four times higher than White women (E. Howell & Zeitlin, 2017), and perinatal heath representing the most substantial disparity among all the conservative population measures (Callaghan, 2012). Socioecological conditions such as low-income, lack of insurance, unemployed women and women with less educational attainment, lower quality care, gaps in care, delayed treatment, and limited access to care influence and exacerbate health disparities and the risk of poor health outcomes compared to nonminority and more privileged population groups.

Health and Health Care Disparities

Health disparities in health care access, utilization, and health outcomes are significant social injustices primarily affecting minority population groups in the 21st century. Health disparities are a public health concern affecting low-income and racial-ethnic minorities and threatened by economic, societal, cultural, environmental, and social circumstances (Benfer, 2015; Healthy People 2020, 2015; Semega et al., 2017). Health disparities are health differences threatened by cultural, economic, environmental and social disadvantage and “historically linked to discrimination or exclusion” (Healthy People 2020, 2014, p. 1). Researchers find that health disparities and health outcomes are concentrated in racial-ethnic minority communities and low-income neighborhoods and the highest rate of poverty is within the African American population at 26.2%, Hispanics at 23.6%, the Asian population at 12% and the lowest at 10.1% is the White population (Benfer, 2015; Caldwell et al., 2016; Hall et al., 2014). The National Healthcare Disparities Report (NHDR) in 2014 informed conditions experienced by specific populations in which they live and work, reflects the variations in health status impeded by inequitable social structures (AHRQ, 2015).

Despite efforts to improve health among low-income neighborhoods, minority communities are impeded by inequitable social structures not designed to consider multilevel structural and social determinants (Caldwell et al., 2016). Health disparities continue to be a challenging national health concern in the U.S health care system and persist through complex mechanisms (A. Brown et al., 2019; Hughes, Baker, Kim, & Valdes, 2019). There are several kinds of literature about health disparities, the extent of the problem, consequences of populations health outcomes and a collective number of innovative programs and policies interventions (Beck, Sandel, Ryan, & Kahn, 2017; A. Brown et al., 2019). Few explicitly focused their impact on minority health, and health disparities using evidence-based structural interventions aimed at the multilevel structural and social determinants and support sustained improvements. For instance, minority populations experience multiple levels of structural disadvantage such as structural conditions in which individuals are born, live, learn, and work are recognized as critical determinants contribute to poor health outcomes (A. Brown et al., 2019).

Determinants of Health Disparities

Attainment in the highest level in health, health care, and population health outcomes are essential to the quality of lives across the nation. The literature has shown factors influencing health disparities include racial-ethnic backgrounds, educational attainment, health care access, SES (C. Brown et al., 2019; Docherty & Johnston, 2015; Kirzinger et al., 2018). Similarly, social determinants include access to health care by sex, age, income, disability status, and geographical characteristics emphasizes socioeconomic disadvantages among different populations (Durkin et al., 2015; Kothari et al., 2017). Racial-ethnic minorities, marginalized, and underserved populations are more likely to experience health disparities when compared to nonminority and privileged populations (Beckham et al., 2015; Guerra-Reyes & Hamilton, 2017; Liddell et al., 2018). The NHDR, in 2014, reported that racial-ethnic minorities such as Black/African Americans, non-White Hispanics/Latino Americans are more likely to receive a more inferior quality of care than Whites reflecting 42% of quality measures (AHRQ, 2016).

The 2014 NHDR indicate that low-income groups and more indigent individuals receive inferior care than individuals with higher income, reflecting 61% of quality measures. Black/African Americans and non-White Hispanic/Latino Americans experience more enormous challenges accessing health care when compared to their White counterparts (AHRQ, 2016). Racial-ethnic minority children experience higher health disparities in receipt of various preventable health care services when compared to nonminority children counterparts (C. Brown et al., 2019). Racial-ethnic minority households at the low end of the socioeconomic ranking are more likely to experience higher behavioral, mental and physical health issues when compared to nonminority and privileged counterparts at the more top end (Han & Redlich, 2018; Hughes et al., 2019). Socioeconomic health burdens such as obesity, depression and drug use and abuse were common among lower-income neighborhoods at the lower end of socioeconomic ranking (Han & Redlich, 2018; Hughes et al., 2019). The 2010 U.S. Census Bureau reported that 20% of American children live in low-income households or at or below the poverty level, with Black/African American and non-White Hispanic/Latino American children accounting for the largest percentage (Semega et al., 2017).

The literature highlights that the persistence of health disparities and the increasingly diverse population in the U.S pose a severe public health threat (Hsieh & Ruther, 2017; Miller et al., 2017; Yearby, 2018). Many promising health interventions have targeted factors of health disparity on the interpersonal and community-level, the evidence on how enduring these interventions are in supporting sustained improvements in population health and reducing health disparities remain sparse and need further understanding (C. Brown et al., 2019). There is a need not only to recognize and generate awareness surrounding the causes of disparities in health access and health outcomes experienced by various populations but to develop interventions to sustain improvements in population health (Miller et al., 2017; Roman et al., 2017). Supporting evidence should help to inform effective policy interventions focused on eliminating the causes of health disparities, promote health equity, access and use, for all Americans despite their ability to pay.

History of Black/African American Population in the United States

Black/African Americans, one of the largest of the many racial-ethnic groups in the United States mainly of African ancestry, although many have non-Black ancestors (Anderson & Metzger, 2011; Bondarenko, 2017). Black/African American population nationally have significantly varied since institutionalized slavery and the Civil War in the U.S (Anderson & Metzger, 2011; Bondarenko, 2017). The beginning of the 21st century, there were over 36 million Black/African Americans living in the south and concentrated in large cities; 2 million in New York City, 1 million in Chicago, and Detroit, Houston, and Philadelphia had between 500,000 to 1 million Black/African Americans (U.S. Census Bureau, 2017). The exploration of better economic opportunities has primarily dictated the changes over the years, such as migration to the north, state-by-state. Although Black/African Americans have attained improved opportunities through the years, some lingering challenges, such as economic well-being, educational attainment, income equality, and quality health care access and use, trail other groups of people in the U.S (Semega et al., 2017). The U.S. Census Bureau reported as of 2017 there are 46.8 million Black/African population in the United States 87.1% completing high school with 87.3% age 25 and older obtaining a high school diploma or higher, 9.5% unemployment rate, 19.2% poverty rate and 10% without insurance (U.S. Census Bureau, 2017). Females make up 52.2% of the population and of that 50.3% are between age 18-34, 62.3% are employed 8.7% unemployed, single female with children under age 5 makes up 42.7%, and 3.9% poverty rate for unmarried women with children under 5 (U.S. Census Bureau, 2017).

History of Hispanic/Latino American Population in the United States

The U.S. Census of 1790, the first known U.S. Census noted there were 20,000 people of Hispanic and Latino living in British colonies which were based on their surnames (Lieberson & Waters, 1988). The history of Hispanic/Latinos spanned 400 years, Hispanics (criollo or mestizo) became the first American citizens in the southwest territories following the Mexican American War ending 1783, remained the majority until the 20th century (Blakemore, 2017; Chavez 2002). As of late 1783, Spain held claim to 50% of the United States until it was reclaimed in 1800 by the treaty of San Ildefonso (Chisholm, 1911). The history of Hispanic/Latino-American discrimination primarily began in 1848, during the Mexican American War (Chavez 2002). The Guadalupe Hidalgo Treaty in 1848 marked the end of the war, granting 55% of Mexican territory to the United States (Pitt & Gutierrez, 1999), which became new citizens. Mexicans who decided to stay in what is now the United States territory were granted citizenship, gaining significant Mexican American population (Pitt & Gutierrez, 1999). In the 19th century, the influx of Mexico migration to the United States became common, allowing American employers to capitalize on cheap labor (Blakemore, 2017). Anti-Latino immigration sentiment was visible in which Latinos have barred entry into Anglo establishments and experienced segregation into poor urban areas (Blakemore, 2017; Rodriguez & Ruiz, 2000). Although Latinos were American citizens and crucial to the United States economy, the pretext of discrimination encompassed their language, skin color, to their country's origin. Anglo-Americans treated Latinos as a foreign underclass, and they experienced stereotypes by speaking Spanish considered lazy, stupid, and undeserving even noted cases of prejudices turning fatal (Blakemore, 2017; De León, 2015; Rodriguez & Ruiz, 2000). Historians William D. Carrigan and Clive Webb noted mob violence against Spanish-speaking people was common in the late 19th and early 20th centuries, estimating thousands of Latinos killed by mobs, though only 547 documented cases (Mendoza, 2014; Rodriguez & Ruiz, 2000).

In the 1870s, Hispanic/Latino American children were expected to attend separate Mexican schools in the southwestern U.S (Mendoza, 2014; Ruiz, 2006). By the 1940s, about 80% of Hispanic/Latino children attended different schools. Spanish schools lacked necessary supplies and enough teachers, offered vocational schooling instead of the full 12-year instructional classes and Spanish children were forced to attend based on their complexion and last name and also considered inferior in aptitude, English language, personal hygiene, and economic contribution (Mendoza, 2014; Rodriguez & Ruiz, 2000). It is estimated there are 54 million Hispanic/Latinos Americans in the United States and approximately 43 million of them speak Spanish. Today, Hispanic/Latino Americans represent the largest minority in the United States and anti-Latino prejudice is still visible. In 2016, a survey by the Pew reported as many as 52% of Hispanic/Latino American reported they had experienced discrimination (Mendoza, 2014; Rodriguez & Ruiz, 2000).

In the 1920s the anti-Mexican sentiment grew into the great depression, and unemployment soared, and Anglo-Americans accused Mexicans of stealing their jobs. As the fear grew, the government prevented charitable aids and forcibly removed approximately 2 million Hispanic/Latinos from the United States although 60% were American citizens (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006). Repatriations were common among American employers and Anglo-Americans who drove, provided train tickets, or raided gathering of Hispanic/Latino Americans and forced them to the border (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006). INS officials illegally deported approximately 82,000 Hispanic/Latino during the 1930's era (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006). Light-Skinned Hispanic/Latino Americans tried to pass as Spanish, not Mexicans to evade deportation, and those with disabilities and illnesses were removed hospitals and deported (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006). When deportation ended in 1936, roughly 2 million Hispanic/Latino Americans were informally repatriated, and one-third of Los Angeles' Mexican and Texas' Mexican-born populations left the country (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006). There was anti-Hispanic/Latino discrimination school segregation similar to explicit laws preventing Black/African American children from attending school with White children in the south; there were no segregation laws in the southwestern U.S (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006). Similar to Black/African Americans, Hispanic/Latino Americans were excluded from movie theaters, restaurants, and schools (Lacy, 2001; Rodriguez & Ruiz, 2000; Ruiz, 2006).

Characteristics of Black/African Americans in the United States

The U.S Black/African American population is heterogeneous, primarily because of immigration of Blacks from Africa and Caribbean countries. Among the 11% of Black/African Americans who are born outside the U.S, more than 50% are from the Caribbean (Mckinnon & Bennett, 2005). Caribbean Blacks are an important population subgroup, primarily concentrated in large East Coast cities (Council on Foreign Relations, 2014; U.S. Census Bureau, 2017). Whereas Caribbean Blacks and African Americans share a racial identity, Caribbean Blacks differ in ethnicity, economic status, educational attainment, environmental exposures, and physical health (Council on Foreign Relations, 2014; U.S. Census Bureau, 2017). Studies reportedly note that African immigrants, when compared to other immigrant groups such as Hispanic/Latinos, are considered favorably in educational attainment, English language proficiency, and unemployment rates (Bideshi & Kposowa, 2012; Kusow, 2014). Comparatively, statistics indicated that on average African immigrants complete 14 years of education, compared to African Americans at 12.4 years, Afro-Caribbeans at 12.6 years, Asian Americans at 13.9 years, and Whites at 13.5 years (Kusow, 2014).

Although Blacks/African American represents all levels on the socioeconomic ladder (Kusow, 2014), there are noticeable disparities in educational attainment and adequate income even though these studies in the United States have consistently found that Black/African Americans persistently experience poor socioeconomic conditions (Kusow, 2014). Consistent with previous studies indicating that even with high educational and occupational attainment of Black/African Americans, who constitute 17% of the population, experience racism and exclusion, and currently have higher rates of poverty, unemployment, and chronic medical conditions when compared to Whites (HHS, 2017; U.S. Census Bureau, 2017). Race and ethnicity remain critical factors in the prevalence of disparities among Black/African Americans and Hispanic/Latino American group.

As the United States becomes increasingly more racially and ethnically diverse, it increases in wealth and income inequality. There are significant variances of analysis of incomes for Black/African Americans compared to White Americans. A large body of the literature indicates that there is a connection between health and income inequality (Cobb, & Stevens, 2017; Matthew & Brodersen, n.d.). In an uncomfortable way, the wealth and income gap are evident along racial and ethnic lines. The Institute on Assets and Social Policy reports in 2015 that the typical Black/African American household has

6% and Hispanic/Latino household has 8% of the wealth of the average White household (Kochhar & Fry, 2014; Picketty & Saez, 2013; Traub et al., 2015). In more specific terms, the U.S. Census Bureau Survey of Income and Program Participation reported that White households had $111,146 in wealth holdings when compared to $7,113 for median Black/African American and $8,348 for median Hispanic/Latino household (Picketty & Saez, 2013; Traub et al., 2015). Disparities in homeownership fall along the racial-ethnic lines accounting for 73% of White homeowners when compared to 45% of Black/African and 47% for Hispanic/Latino homeowners (Picketty & Saez, 2013; Traubet al., 2015). A college education means flourishing in the labor market, acquire financial stability, and increase wealth. Gaps in educational attainment have widened over the last decade along the racial-ethnic lines, in which 34% of Whites completed four-years colleges when compared to 20% of Black/African Americans and 13% of Hispanics/Latinos (Bloome, Dyer & Zhou, 2018). As college costs become a challenge to college attainment, it forces households to take on student debts. But for Black/African or Hispanic/Latino Americans obtaining a bachelor's degree is to escape the racial wealth gap. The return on investment after a four-year degree is considerably higher for median White family return of $55,869, Black/African American family return of $4,960 and Hispanic/Latino family $4210 (Bloome et al., 2018).

The labor markets provide economic security, among other things from earned income, employer-provided healthcare, and retirement plans. Inequality persists in the labor market and is responsible for the 25% growth in the racial wage gap and 11% for unemployment (Bloome et al., 2018). Income or wage disparity in the labor market may come from discrimination in employment or geographic barriers to jobs. Typically, a White family earns $50,400 when compared to the typical Black/African American family earning $32,028 and the average Hispanic/Latino family earning $38,690. The standard White family earns $50,400, whereas the typical Black family earns $32,038, and the typical Latino family earns $36,840. The wealth return to a dollar of earned income is determined by the amount the individual has the opportunity to save (Z. Chen & Gotway Crawford, 2012; Deurzen, Ingen & Oorschot, 2015; Traub et al., 2015). In relative terms of the wealth gap, if you earn 80 cents on the dollar a White family earns, it leaves you with 20% less opportunity to save because of the need to meet your consumption may require every dollar earned. Arguably, Black/African Americans and Hispanic/Latino Americans earn a lower return on their income and are less able to save every dollar of their return on income into wealth (Deurzen et al., 2015). In specific text, the White family will see a return of $19.80 for every dollar earned when compared to $4.94 for Black/African American and $3.85 for Hispanic/Latino families (Deurzen et al., 2015). Comparatively, uneducated Blacks/African American and Hispanic/Latino Americans are the recipient of low-level jobs, such as cleaning and janitorial jobs, retail and restaurant workers and live at the lower end of the socioeconomic ladder (Bloome et al., 2018).

Characteristics of Hispanics/Latinos in the United States

The terms Hispanic or Latino refer to an ethnicity sharing a common culture, history, and language. Scholars have reported since 2003 that Hispanics/Latinos have surpassed Black/African Americans as the largest racial-ethnic minority group (Deurzen et al., 2015). The Pew Research Center 2016 reports Hispanic/Latino Americans comprise more than 18% or 57 million of the United States population. Whereas Hispanic and Latin Americans come from diverse social, economic, and geographic backgrounds, depending on their family heritage, cultural similarities are bringing these diverse backgrounds together (Flores, 2017; Kochhar & Fry, 2014). The most common cultural characteristic of the Hispanic/Latino American culture is the Spanish language. In 1980, Spanish speakers in the United States represented 11 million or 5% of the population, by 2012 Spanish speakers increased to 13% or 38 million according to the Pew Research Center, it is common for Hispanic families to teach their children Spanish. The Pew Research Center reports that over 50% of the Hispanic/Latino American population reside in California, Texas, and Florida, representing 14 million in California, 10 million in Texas and 4 million in Florida population respectively (Kochhar & Cilluffo, 2018). The New York Hispanic/Latino population grew to over three million. In addition to these states, many other cities in the United States have a very vibrant Hispanic and Latino American community.

The Hispanic-Latino population in the United States since, 2016, represents the nation's largest ethnic or racial minority. The U.S. Census Bureau (2015) projected that the Hispanic/Latino population in the United States will constitute 28.6% or 119 million by 2060. The Hispanic/Latino origin in the United States as of 2016 were 63.2% Mexican, 9.5% Puerto Rican, 3.8% Salvadoran, 3.9% Cuban, 3.3% Dominican, and 2.5% Guatemalan, others were Central American and South American origin (U.S. Census Bureau, 2015). There are nine states with one million or more Hispanic/Latino residents as of 2016, they are Arizona, California, Colorado, Florida, Illinois, New Jersey, New Mexico, New York and Texas, representing 54.4% of the Hispanic/Latino population (U.S. Census Bureau, 2015). Families and children represent 16.7 million of the number of Hispanic households in the United States in 2016. There are 48% of Hispanic married-couple households, 57.5% had children younger than age 18, and 67.2% lived with two parents in 2016. There were 13.3% or 40 million United States residents age 5 and older who spoke Spanish at home, and 57.5% of Hispanic Spanish speakers spoke English very well in 2016. Majority of Hispanic/Latino Americans claim a Christian faith, Catholicism, or Protestant (U.S. Census Bureau, 2017).

Trends in Hispanic/Latino Americans in the United States

There is a 19.4% poverty rate among Hispanic/Latino Americans, 16% who lacked health insurance, in 2016 (U.S. Census Bureau, 2017). There are 61.7% of Hispanic/Latino Americans age 25, and older who have at least a high school diploma, 15.3% or 5 million age 25 and older with a bachelor’s degree or higher, 1.6 million age 25 and older with an advanced degree, 17.4% enrolled in college, and 24.7% enrolled in kindergarten through 12th grade, in 2016. Of the Hispanic/Latino Americans, 34.2% was foreign-born, and between 2011 – 2015 there were 62.4% or 22.3 million noncitizens living in the United States who were born in Latin America or the Caribbean (U.S. Census Bureau, 2017). There were 67.3% Hispanic/Latin Americans age 16 and older in the labor force, and 21.2% of those employed work in arts, business, management, and science occupation, in 2016 (U.S. Census Bureau, 2017). In the 2016 election, 9.2% were

Hispanic/Latin Americans compared to 4.7% voting in 1996, and 7.3% voters in the 2014 congressional election (U.S. Census Bureau, 2017).

In summary, the United States has and will continue to experience a cultural shift of the increase in the number of diverse groups through immigration making for a diverse population. Many migrate to the United States in pursuit of better socioeconomic opportunities or to join families. Many various groups seek opportunities in the United States whereas others are less able to or afforded similar opportunities or circumstances for many different reasons. Health disparity and health-related outcome address this under-researched area, from the perspectives of the women themselves, surrounding their unique experiences related to health care access and barriers to care related to socioeconomic factors and racial-ethnic groups. It is necessary to understand the essential health needs of Black/African Americans and Hispanic/Latino Americans (Douthit et al., 2015; Markus & Conner, 2013) and tailor policy interventions to address the unique challenges of these populations.

Health of Minority Pregnant Women in the United States

The United States remains one of the few countries with the most diverse population and attracts 22% of the world's immigrants (Council on Foreign Relations, 2014). The rapid growth of immigrants in the United States population including Hispanics/Latinos and Blacks/Africans groups since the 1980s (Council on Foreign Relations, 2014), has made the health of racial-ethnic minority a substantively significant public health concern. Douthit et al. (2015) argue that minority groups are one of the most underserved population subgroups and expose some critical barriers to health care access. Considerably, the health concerns encompass barriers to health care access, essential health care needs, and variations in use patterns among minority pregnant women (Han & Redlich, 2018). Much of the literature focuses more on maternal weight gain and less exploring areas such as significant barriers to access, challenges, health risks and health outcomes (Douthit et al., 2015). Improving negative health-seeking behavior in minority pregnant women according to (KFF, 2018) includes improving health insurance, provider availability, provider linguistic and cultural sensitivity, and quality of care.

Minority Health Policy Issues

The 2010 U.S. Census reports more than 36% of the population belongs to a racial or ethnic minority group. The health of the minority population determines the health of the nation as the United States becomes increasingly diverse in the past century (CDC, 2014). Though health indicators such as infant mortality and life expectancy may have improved for most Americans; however, some minorities still experience a disproportionate burden of preventable disease, disability, and death when compared to non-minorities (CDC, 2014). The literature has shown a small researched area of minority pregnant women because of their low population in the United States (Douthit et al., 2015), a parsed view showed that the socioeconomic toll of poor health among women and children is notably costly (Bloom, 2011). An urgent need to design policy interventions and sustainable programs tailored to reach these high-risk minority pregnant women and reduce their risk of poor birth outcomes exits. Insufficient scientific evidence impedes the efforts of policymakers, providers, insurance companies, and community organizers to determine targeted and sustainable interventions to meet the specific needs of this population's current and ongoing health challenges.

Minority Health Outcome and Health Paradox

Minority pregnant women experience pregnancy with less internal (control over circumstances) and social (partner support) resources that could assist them in coping with or reducing their stress, according to Public Health researchers (Erving, Thomas, & Frazier, 2019), a study in racial and ethnic differences in "personal capital" during pregnancy. For instance, when a woman loses her job and insurance during pregnancy, having a partner or family to help emotionally and financially can help reduce stress as well as the less negative outcome on her pregnancy. Studies indicate that the risks associated with poverty, being a single parent, and low levels of acculturation, contribute to low personal capital for many minority pregnant women. The health advantage of minority pregnant women is known as personal capital (Keyes, 2009; Erving et al., 2019). Literature comparing minority pregnant women and nonminority pregnant women on personal capital reveals better health outcomes among nonminority groups (Erving et al., 2019).

Varied disparities in postnatal outcomes exist between women of different race-ethnicities because of the prevalence of inadequate receipt of PNC. These disparities are rooted in maternal health behaviors, sociocultural differences, and access to and quality of health care. One of the major health indicators for pregnant women is the health advantage of antenatal care coverage (at least four times during pregnancy) which contribute to better health outcomes for mother and infant. Studies indicate that the differences in personal capital vary by race and ethnicity in unique ways. For example, Hispanics/Latinos historically had better health outcomes than Black/African American and White women of comparable SES, which is commonly called the “Hispanic/Latino Paradox.” However, various studies indicated Hispanic/Latino women reported lower personal capital than White women (Erving et al., 2019). The differences in personal capital were explained by low SES of the Hispanic/Latino women. For instance, deficits in medical care perinatal care (Erving et al., 2019), in access to and quality of care.

Health indicators for pregnant women proposed by Healthy People 2020 (2015) encompass infant deaths and preterm live births. Having access to and use of quality care provides an opportunity for early identification and treatment of existing health risks, prevent future health problems for mother and infant to avoid death, disability and unhealthy weight (CDC, 2014; Healthy People 2020, 2015; Martin et al., 2009). Wide disparities in the literature in perinatal outcomes exist among women of different racial ethnicities. These disparities include educational attainment, maternal lifestyles, medical care utilization such as PNC (AHRQ, 2016; Martin et al., 2009), and more importantly, levels of late and no PNC. Studies on pregnant women mostly focus on weight gain and complication and are much scarce attending to health care access and utilization (Scherman et al., 2018).

The specific cause of the phenomenon of Hispanics paradox decisive factor is the birthplace and that of the birthing or neonatal practices. A lack of breastfeeding and birth trauma collective in American obstetrics and subsequent mental and physical illness, compounded by the impact of psychological problems (Bower, 1998; Bower, 2004;

Horvath et al., 2016; Turra & Goldman, 2007), are theories of low mortality among immigrants. It is suggested that there is a tendency for ill immigrants to return to their birth country before death and that new immigrants are healthier when compared to their birth country population. Others believe that Hispanic Paradox is a myth and inaccurate counting of Hispanic deaths in the United States resulting in an underestimation of Hispanic/Latino mortality (Smith & Bradshaw, 2006).

The Black-White Health Paradox

Findings from the literature reveal that Black/African Americans have lower rates of some common mental disorders, considered mentally resilient and seen as having higher rates of flourishing when compared to their White counterparts (Erving et al., 2019). The lower rates are due in part that Black/African Americans experience greater social inequality and exposure to discrimination (Keyes, 2009). Although there are reported higher rates of physical morbidity linked to distinctive risk factors for emotional distress and mental illness compared to the general population, Black/African Americans showed mental health advantage than Whites but longer duration (Erving et al., 2019). Findings, when controlled for perceived discrimination, indicates that Black/African American advantage showed 12 of the 13 signs of flourishing, which suggest better mental health if discrimination was omitted (Erving et al., 2019). However, adaptive behaviors may be considered the central reason for the resilience seen in the Black/African American population.

Studies suggest minority pregnant women were more likely to have unmet medical care needs citing reasons such as cost, depression, frequent mental distress, and poor health when compared with nonminority pregnant women (G. Gonzales & Blewett, 2014; G. Gonzales, Quinones, & Attanasio, 2019; Howard et al., 2014; Lobel et al., 2008). Numerous studies have shown some women were more likely to report anxiety and stress during pregnancy. Reports of higher stress levels during pregnancy are linked to complications such as miscarriages, preterm births, and low birthweight infants (Lobel et al., 2008; Schetter & Tanner, 2012). Health, access to care, and health risk are factors influencing adverse pregnancy outcomes (Everett, Kominiarek, Mollborn, Adkins, & Hughes, 2018; G. Gonzales et al., 2019). No health insurance, usual source of care and/or personal doctor were indicated as unmet medical care needs (G. Gonzales and Blewett, 2014; Howard et al., 2014; Hsieh & Ruther, 2017). Healthy People 2020 (2015) recommends, pregnant women should see their obstetrician at least four times during their pregnancy for routine checkup, some minority pregnant women are not experiencing the same health equity and favorable health outcomes. The American College of Obstetricians and Gynecologist reported disparities in health care access and services among racial/ethnic women in the first trimester varies among different racial backgrounds. In which Asians represents 84%, Black/African Americans represent 74 %, Hispanic/Latino represents 76%, and Whites represents 89% of women in receipt of PNC (Finer & Zolna, 2014; March of Dimes, 2016; Martinez et al., 2013).

Despite the amount of attention documenting health disparities in morbidity and mortality, many questions are unanswered regarding the socioeconomic conditions that lends focus to health equity and health outcomes (Colen, Ramey, Cooksey & Williams, 2018). Even with overwhelming studies and interventions meant to increase health equity among all populations regardless of their ability to pay, policy program falls short in ensuring sustainable programs targeting high-risk minority pregnant women. There is a gap in understanding the minority pregnant women access to care and use across the reproductive life course (Scherman et al., 2018), needs further examination. More research and programs should focus on perinatal care targeting diverse families before, during and after pregnancy (Lobel et al., 2008), this may help understand and correct the health disparities of the minority population. Studies suggest low-income, single and minority pregnant women would benefit from programs offering comprehensive resources, such as individual, group, and couples counseling, group PNC, legal aid for single mothers to obtain child support, and neighborhood-based childcare (E. Howell et al., 2016).

Review of the Current Related Studies

As the United States becomes increasingly diverse, the health care community is more aware of how stressors affect minority populations differently, and that there is a justifiable need for research and policy intervention focused on targeting high-risk and underserved populations. Although there is limited research on first-time pregnant minority women access to and use of health care services, there is a need to understand the health need and health outcomes of this population (Beckham et al, 2015; Guerra-Reyes & Hamilton, 2017; Liddell et al., 2018). Evidence from research reveals that minority American women are marginalized in multiple domains of life and live in a context of reproductive disadvantage leading to racial inequalities in health (Beckham et al., 2015; Guerra-Reyes & Hamilton, 2017; Liddell et al., 2018). The literature for decades demonstrated that health disparity tends to be pronounced along the racial/ethnic lines (Colen et al., 2018), and the relationship of SES of self-rated health across this group. Health disparities exist in access to and use of essential health care services and resources, including obstetric care, and are seen in population health outcomes between minority and nonminority populations.

In a study by Chedid and Phillips (2019), they used a multijurisdictional approach across Australia, Canada, Ireland, United Kingdom, and lastly the United States to examine the effect of prenatal health programs targeted reducing prenatal health disparities among at-risk populations. The study indicated prenatal health programs could be achieved by accessible and inclusive prenatal health care through the collaboration of provider training and community stakeholders. Chedid and Phillips (2019) assessed prenatal health guidance documents from clinical associations and regional governments to evaluate and mitigate variable risks to pregnancy. The studies were categorized by the type of outcome examined; 14/20 focused on minority pregnant women health outcomes. The concentration of prenatal programs focusing on minority women indicates the importance in the provision of accessible health education, services, and resources focused on women early life in enhancing public health outcomes (Ramsey & Mayes, 2018).

In the study by Chedid and Phillips (2019), they examined the effect of federal programs focused on removing health disparities and improving health outcomes for minority pregnant women. The study indicated the impact of the program varied by geographical location and sociodemographic population. Chedid and Phillips used a multijurisdictional approach across Australia, Canada, Ireland, United Kingdom, and the United States to evaluate two programs targeting health disparities in minority pregnant women outcomes: evidence-based, surveillance/monitoring, and expert/stakeholder collaborations. They examined prenatal health in areas of health education, PNC, and related services to women. The concentration of programs focused on minority pregnant women indicates the importance of increasing first-trimester PNC use throughout the perinatal capacity.

Despite the HHS recommendation for community involvement to remove health disparities for high-risk and underserved population's access to health care services and resources, Chedid and Phillips (2019) argue that although standardized guidelines inform clinical screening, PNC, and testing, gaps exist regarding comprehensive prenatal health programs to mitigate variable risks to pregnancy. They found that researchers associate health disparities with race and ethnicity and variations in SES. Minority pregnant women with low SES were found to receive more indigent care and adverse health outcomes when compared with nonminority counterparts. The studies used in this review emphasized the value of prenatal health by integrating PNC services with health programs (Chedid & Phillips, 2019). This current study is unique and different from other studies as it aims to understand health disparities and health outcomes described by the experienced perceived minority pregnant women.

In a related study, Tesfaye, Chojenta, Smith, and Loxton (2018) believed that access to and disparities of care experienced by minority pregnant women are somewhat interrelated, and the origins are undoubtedly multifactorial. In this study, Tesfaye et al.

noted that existing health care access models focused on individual-level factors, e.g., financial limitation or cultural health belief, such as the ANFHSU (Andersen & Newman, 1998) generate gaps in efforts to understand and mitigate health disparities. Disparities in pregnant women health have been observed among various racial and ethnic populations and different SES (Tesfaye et al., 2018). The authors argued that understanding the nature and extent of disparities in maternal behaviors that affect maternal or infant health outcome should be explored (Tesfaye et al., 2018). They further implied that identifying these disparities can inform public health authorities in developing policies and programs targeting minority pregnant women at highest risk for adverse health outcomes (Tesfaye et al., 2018). In response, (Tesfaye et al., 2018). explored existing health care access and utilization models, e.g., ANFHSU and IOM, to develop a new model.

Community health workers together with policymakers and organizational leaders can facilitate the process toward understanding variations in health care access and use of health care services through government interventions and policy development (Tesfaye et al., 2018), thus increasing antenatal attendance and promoting awareness of obstetric complication addressing PNC. The local and state level, public health programs can achieve the goal of taking essential steps to identify population's health needs together with researchers, health care providers, and stakeholders to ensure the availability of health care services most beneficial to support this group. Mostly, public health programs have an essential role in achieving standards aimed at guaranteeing competency in providing sustainable and effective public health care services. The established standards are the foundation for evaluating the effectiveness of the evidence-based public health policy intervention (Tesfaye et al., 2018). The authors recommend approaching disparities in public health in identifying concrete steps toward policy interventions to improve health care access and address gaps using modifiable factors of the framework for program consideration (Tesfaye et al., 2018). Many factors cause disparities in health outcomes, in which the authors suggest these factors are amenable to the modification to increase interventions for antenatal care uptake to mitigate poor utilization.

In another study about the prenatal outcome, Mazul, Salm Ward, and Ngui (2017) examined low-income African American women perspective on barriers and facilitators related to the use of PNC services to address variations in mortality. Mazul et al. reported that early and consistent PNC services reduce mortality and improve poor birth outcomes. The team conducted six focus groups with 29 and two independent structured interviews with minority pregnant women to understand barriers and facilitators to receive PNC. In this study, Mazul et al. (2017) noted that minority pregnant women reported various barriers such as structural (e.g., transportation, insurance, negative attitudes towards PNC, perceived poor quality of care, unintended pregnancy, and psychosocial stressors) and facilitators include positive experiences (trusting relationships with providers, respectful HCPs, social support). The authors argued that suggestions to improve care mirrored the facilitators identified to make PNC better accessible, available, and more reflect the complex needs of this population (Mazul et al., 2017). Findings from the study highlighted essential components in PNC model to facilitate the process to engage low-income African American women.

In a related study by preformed Parekh et al. (2018) to investigate prenatal disparities in health care use between Black/African, Hispanic, Asian, and White pregnant women in Pennsylvania. Findings from the study indicated late, or no use of health care services contributed to adverse health outcomes in racial/ethnic minority women compared with White women (Parekh et al., 2018). The authors performed a cross-sectional evaluation representing pregnant women who delivered live births from November 2011 to 2015 to assess the variations of gaps in the provision and timeliness of prenatal and postpartum care for women enrolled in Pennsylvania Medicaid relevant to differences in outcomes by race, ethnicity, region, year, and MCO (Parekh et al., 2018).

The study findings noted wide disparities in perinatal outcomes between Black/African and Hispanic/Latino American women and White and Asian women. Remarkably, Black/African and Hispanic/Latino American women reported less frequent and timeliness of prenatal and postpartum care when compared with Asian and White American women (Martin et al., 2017; Parekh et al., 2018). Disparities by race revealed that White and Asian women had higher likelihoods of all outcomes when compared to Black/African American women. The findings were consistent with NVSR and KFF where White women represented 12-15% higher rates of timeliness in PNC when compared with Black/African American women (Martin et al., 2009; Martin et al., 2017). In an open letter to 2012 presidential candidates the American College of Obstetricians and Gynecologists provided statistical data of scientific facts to emphasize the importance of PNC in reducing premature births, which is the cause of premature newborn death and disability, costs of preterm births ($26.5 billion annually or $52,000 per infant born preterm), and strategies for prevention (Martin, 2012; Martin et al., 2017). Potential reasons for regional disparities include geographical barriers of access to care such as transportation costs, variation in health literacy, and increased difficulty communicating with patients for coordinating care. Disparities in ethnicities showed Hispanic/Latino women had regular PNC when compared with other ethnicities. Potential explanations are different cultural norms by the region where some Hispanic communities may use formal healthcare systems more than others as well as various SDH (Parekh et al., 2018). Parekh et al. (2018) reported the differences by year where measure performance worsened in 2014 and rise in 2015, were due to closure in obstetrical units, transportation to clinics and severe winter conditions. Pennsylvania Medicaid expansion was responsible for improvements in PNC. Disparities within MCO showed that when plan performance worsened, racial inequality within the MCOs widened, resulting in the worst Black-White variation occurring in the frequency of PNC outcome (Parekh et al., 2018). Interestingly, the authors noted that the women enrolled in Medicaid of different races were similar across a variety of socioeconomic confounders. Parekh's et al. (2018) study results suggest that the need for studies to facilitate the process in understanding disparities by race, region, and MCO in promoting health equity.

Pregnant women in Pennsylvania met Medicaid eligibility criteria and were enrolled in the Medicaid program, expanding available insurance coverage and health care services before becoming pregnant. Although, PNC disparities have generally improved over the last two decades in the United States and despite the expansion in insurance coverage, study results indicated that statistically substantial differences and disparities in health care use continued to exist between Black/African and Hispanic/Latino Americans and Asian and White Americans (Parekh et al., 2018). Despite health insurance coverage, disparities persisted, which is consistent with IOM Unequal Treatment Report findings that reported disparities in health equity for minority populations when accounting for health insurance and income (Parekh et al., 2018; Smedley, 2008). Hence, there is a need consider the underlying factors of specific population groups, such as racial-ethnic minorities, in studies and policy interventions for addressing health disparities and health outcomes in the use of PNC services.

In a similar study based on a collated county-level birth data, Docherty and Johnston (2015) explored the influence of Hispanic ethnicity on disparities in first-trimester PNC utilization and health outcomes among minority and nonminority pregnant women. The authors used maternal race and ethnicity birth data from 2000 to 2010 in all 36 Oregon and 39 Washington counties recorded at the time of delivery (Oregon Health Authority, 2012a), ethnicity was categorically recorded as Hispanic -White or Other, and non-Hispanic: White, African American, Native American, Asian, Native Hawaiian, and Pacific Islander. Using data from both sources, the authors considered disparities for various health indicators (e.g., maternal tobacco use, maternal education, and pregnancy deliveries funded by OHP/Medicaid) between maternal non-White and White ethnicities (Docherty & Johnston, 2015). The authors used time-series regression analysis for both states to assess the influence of maternal determinants impact of first-trimester care utilization.

Study findings indicated maternal education and Medicaid status significantly influenced disparities in health outcomes. There was a strong association between health outcomes, maternal education, and poverty level variables (Docherty & Johnston, 2015). The authors also found that controlling for county poverty determined if the use of first-trimester PNC of non-White mothers with access to Medicaid was magnified or mitigated (Docherty & Johnston, 2015). For example, non-White mothers with Medicaid coverage experienced the worst health outcomes when compared with White mothers with Medicaid coverage. Docherty and Johnston (2015) attributed disparities in first-trimester PNC use between nonminority and minority women, e.g., maternal education, immigration status, and the percentage of Medicaid coverage.

The study findings of Docherty and Johnston (2015) were consistent with similar investigations on minority pregnant women that associate health disparities with health outcomes between minority and nonminority for characteristics unique to minority pregnant women. Factors include maternal education, un-insurance or limited insurance, and quality PNC use (Coley & Aronson, 2013; Hahn, 2013; Kenney, Coyer & Anderson, 2013). Although Docherty and Johnston's study showed variations in negative births among minority and nonminority families to maternal education and Medicaid status, research revealed that controlling for county poverty did not remove disparities and exposed an available gap that needs to be further explored. The justification of the current study is to explore health disparities and health outcomes from the perspective of minority pregnant women.

In a similar study on minority pregnant women in the United States, Gadson, Kpovi, and Mehta (2017) argued that disparities in PNC utilization influence maternal outcomes. The authors explained that the racial/ethnic maternal morbidity and mortality are rising in the United States and Black/African American women are at highest risk for these outcomes when compared with other race/ ethnicities. Black/African American women were less likely to have timeliness and more likely to be inadequate users of PNC services. Persistent health disparities in health care access are linked to maternal morbidity and mortality (Gadson et al., 2017). The rate of occurrence of severe maternal morbidity has increased in the United States and is experienced by minority women when compared with their White counterparts (Gadson et al., 2017; James, Thomas, Ranji, Lillie-Blanton, & Wyn, 2009; S. Lee et al., 2015). Lack of or late PNC potentially influences maternal outcomes. PNC is a useful mechanism to engage women in the early stages of pregnancy providing risk assessment such as psychosocial, cultural, and educational support to enhance maternal outcomes.

To mitigate the challenges of health disparities, Gadson et al. (2017) argued that there is a need for PNC innovations demonstrating the potential to engage with the social determinants of maternal health. Their study is consistent with other researchers (Creanga et al., 2015; Edmonds, Mogul, & Shea, 2015; Heaman et al., 2015) that there are risks for late entry into PNC and the calling for careful examination in the variations of social determinants such as insurance status, availability of social support, SES, neighborhood, and transportation. Gadson et al. emphasized that all likely play some role in PNC utilization and there can be no sustained solution to health disparities in minority health without considering the complexities of underlying causes including income equality, access to education, financial security, free of violence and freedom of decision-making power. The authors further pointed out understanding of the psychosocial factors such as pregnancy-related stress, mental illness, and partner violence contribute to maternal morbidity and mortality. This current study explored the minority pregnant women perception of access disparities of their experiences in accessing health care.

Summary

Research cited in this review of the literature indicated that health care disparities are a complex challenge for minority pregnant women's' access to PNC disparities exist in the United States. Even with the implementation of policy and program interventions at the local, state and federal levels to improve health equity, studies reveal evidence of persistent inequalities in health care access and use among minority and nonminority pregnant women (Creanga et al., 2015; Gadson et al., 2017). The literature review indicated that health care access disparities negatively affect minority pregnant women who are uninsured, have low income, live in poverty neighborhoods and do not have access to quality PNC (Docherty & Johnston, 2015; Gadson et al., 2017; Parekh et al., 2018), which influences poor health outcomes for mother and infant. Researchers indicated disparities in access to and use of health care experienced by minority pregnant women (Edmonds et al., 2015; Johnson et al., 2011; Meyer et al., 2016). The studies reviewed emphasized health disparities in prenatal outcomes such as variations in maternal and infant morbidity and mortality along the racial-ethnic lines, and income and insurance status (Chedid & Phillips, 2019; A. Collins, 2006; Edmonds et al., 2015; Hahn, 2013; Parekh et al., 2018).

Researchers argued that health care disparities and minority health are complex challenges which are a well-researched and ongoing problem in the United States health care system (Bloome et al., 2018; Creanga et al., 2014; E. Howell et al., 2016; Walker & Chestnut, 2010). Also, in the review, researchers voiced that several policies and program interventions focused on mitigating health disparities such as WIC, CHIP, and Medicaid. However, it is important to highlight there is a substantial unmet gap in the literature on health care disparities and health outcomes from the perspective of the experience of minority pregnant women. In my review of the research in this chapter, there is clear evidence of the gap in the literature focused on the health of minority pregnant women. Moreover, there was a lack of research focused on health from the perspective of first-time minority pregnant women.

In Chapter 2, I provided an extensive review of the literature relevant to this current study in which I discussed an exhaustive understanding of health access disparity experienced by minority pregnant women in the United States. Since there is an existing gap in the literature concerning the health of minority pregnant women, I completed an exhaustive review of the literature on health disparities and health outcomes from the perspective of minority pregnant women. Most of the literature focused on maternal child mortality and morbidity, hence, supporting the need for further research in minority pregnant women health outcome from their perspective. In Chapter 3, I discussed the research methodology used to underpin this study, including the study population, sampling methods, and study instruments. Chapter 3 further highlighted how I collected, organized, analyzed, and disseminated the research findings. Also, in this chapter, covered potential study limitations and the strategies I used to minimize the weaknesses.

Chapter 3: Research Method

Introduction

Socioeconomic factors and racial-ethnic identity influence the growing health disparity experienced by minority pregnant women as they seek prenatal health care for the first time. Salient factors such as race, ethnicity, occupation, and unemployment contribute to disparities in the uninsured rates among the non-elderly population of 8.4% and children 2.9% (Kirzinger et al., 2018). Moreover, the HHS reported in April 2017 that racial-ethnic minorities are less likely to receive the preventive care they need to remain healthy, more likely to suffer from serious diseases, and less likely to gain access to quality health care (RWJF, 2018). Despite the reports indicating health disparities disproportionately affect racial-ethnic minorities, there is little research focused on understanding minority pregnant women experiences as they seek health care services for the first times.

In this chapter, I emphasized the details of the research methodology I used to address the study problem and purpose. I detailed the steps I followed to explore the experience from the perspective of minority pregnant women health disparities as they seek health care services. In this chapter, I provided details relating to the research design and explanation of my rationale, my role as the researcher, research questions, context of the study, recruitment strategies, criteria for selecting participants, data collection, and procedures for analyzing data. I also highlighted strategies for addressing issues of trustworthiness, including credibility, transferability, dependability, confirmability, reliability (coding where applicable), and ethical procedures.

Research Design and Rationale

For this study, I chose a design that most closely aligned with the different components of the study to ensure that the study results addressed the central RQ (see Creswell, 2009; Patton, 2002). Research design is a framework created to find answers to different parts of the research, such as research questions, problem, purpose, and methods to ensure the cohesiveness of the study. It gives the direction of and systematizes the research (Patton, 2002).

In narrative research, the primary RQ is formed by the personal interest of the researcher (Hageman & Frederick, 2013). Qualitative research involves the gathering of narratives, either written, oral, or visual, focused on the meanings people assign to their experiences by providing insight that describes the complexity of human lives. Narrative description RQs aim to facilitate the identification and understanding of events directly from the context of and lessons experienced by participants (Trahar, 2013; Caine et al., 2018). With the constructs in mind, I formulated the following three questions to guide this study:

- RQ1: How do the experiences of women, minority and underserved, of childbearing age as they seek health care affect their ability to achieve positive pregnancy outcomes (defined as term vaginal delivery, appropriate birth weight for infant and pregnancy weights for mother, and to avoid postpartum depression and infant mortality)?
- RQ2: What are the self-reported health disparities in first-time pregnant minority women as they seek health care for the first time?

- RQ3: How has the experiences of health disparity affect the health-related outcomes in first-time pregnant minority women as they seek health care for the first time?

These three research questions allowed me to gain an understanding of the health disparity experienced by first-time pregnant minority women as they seek health care for the first time in the United States.

Phenomenon

In this study, I explored the phenomenon of health disparity in health care access experienced by minority pregnant women in the United States. Amid current healthcare reforms and rising immigration, racial-ethnic groups are at disproportionate risk of being uninsured, lack access to care, and experience poorer health outcomes. Inequities in SES have continued to negatively impact the effectiveness of improvement in quality access measures (AHRQ, 2017), including health insurance or a usual source of care, easy access to care, and the outcome of successful receipt of needed services. Early access to PNC is essential to the outcome of successful receipt of services required for both mother and child (Heaman et al., 2015). When there is the presence of specific resources that facilitate health care, including timely use of personal health services, attaining good access to care, finding providers who meet their needs, and ongoing care, gaps in care and delayed treatment are reduced by 35% (AHRQ, 2017). Timely access to ongoing care during pregnancy has been shown to reduce the infant mortality rate and improve health outcome. Hence, the infant mortality rate increased by 7% between 2016 and 2017 among non-Hispanic Black infants but decreased by 7% among non-Hispanic White infants and 13% among Hispanic infants (AHRQ, 2017), which emphasizes that even with facilitators to health care they are still barriers competing with the patient’s perception of need. The purpose of this research study is to identify (a) what SES, provider’s perception of their race/ethnicity, (b) knowledge and care-seeking factors influenced first-time pregnant minority women’s access and use of health care, and (c) what first-time pregnancy health disparity may be unique to this population.

Research Tradition

This study followed a narrative description of qualitative tradition, which provides informative value and advocates for the usefulness of narrative inquiry. Narrative inquiry is appropriate for real-world measures, and when real life problems are investigated (Caine et al., 2018; Gilstein, 2018). The narrative approach is a way of organizing events and accounts of actions incorporating facts of time and place and represents a connected succession of events (Caine et al., 2018; Gilstein, 2018). The narrative inquiry affords the researcher the understanding of the experiences from the direct personal accounts and provides facilitating contexts encouraging participants to tell comprehensive stories about important moments in their lives (Caine et al., 2018; Gilstein, 2018; Trahar, 2013). Using a narrative approach enabled me to obtain subjective information in a narrative inquiry space by engaging with participants about experiences of their storied lives (F. Connelly & Clandinin, 2006).

Scholars from various disciplines have used a narrative approach in studies focused on gaining a detailed understanding of the experiences from direct personal accounts of study participants concerning a specific phenomenon being studied (Caine et al., 2018; Gilstein, 2018; Trahar, 2013). Caine et al. (2018) used narrative to capture the experiences of the personal dimensions of social justice, considering the relationship between individual experience and cultural context. Coxon, Sandall, and Fulop (2015) used narrative study to explore the influence of pregnancy and birth experiences on women's choice of birth in obstetric units. Authors Coxon, Sandall and Fulop suggested, that in-depth narrative interviews, nonverbal observation, and descriptive content within the interview provided greater insight into real-life events of women with complicated pregnancies.

Narrative face-to-face interviews not only allowed me to create constructed stories from study participants but also helped me make sense of the ambiguity, complexity and multi-layered nuances of human lives as well as enable me to observe nonverbal responses. Thus, a narrative approach was appropriate for this study to examine and make sense of past accounts and interpreted events to bring together layers of understanding personal experiences of pregnant minority women. The use of open-ended, semistructured narrative questions allowed participants to shape their story from memorable and interesting knowledge in a conversational manner.

Role of the Researcher

Researchers play a fundamental part in qualitative research. In contrast to quantitative studies, where the investigator can be independent of the study, in qualitative research, the researcher is the primary instrument of the study and is centrally involved at each step of the research process (Caine et al., 2018; S. Lee et al., 2014; Sutton & Austin, 2015). In qualitative designs, such as the narrative approach, the researcher prescribes the decisions throughout the study. The ways in which shared stories are shaped through dialogue and co-construction, the researcher must ensure a reflexive layer concerning their positioning of the study under investigation to not compromise the study findings (Caine et al., 2018; Sutton & Austin, 2015). As a primary instrument, I played a central role in this study, including the design of the study and validating the data collection tools. Further, I had the sole responsibility in participant selection, collecting and analyzing data, interpreting results, and documenting final findings. I have no relationship with any of the participants.

As a researcher, I was responsible for remaining objective to recognize and limit any personal biases which could influence the process or final findings of the study. I made sure to set aside all my preconceptions and prejudices and remain objective during the interview process with participants. I set aside any biases by engaging in the self-reflective process of "bracketing" (Tufford & Newman, n.d.) about the phenomenon in question and attend to participants with an open mind. Some qualitative research scholars have argued that bracketing should occur during the conceptualization and through the research (Rolls & Relf, 2006), whereas other authors have advocated limiting bracketing to the analysis phase (Sorsa, Kiikkala, & Åstedt-Kurki, 2015). Bracketing draws awareness to presuppositions at each aspect including project conceptualization, research questions, data collection, data analysis, and writing from critical analysis and understanding (Tufford & Newman, n.d.). Since preconceptions may surface at initial stage and filter into other stages of the study, monitoring biases throughout the study can be a source of insight and awareness to potential problems (Tufford & Newman, n.d.).

Commitment to methods of bracketing include reflexive journaling at the beginning of the study, which may raise the awareness of or prepare for potential role conflicts, memos were used to reflect my engagement with the data. Both methods of bracketing complemented one another and remained well-intended in different stages of this study. I also ensured that the study has met IRB and federal requirements for the moral and ethical treatment of human participants (Levy, 2015; Trahar, 2013). Participants had the autonomy and freedom to volunteer to participate and share their experiences. They also had the right to terminate their participation at any time, even in the middle of an interview, if necessary. I ensured the privacy and confidentiality of study participants information provided throughout the interview process.

Methodology

Participant Selection Logic

This study targeted pregnant minority women living in the northeast metropolitan region of the United States. Purposive sampling is the most appropriate choice selected for the study participants. The purposive sampling strategy is justified for this study to elicit information-rich cases related to the phenomenon being studied (Benoot, Hannes, & Bilsen, 2016; Palinkas et al., 2015). Purposive sampling allowed me to select first-time pregnant minority women using essential health care for the first time in their pregnancy and are prepared to articulate their experiences voluntarily. Although there are no rules to the size of recruiting participants in narrative and other qualitative studies, (Mason, 2010; O’Reilly & Parker, 2012; Patton, 2002) noted that qualitative researchers should acquire participants that are large enough to obtain enough data to sufficiently describe the phenomenon being investigated and address the research questions. Saturation point is when the recruitment of additional participant(s) results in the replication or redundancy of data (Marshall, Cardon, Poddar, & Fontenot, 2013). Some researchers have debated the concept of reaching saturation, suggesting saturation does not determine the number of recruited participants. Though there are limited guidelines intended to be reference tools for qualitative recruited participants, these authors agree that saturation can be achieved at a comparatively low level (Guest, Bunce, & Johnson, 2006; Fusch & Ness, 2015), and generally thick data does not necessarily equal rich data, and the depth of data is typically more important than numbers (Burmeister & Aitken, 2012; Fusch & Ness, 2015). Guest et al. (2006) study reached saturation after achieving rich data from their interview analysis of approximately 12 participants. In a related narrative study that used in-depth unstructured interviews to pregnant women in India to understand health information-seeking behaviors, barriers to care and access, and the negative associations between poverty, low levels of literacy, and women adverse maternal and child health outcomes, Das & Sarkar (2014) used 10 expectant mothers from rural India who provided rich data which was adequate for their study.

Of the comparable studies cited above, I recruited 12 participants, which I anticipated would provide rich and adequate information to answer my research questions. Participants I recruited in this study self-identified as Black/African American and Hispanic/Latino American first-time pregnant woman living in the northeast metropolitan region of the country. As reported earlier, the northeast MA is largely condensed areas of multi-ethnicities with 63.7 % Black/African Americans and 4.2%

Hispanic/Latino Americans (U.S. Census Bureau, 2017). This northeast metropolitan region is considered one of the largest MA with 622,000 population since 2018 and host to multi-diverse communities (World Population Review, 2018).

After receiving my IRB approval number [09-18-19-0078198], I collaborated with multiple community health care workers, churches, Catholic charities, and ethnic restaurants and grocery stores to recruit study participants. Catholic charities and churches were common points of contact for Hispanics and Latinos to go for spiritual guidance and financial and emotional support. Community centers were other points of recruiting efforts.

I collaborated with local business owners, church organizer, community health care workers to distribute study fliers at community centers, clinics, churches, local restaurants, and grocery stores to recruit study participant with detailed information to contact the researcher. Publicizing my study through announcements and fliers were appealing and helped to facilitate the recruitment efforts to interesting parties. Also, the local Hispanic/Latino market was used to publicize my study, which is accessible to their customers. Hispanic/Latino markets are high traffic for multi-ethnic customers in the MA. The recruitment flier included my telephone number and email address for potential participants to contact me for information about the study. I used a community center venue for my interviews because it is a diverse community, strategically populated multi-ethnic cities, which is already an accessible commonplace.

I employed additional recruitment processes as plan B, which included referrals to ensure I had adequate responses from participants. Although, I was unsure of the number of participants I would need to gather rich data to reach saturation, I ensured beforehand to avoid unforeseen delays. I used the first two study participants recruited to conduct a pilot study to test the quality of my designated methodology, which included the study recruitment plan, data collection tools, and data analysis techniques. The pilot study informed me if the interview guide could generate rich data to answer the research questions. There were no modifications needed to the interview questions for my primary study.

I ensured potential participants recruited for my study were provided with the background information about the study, and I conducted a demographic survey and eligibility screening, which is crucial to the study. I scheduled an appropriate time following the screening with participants interested in participating in the study at their convenience to complete the interview. Potential participants recruited for the study who did not meet the criteria were informed of their ineligibility and thanked for their interest and time. Eligibility for this study met the following requirements:

- Are legal, female who self-identifies as Black/African American and non-White Hispanic/Latino American 18 years or older.
- First-time pregnant minority women.
- First-time accessing professional health care (i.e., prenatal or essential care).
- Are willing to travel to the interview venue to voluntarily participate and discuss their experiences in a private voice-recorded interview.
- Can read and speak English.
- All participants signed an informed consent before participating in the study

(required by Walden University's IRB).

Instrumentation and Data Collection

As the principal instrument in this study, I implemented other tools to facilitate participant selection and data collection process. Deciding on the appropriate data collection method is central to enhancing the quality and credibility of the data collected (Burmeister & Aitken, 2012; Fusch, 2015). In considering the quality of instrumentation and the collection of data, Fusch (2015) noted that the interviewer should focus on the rigor in which data collection was executed. Narrative study is used within the context of a method of inquiry in qualitative research to understand the study participant (Chase, 2005), specifically focused on stories told by individuals account of a series of events rather than replicating results for the mean of another setting from the study findings (Burmeister & Aitken, 2012; Creswell, 2009; Fusch, 2015). The main aim is to recognize study participants appropriate for the study to provide rich data to reach saturation point (Burmeister & Aitken, 2012; Fusch, 2015). I created the interview guide that I used to conduct face-to-face interviews for this study (see Appendix D).

Face-to-face interviews are beneficial and preferred choice as the primary data collection method for the study. Following the initial eligibility screening, I scheduled face-to-face interviews with study participants conducted in a private office space. Using a private office space ensured privacy, confidentiality, and uninterrupted scheduled time allotted. I provided a comfortable rapport to establish mutual trust with study participants to allow them to share their stories of events. Before the interview, I shared a short background about the study, reviewed informed consent signatures of all study participants, and asked study participant’s permission to record the full interview. I conducted one-on-one, face-to-face, semistructured interviews using open-ended questions to obtain a detailed account of events of their experiences of health disparities. Face-to-face interviews and note-taking can supplement the audio recording of an interview. In the face-to-face approach, notes can be used to capture nonverbal language or elements of the interview (Doody & Noonan, 2013; Irvine, Drew, & Sainsbury, 2013), including body language and mannerisms. Face-to-face interviews enable the interviewer to follow-up on questions and nonverbal communication behind articulated responses by participants, which will produce richer texts to elicit a more in-depth understanding of the issue being investigated (Mealer & Jones, 2014). The use of several data collection techniques allowed me to compare transcribed data with field notes to ensure high fidelity, accuracy, and consistency in the quality of data using triangulation during analysis. Member checking is another valuable source of data and insight, allowing participants to review the interpretations. Indeed, member checking is a follow-up data collection which extends the researcher’s data analysis (Creswell, 2009).

Audio Recording: Audio recording has been used more and more as the primary data collection tool in social research. Many qualitative studies collect audio data during interviews and transcribed into written form for comparison and accuracy with other data collecting tools (Bailey, 2008; Sutton & Austin, 2015). Transcribing is a technical task involving decisions about non-verbal proportions of interaction and data interpretation (i.e., distinguishing ‘I don’t know’ from ‘I don’t, no’) into an interpretive process (Sutton & Austin, 2015). An audio recording was used as the primary source of data collecting in this study.

Field Notes: Field notes are written language representing a linguistic variety of participants articulation from verbal interaction. Written representations help gather data which may not be captured by other data collection tools and reflects the researcher's interpretation (Creswell, 2009). Field notes represent a record of observational data by the researcher of contextual data collected in the field (Sutton & Austin, 2015). Field note was used to help complement the audio recording, which cannot capture quotations or salient attributes of participants behavior (i.e., nervous laughter) or nonverbal cues. Field notes provided valuable context and an added layer in understanding the phenomenon being investigated during data analysis.

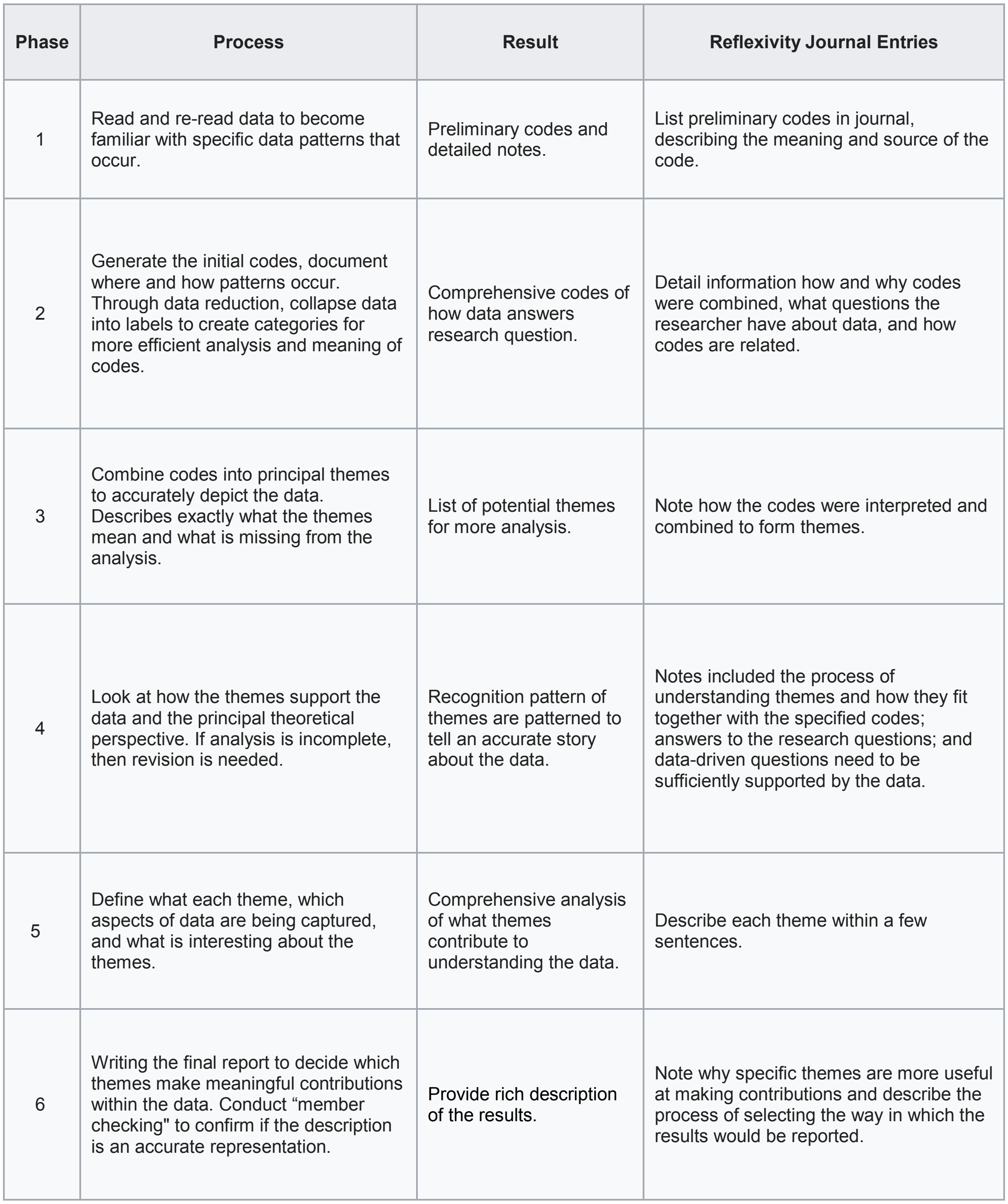
Memos: Memoing is the recording of reflective field notes by the researcher to themselves about the phenomenon in question or what they are learning from the data (Groenewald, 2008). Memos contribute significantly to the credibility of the qualitative research process (Groenewald, 2008). Jotting down keywords, brief phrases, and quotes, during unobtrusive moments, helped to jog my memory when comprehensive fieldnotes were collected.

NVivo 12 Pro and thematic analysis data analysis technique (Braun & Clarke, 2006; Yahmady, Hilal, & Alabri, 2013) was used to catalog and analyze collected data. The thematic analysis developed by Braun and Clarke (2006) as a "method for identifying, analyzing and reporting patterns within data" (p. 79). I chose thematic analysis as my method of analysis because it allows flexibility of use with the theoretical framework and rich, detailed, and complex description of collected data (Braun & Clarke, 2006). Thematic analysis guidelines:

1. Familiarizing yourself with your data by transcribing data by actively reading and rereading data and take notes on initial ideas before coding;
2. Generating initial codes with the aid of NVivo software and data identified by similar codes collated together;
3. Searching for themes included a broader level of themes by sorting different codes into potential themes into a collection of themes and sub-themes;
4. Reviewing themes may involve the refinement of themes into one theme, or the breakdown of themes into smaller components, (level 1) ensures data forms coherent patterns or (level 2) relationship between the themes reflect the meaning of the data;
5. Defining and naming themes should identify and capture the essence of the themes;
6. Finally, producing the report involves providing sufficient evidence of each theme of the data, which is the final analysis. Validating findings with each participant was included in this step.

Transcripts

The graphical illustration of Braun and Clarke's thematic analysis method outlines the guideline to interpret, analyze, and report the with the theoretical framework providing rich, detailed description of the data collected.



Phase	Process	Result	Reflexivity Journal Entries
1	Read and re-read data to become familiar with specific data patterns that occur.	Preliminary codes and detailed notes.	List preliminary codes in journal, describing the meaning and source of the code.
2	Generate the initial codes, document where and how patterns occur. Through data reduction, collapse data into labels to create categories for more efficient analysis and meaning of codes.	Comprehensive codes of how data answers research question.	Detail information how and why codes were combined, what questions the researcher have about data, and how codes are related.
3	Combine codes into principal themes to accurately depict the data. Describes exactly what the themes mean and what is missing from the analysis.	List of potential themes for more analysis.	Note how the codes were interpreted and combined to form themes.
4	Look at how the themes support the data and the principal theoretical perspective. If analysis is incomplete, then revision is needed.	Recognition pattern of themes are patterned to tell an accurate story about the data.	Notes included the process of understanding themes and how they fit together with the specified codes; answers to the research questions; and data-driven questions need to be sufficiently supported by the data.
5	Define what each theme, which aspects of data are being captured, and what is interesting about the themes.	Comprehensive analysis of what themes contribute to understanding the data.	Describe each theme within a few sentences.
6	Writing the final report to decide which themes make meaningful contributions within the data. Conduct “member checking" to confirm if the description is an accurate representation.	Provide rich description of the results.	Note why specific themes are more useful at making contributions and describe the process of selecting the way in which the results would be reported.

Figure 1. Graphical illustration of the process of Braun & Clarke (2006) data analysis model.

I used NVivo 12 Pro qualitative data analysis software to code statements significant to the phenomenon of health disparities in pregnant minority women as they seek PNC narrated by study participants. NVivo 12 Pro facilitated the organization and analyzed the data transcribed into groups and themes in an efficient way to ensure easier understanding of the phenomenon in question.

Trustworthiness

Trustworthiness is an essential concept in the research process and is pertinent for qualitative researchers to establish that the research findings are credible, confirmable, dependable, and transferable are evident in their study. Researchers must establish trustworthiness through the quality of the whole research process and support the argument that the research findings are significant (Hadi & Jose Closs, 2016). Having these components of trustworthiness in qualitative research confirm a level rigor in the choice of instrumentation, participants recruited, collection of data, and analysis technique.

Because researchers are the principal study instruments and actively make study decisions, Hadi and Jose Closs (2016) argues that researcher biases notedly are the greatest underlying threat to trustworthiness in qualitative studies. Therefore, to enhance the trustworthiness of this study, as a researcher, I used reflexivity to examine assumptions and preconceptions I had and the crucial implications on the overall study (Berger, 2015). The process of reflexivity allowed the transparency regarding my position and personal motivations, possible influence in being objective during data collection and analysis, and the threat to the accuracy of the research outcomes (Berger, 2015; Hadi & Jose Closs, 2016; Sorsa, Kiikkala, & Åstedt-Kurki, 2015).

Credibility is the confidence of the researcher in the truth and accuracy of the research findings. I conducted a pilot study to test the quality of the interview process to help identify potential researcher biases and ensure the choice of data collection generate data which accurately answers the research question. Qualitative researchers can use triangulation to show the research study's findings are credible (L. Connelly, 2016; Hadi & Jose Closs, 2016; Patton, 2002). Credibility contributes to trustworthiness of data through (a) prolonged engagement with participants, (b) persistent observations in the field, (c) triangulation, (d) participant checks, and (e) researcher reflexivity. Notedly, triangulation and member checks are primarily, and commonly used methods to ensure credibility (L. Connelly, 2016; Hadi & Jose Closs, 2016; Lincoln & Guba, 2002) and was conducted for internal consistency and added rigor in this study. Moreover, a thorough description of source data and emerging analysis added richness to study findings.

To ensure confirmability and dependability in this study, I have clearly outlined the methodology and thoroughly applied it throughout the research process. I have thus so far provided the rationale for methodological decisions and implemented the interpretive judgment in this study (Jefferies et al., 2019). The degree of neutrality, consistency, and ensuring clarity of methodology used in this study allow readers who may not share my interpretive views to discern how I reached the research findings. Establishing and maintaining an audit trail includes highlighting every step of the data analysis process to provide a rationale for the decisions throughout this study. NVivo's query was useful to audit study's findings accurately portray participants' responses

(Yahmady et al., 2013). I applied the audit trail technique as recommended by Miles, Huberman, & Saldaña (2014) to facilitate the consistent organizing, documenting, and tracking of data collection.

Ethical Consideration

Ethical standards imposed by Walden University's Institutional Review Board (IRB) and federal regulations force research studies involving human subjects to meet regulated guidelines to protect the human rights of participants (Walden University, 2012g). All ethical requirements by Walden University's IRB was followed throughout this study. Walden University requirement is that Ph.D. students do not engage in recruitment activities or data collection without IRB approval and assigned number. I included IRBs approval number to all documents used in recruitment activities or data collection such as study invitation poster, consent form, etc. All potential participants were briefed on the background of the study highlighting their rights to participate and withdraw from the study and ensure participation is voluntary, confirmed by acknowledgment.

Eligible participants signed the informed consent confirming they are volunteering to participate in this study. Participants were made aware that they have the right to withdraw without any consequences and informed that the interview would remain private and confidential and strictly used only for academic and research purposes. I confidently secure all data collection and ensure sole access to the collected data and securely destroy all data post-study rule of 5-years to protect all participant's information.

In ensuring complete privacy and confidentiality of study participants, interviews were conducted in a private office to an allotted time without an interruption in advance and to secure secondary private office space to prevent any unforeseen issues. A "do not disturb – session in progress" sign was placed outside the room to ensure uninterrupted sessions and noise reduction. Most importantly, pseudo names were assigned to identify study participants. To ensure participation was not be encouraged through gifts or gains, I provided each participant $10 gift card thanking them for participating in the study. Data such as anonymized unidentifiable interview transcripts, audiotapes and hard copies are stored separately and secured in a locked cabinet and computer files password-protected and having sole access to all research data.

Summary

The central research question in this study focused on the experiences of health disparities among first time pregnant minority women as they seek health care for the first time. I explored a qualitative narrative approach to understand the phenomenon in the question of health disparities in access to care narrated by minority pregnant women experiencing the phenomenon and voluntarily share the series of events. In this chapter, I discussed the research design and rationale for selecting qualitative narrative approach as the appropriate choice for this study. I discussed the importance of transparency of my role as a researcher, the logic for recruiting methods, possible recruitment, participant selection, and the study instrument I used for data collection. Also covered in this chapter are the techniques for organizing and analyzing the collection of data, the importance of addressing trustworthiness and ethical concerns to enhance the trustworthiness and transparency of this study. In Chapter 4, I discussed details of the setting, participants' demographic background, data collection, evidence of the research quality, and research outcomes.

Chapter 4: Results

Introduction

The purpose of this inquiry was to understand (a) what SES, provider's perception of their race-ethnicity, knowledge, and care-seeking factors influenced first-time pregnant minority women's access and use of health care, and (b) what first-time pregnancy health disparity may be unique to this population. I conducted in-depth, face-to-face interviews with 12 Black/African American and non-White Hispanic/Latino American first-time pregnant women using semistructured narrative description questions (see Appendix D) to gather detailed data required to answer the three RQs that follow:

- RQ1: How do the experiences of women, minority and underserved, of childbearing age as they seek health care affect their ability to achieve positive pregnancy outcomes (defined as term vaginal delivery, appropriate birth weight for infant and pregnancy weights for mother, and to avoid postpartum depression and infant mortality)?
- RQ2: What are the self-reported health disparities in first-time pregnant minority women as they seek health care for the first time?
- RQ3: How has access disparities affect the overall experience and perception of first-time pregnant minority women as they seek health care for the first time?

In this chapter, I discussed details of the setting, participant's demographic background, data collection, evidence of the research quality, and research outcomes.

Pilot Study

Following IRB approval and updating the study invitation flyer, consent form, and interview guide, I collaborated with community organizations to recruit potential study participants. I recruited and completed a pilot study with two initial study participants. Pilot studies are a fundamental phase of a study that allows the researcher to conduct and evaluate the feasibility of some crucial components, e.g., process, resources, or data management of the full-scale study (F. Gonzales, Le, & Perry, 2014). The pilot study helped me to test critical steps of the study methodology, including the participant recruitment rate, time and resources, problems with data collection tool (see Appendix D), and data analysis techniques. Results of the conducted pilot study indicated the feasibility of the interview guide to generate the needed data to address precisely the study questions. The recruitment process for the main study was identical to the pilot study without change to the protocol. The pilot study participants met the eligibility criteria detailed in the study invitation flyer (see Appendix A). I screened participants using the initial eligibility screening tool since there were no changes to the protocol (see Appendix B) and requested that participants complete the demographic data form (see Appendix C). Before the interview, I read the consent form in the entirety to each participant to dismiss any ambiguity then obtained their signature as an indication of consent to participate in the pilot study. Both pilot study participants' answers to the interview questions explicitly addressed the three research questions. More importantly, the responses of the pilot study participants confirmed the alignment of the study flyer, demographic form, eligibility screening tool, and the consent form with the study problem and purpose. During the recruitment and interview process, study participants did not seek further clarification indicating all study documents were easily understandable. The voice recorders produced uninterrupted feedback indicating privacy of the interview room. Without issues of the pilot study, the result was successful; without changes to protocol about the interview guide. The experience of completing a pilot study provided crucial insight into my interviewing skills (strengths and weaknesses), which augmented my confidence during the primary study interviews.

Study Setting

The participants' responses to the interview questions formed the only data source used in this study. Face-to-face interviews conducted with each study participant took place in a private room at a local community center in the MA. Irvine, Drew, & Sainsbury (2013) emphasized that face-to-face interviews are far more advantageous in a private setting enabling researchers to leverage visual and personal interaction to connect with participants allowing them to feel safe and understood to open up and share their emotions freely. Privacy is paramount in one-on-one interviews, allowing participants to let their guard down and trust the qualitative interview process (Mealer & Jones, 2014). Participants felt an overall sense of comfort to share the series of events and lessons learned from their experiences because of uninterrupted privacy. Social cues, such as voice, intonation, or body language of the participant, can provide the interviewer additional information that can be added to the verbal response from the interview questions (Doody & Noonan, 2013; Irvine, Drew, & Sainsbury, 2013).

I decided to engage participants in light conversation to ensure a level of comfort and to build a trusting relationship before the start of the interview. In line with the assertions of Irvine et al. (2013), showing a welcoming start helped me earn the participants' trust enabling them to share freely their series of events from their experiences, which allowed me to capture their emotions during the interview process. During this time, I gave participants a $10 gift card as an assurance that it was not compulsory to complete the interview to be compensated. As stated in previous chapters, I used additional data collection tools, including field notes and memos to record additional data from observing and listening to participant responses during the interview process. The importance of triangulation provides the consistency of results generated by different data collection methods (Denzin, 1978; Montgomery & Bailey, 2007; Patton, 1999; Tessier, 2012), which helped facilitate a more in-depth understanding. Because a single method may not adequately illustrate the phenomenon or produce an understanding, I used data from field notes and memos to enhance my recorded interview transcriptions, which corroborated my findings (Patton, 1999). Patton asserted that the triangulation method provides a rich, robust, comprehensive, and well-developed study. After obtaining responses to all interview questions, I addressed any outstanding concerns, then briefed participants on the next steps after data collection and thanked them equally for participating in the study.

Participant Demographics

Participants provided relevant demographic information needed explicitly for this study by completing the demographic checklist (see Appendix C), including participants' age, marital status, race/ethnicity, current place of residence, level of education, employment status, household income, and health insurance status. Table 1 outlines the key demographic information of recruited study participants. The age of participants ranged between 23 years and 44 years. Approximately 20% of participants were married, 60% were single mothers, and 30% lived with boyfriends. Almost 55% of the participants self-identified as Black/African American and (45%) as non-White Hispanic/Latino American. All study participants (100%) confirmed residence in the targeted geographic area. More than 70% reported having a high school degree, 20% reported an associate degree or equivalent diploma, 10% reported a bachelor’s degree or higher, and only two participants (20%) had education below high school level. More than 55% of the participants were not working at the time of the interview; only 45% had employment, and overall, 20% were enrolled in higher education. I assigned random pseudonyms to maintain confidentiality (i.e., Taylor, Tiffany, Tammy, Toya, Tamica, Tori, Tess, Tandy, Terri, Tina, Tanya, Tommy).

Table 1

Demographics of Study Participants (N = 12)

Participants	Age	Marital status	Residence	Education	Employment	Household income
Taylor	31	Single	MA	HS	Employed	Low
Tiffany	28	Single	MA	LHS	Employed	Low
Tammy	25	Lives w/boyfriend	MA	HS	Unemployed	Low
Toya	30	Married	MA	Associate's	Employed	Middle
Tamica	26	Single	MA	HS	Unemployed	Low
Tori	42	Single	MA	Bachelor's	Employed	Middle
Tess	27	Lives w/boyfriend	MA	HS	Unemployed	Low
Tandy	35	Married	MA	HS	Unemployed	Low
Terri	23	Single	MA	LHS	Unemployed	Low
Tina	29	Lives w/boyfriend	MA	HS	Unemployed	Middle
Tanya	24	Single	MA	HS	Employed	Low
Tommy	44	Divorced/Single	MA	Associate's	Employed	Low

Note. MA = Metropolitan Area; HS = High school; LSH = Less than high school.

Data Collection

I collected data from 12 first-time pregnant minority women, living in different cities in the MA, who volunteered to share the series of events and lessons learned from their experiences through answering the interview questions listed in Appendix D. Participants were (a) legal United States residents or citizens, (b) Black/African American and non-White Hispanic/Latino women living in northeast MA, (c) 18 years and older, (d) first-time pregnant minority women, (e) first-time use of prenatal or essential care, (f) able to speak and read basic English.

Table 2

Eligibility Characteristics of Study Participants (N=12)

Mother's name	Type of health insurance	Gestation at time of prenatal care visits
Taylor	State-funded	11 weeks
Tiffany	State-funded	9 weeks
Tammy	State-funded	12 weeks
Toya	Private	5 weeks
Tamica	State-funded	8 weeks
Tori	State-funded	6 weeks
Tess	State-funded	10 weeks
Tandy	State-funded	10 weeks
Terri	State-funded	12 weeks
Tina	State-funded	14 weeks
Tanya	State-funded	9 weeks
Tommy	State-funded	6 weeks

Note. All participants recruited in this study responded to invitation flyers (see Appendix A)

First-time pregnant minority women who showed an interest in participating in the study contacted me directly using the information provided on the study invitation flyers. I gave each prospective participants a brief introduction to the study and completed an initial screening process (Appendix B) that lasted 7 to 10 minutes to determine eligibility. After determining the eligibility of prospective participants and confirming their interest to participate, we worked together to schedule a convenient date for the face-to-face interview. Potential participants who did not meet the screening criteria were informed immediately of their ineligibility and thanked for their interest and time. During the interviews, I asked the study participants several semistructured questions relating to the phenomenon of access disparities in PNC services listed in the interview guide. Walden University's IRB and dissertation committee approved the content of the data collection tool—interview guide. As mentioned, I emphasized the confidentiality of participants by omitting their real names and assigned pseudo-names, used during data collection, analysis, and reporting of study findings. Interviews conducted without incident for all participants, with no significant concerns during the process. The duration of each interview lasted approximately 30 and 45 minutes, during which study participants voluntarily shared stories of the series of events and lessons learned of their personal experiences related to the phenomenon of access disparities in PNC.

I used an audio-tape recorder for the interviews. To supplement audio-recording of each interview, note-taking were used to capture nonverbal language and elements of the interview and field notes to complement the audio recording, capturing quotations and salient attributes of participants' behavior (i.e., nervous laughter) or nonverbal cues. Memoing in addition to notetaking and field notes provided additional recording of reflective field notes about the phenomenon in question. Jotting down keywords, brief phrases, and quotes, during unobtrusive moments, helped to jog my memory when collecting comprehensive fieldnotes. There were no variations from the initial plan set forth of the multiple approach to record the data during the interview process.

After completing the interview process, I immediately transferred all recorded interviews to a single file folder on my computer secured with an encrypted passcode. I transcribed all interview audio-recordings into word documents. I conducted member checking of the transcribed data with all participants via phone calls in which two participants requested slight changes which were edited and reflected in the data.

I stored duplicate copies on an external device stored in a secured safe to ensure the transcribed data is in multiple secured locations to avoid data loss from an unexpected technology failure. Also, I have placed field notes and memos securely in a pass-coded cabinet accessible only to me.

Participant Profiles

Below are brief profiles of 12 first-time pregnant minority women I interviewed in this study identified by only the assigned pseudo-names. Each profile detailed the participant's demographics, including age, marital status, residence, education level, employment status, household income, and insurance status. Also, profiles include information related to the types of health insurance participants had during the time of PNC, as well as the time of gestation of their first PNC visit.

Participant 1, Taylor, was a 31-year-old married woman living in northeast MA at the time of the interview. She identified herself as a legal female born in northeast MA. Taylor has a high school diploma from an area school in northeast MA and is currently employed part-time as a cashier at a grocery store. Taylor noted that having a high school diploma puts her in a low household income bracket and is qualified for the free state-funded health insurance program for low-income earners. She used the state-funded health insurance program to access PNC services.

Participant 2, Tiffany, was a 28-year-old single woman living in the area at the time of the interview. She had lived in northeast MA by the time of data collection. She came to the United States from Guatemala in 2012 to live with her family. Tiffany reported low household income working as a babysitter three to four times per week and shares she will not have a job the further along she gets in her pregnancy. She obtained PNC using state-funded insurance for pregnant women, and her health insurance status remained the same at the time of data collection. She reported less than high school education.

Participant 3, Tammy, a 25-year-old woman, is one of the youngest participants in this study at the time of the interview. She identified herself as being born in the United States and living in northeast area all her life. Tammy has a high school diploma and believes it is the main reason why she can never find a good-paying job. She is currently unemployed and is living with her boyfriend, who works for BC. Their household income is low, qualifying her for the state-funded health insurance. Tammy reported that she used this state-funded insurance for all her PNC needs.

Participant 4, Toya, was a 30-year-old woman living in northeast area at the time of the interview. She is born in the United States and moved from Tennessee to northeast area in 2015 with her husband. Toya is one of two participants with a post-high school (Associate's) degree in which she states she has always been able to hold employment. She has private insurance through her husband's job and can access her scheduled PNC service. Toya is one of three women in this study who reported middle household income.

Participant 5, Tamica, was a 26-year-old single woman living in the northeast area at the time of the interview. She self-identified as a naturalized United States citizen from Mexico. She arrived in the United States in 2011 with her parents. She believed she would be married after becoming pregnant, which she discussed with her then finance; however, based on cultural differences and distance, they decided to dissolve the relationship. Tamica is currently unemployed with a high school diploma and relies on her mother financially and reports her dad has ill health. Tamica has presently applied for state welfare ahead of the birth of her child. She obtained all her PNC using state-funded health insurance.

Participant 6, Tori was a 42-year-old single woman who is born in the United States and living in northeast area at the time of the interview. Tori is the only participant in this study with a bachelor's degree and one of two participants with a post-high school degree. Tori is currently employed and reported that she is in a middle-income household bracket. She reported that she used to have a decent job with great health benefits until new management changed the health benefits, which made it harder for her to afford private insurance. Tori believed that at her age, she could be in a high-risk pregnancy bracket and needed all the prenatal and postnatal care services available. She has used the state-funded health insurance for the past two months for her healthcare needs.

Participant 7, Tess, was a 27-year-old woman who lives with her boyfriend and his parents in the northeast area at the time of the interview. She self-identified as a legal immigrant from Mexico. Tess moved to the northeast area, 2012, in the hopes of going to school and becoming a schoolteacher. Tess shared that she always seems to acquire low paying jobs even though she can speak the English language and feels undervalued. Tess noted that she completed high school but still had jobs working minimum wage since moving to the United States. She is now unemployed since becoming pregnant and must rely on her boyfriend and his family financially. She reported that even though her boyfriend works, she has lower household income, adding that that is why they had to live with her boyfriend's parents and qualified for public health insurance. Tess used public health insurance to meet her PNC needs.

Participant 8, Tandy, was a 35-year-old married woman living with her husband in the northeast area at the time of the interview. She self-identified as a legal immigrant from Honduras who had moved to the United States in 2012 with her husband. At the time she moved to the United States, she wanted to have children and be a stay at home mom while her husband works. She graduated high school back in her home country but never went on to community college because she felt her husband's income could provide for the family even though she reports lower household income currently. She shared her husband's job does not offer health insurance for them and is frustrated because she is pregnant and needs help with her PNC needs. Tandy used private health care for her PNC needs provided by her husband's employer.

Participant 9, Terri, was a 23-year-old single woman living in the northeast area at the time of the interview. She reported that she is a United States citizen and has lived in northeast area her entire life. Terri is the second person in this study with less than a high school diploma, and she regrets not finishing high school because her father is incarcerated, and she needed to help her severely ill mother. She finds herself in a problematic predicament being pregnant and unemployed and without the help of a significant other or partner to give her the support she needs. Although other family members help with her mother, they have their own lives and family burden. She was currently seeking employment because her mom is doing much better, and she wants to be independent and support her child financially. Unfortunately, she is no longer in contact with her ex-boyfriend and must rely on public health insurance for her PNC needs.

Participant 10, Tina, was a 29-year-old unmarried woman living in the northeast area at the time of the interview. She self-identified as a United States born citizen living in the area all her life. She was living with her boyfriend at the time of the interview and shared that although her boyfriend works a good job because they are unmarried, she is not entitled to his health insurance. She shared that working as a home health aide and lifting her patients became unbearable as she hit her second trimester. Tina preferred to find a job that does not require much standing or lifting. Tina’s boyfriend work with the police department and his income place them in a middle-income household status. Tina obtained PNC services using state public health insurance.

Participant 11, Tanya, was a 24-year-old, unmarried single woman living in the northeast area at the time of the interview. She self-identified as a legal immigrant from Tijuana, Mexico. At the time of the data collection, Tanya reported moving to the United States at age 16 with her parents. They moved to the United States in 2011 because of her grandparent's sponsorship. Tanya has a high school diploma and is employed as a certified nursing assistant at a rehab facility and worked a part-time job at the hospital after becoming pregnant. She was enrolled in a phlebotomy class at her part-time job at the hospital. Tanya is estranged from her boyfriend and reported a low household income. She used public health insurance provided by the state for all her PNC needs.

Participant 12, Tommy, was a 44-year old divorced single woman living in the northeast area at the time of the interview. She self-identified as a United States citizen, living in the area for the past 22 years after moving from Ohio with her then-husband in 1997. Tommy is employed, holds an associate degree in fine arts, and is in the first year of school to become a licensed practical nurse. She works full-time as a dietary aide at a skilled nursing facility. She reports that her new boyfriend is the father, and he is still in her life, but they do not live together. Tommy reported a low household income and qualified for state-funded health insurance.

Data Analysis

In this section, I describe the procedures I followed to analyze the data using the Thematic Analysis 6-step narrative descriptive data analysis technique as detailed in Beng et al. (2014). Data analysis started after interviewing the first study participant and developed side-by-side with data collection. I followed the Thematic Analysis 6-step data analysis technique with the aid of NVivo software previously highlighted in Chapter 3.

The data collected was transcribed into notes. I listened to the audio-recording several times to ensure accuracy then transcribed the data into a note pad. After transcribing each participant's data onto a note pad, I listened to the audio-recording again and read the notes to confirm the accuracy of and to correct any errors in the transcript. I followed the first step in the 6-step thematic analysis as recommended by Braun and Clarke (2006) by reading and re-reading the transcripts to become familiar with the body of data and other relevant data (i.e., interviews, field notes, memo). At this stage, I made useful notes and jotted down early impressions to capture my thoughts about the participants.

In this second step, I generated initial codes way. The use of NVivo 12, a qualitative data analysis software, helped to organize, manage, analyze, and condense transcribed data into codes. New codes were generated and sometimes there were the modification of existing codes with each identified theme as suggested by Braun Clarke (2006). I identified themes by hand initially, working through hardcopies of the transcripts using multiple highlighters, combing through the data more than once until themes emerged.

In Step 3, I grouped commonly used words using a table organized with two columns. One column lists inductive categories and the other column lists participants' responses. In other words, data units included specific words, phrases, sentences, and or paragraphs identified as useful. I looked at the themes that were significant then categorized the themes into larger thematic groups as recommended by Braun and Clarke (2006). At the end of this step the codes were organized into broader themes that reflected specific response to the research question (i.e., they described data patterns relevant to the research question).

For example, assigned code reflected each data unit, i.e., a participant's response relevant to a code is labeled to reflect a specific code. When participants mentioned the code, it is noted to reflect the number of data units related to that code. After thoroughly reviewing each transcript and coded all data, I reviewed the codes. I deleted data not relevant to my research question, to reflect a set of codes related to the study.

Table 3

Sample of Initial Codes

Community should offer support	7	8
Doctor should provide equal care	6	7
Doctor should provide vital education	2	3
Doctor's role	1	2
Would use other sources instead of doctor	5	6
Nurse should be a point of resource	5	4
Nurse could be an advocate	3	4
Nurse's role	1	1
Insurance has impact on care	2	3
Would use other sources instead of doctor	1	2
Irregular appointment attendance	9	10
Unable to judge if questions interpreted properly	11	11
Fear of unspecified disadvantages	7	8
Interaction has an emotional impact	8	9

During this phase, Step 4, I reviewed, modified and developed the preliminary themes that were identified in Step 3 for useful and relevant data until the categories were saturated. I refined themes into one theme and coherent patterns to reflect the meaning of the participants responses, defined and named themes to identify and capture the essence of the themes, and validate findings with the data collected.

Table 4

Sample of a Theme

Prenatal Access Disparities	12	
Convenience of PNC access	3	4
Insurance types	2	3
Uninsured	9	11
Meaning of health access disparities	7	8
Types of prenatal access disparities	8	15
Disparities in access to specialized care	11	14
Unemployment & Low income	10	10
Limited insurance coverage	6	7
Lack of money impacts care	8	8
Limited or no access to privatized care	4	7
Limited access to specialized care/doctors	4	4
Long waiting times	7	8
Incomplete or deficient care	8	14
Low level of PNC	5	5
Limited access to health care information	3	4

In Step 5, I defined and made final refinement of the themes with the goal of identifying the significance of what each specific theme (Braun & Clarke, 2006). At this stage, I asked myself, what does the theme convey? How do the subthemes interrelate and relate to the main theme? How do the relevant themes relate to other themes? When discrepancies raised in the answers to these questions, I adjusted the theme's creation by separating, combining, or deleting and recreating a new theme.

Here I draw on Braun and Clarke's (2006) framework and applied it in a meaningful and systematic manner to define and clarify the process of analysis within the context of PNC access disparities. The findings from the study reflect the phenomenon of access disparities in PNC as viewed from the lenses of participants' accounts of events. I remained consistent throughout the interview process of study participants asking all the same questions. The combined use of NVivo 12 and the Thematic Analysis 6-step data analysis technique enabled me to deduce meaning from the narratives and series of events participants shared about their personal experience related to the phenomenon of access disparities in PNC. Interview questions generated consistent responses throughout that addressed the study questions, and I was able to organize and arrange the data collected consistently to RQs and corresponding IQs.

I analyzed and interpreted the organized data using constructs of ANFHSU, the theoretical framework that guided this study. I created nodes for each interview question rereading data and notetaking on initial ideas from transcribed data capturing best the study participants' personal experiences with the phenomenon of access disparities in PNC. Analyzing the data in this format allowed me to remain organized, to visualize the data, to capture meaning on participant's responses, and to understand themes as well as emerging patterns. There were no discrepancies in the relevant cases.

Evidence of Trustworthiness

Credibility

The initial step I took to ensure the credibility of this study was to conduct a pilot study to test the authenticity of the interview guide. The pilot study aimed to ensure that the data collection tool gathered accurate data needed to answer the three research questions. In Castillo-Montoya's (2016) pilot study, she revealed that interview guides could be strengthened through piloting the interviews to help identify flaws or limitations within the interview design. The pilot study helped me prepare for the primary study, maintain consistency, and ensure that planned data collection procedures were able to generate needed data (Dikko, 2016). Also, I collected different forms of data to support the interview process, including field notes, memos, and audio, allowing triangulation during analysis establishing data consistency, hence strengthening the credibility of study findings (Cleary et al., 2014; Harding, 2013). Similarly, as noted by Tufford and Newman (n.d), I applied bracketing and set aside any preconceptions and prejudices. Remaining objective during the interview process enabled me to maintain a thorough reflection on my study as it progressed.

Transferability

To achieve transferability, I gathered a rich descriptive research context to provide a robust and detailed account of the women's experiences during data collection to define the scope of this study. The facets of data collection helped provide a more robust and fuller understanding of the research setting. Thus, results from this study may be applicable to similar studies conducted by researchers investigating the similar context of the problem, in comparable situations, on related groups or populations (Dye et al., 2019). During the process of this entire study, I remained objective to set aside any preconceptions and prejudices from influencing the study process and findings.

Dependability

To enhance dependability, I thoroughly applied the methodology appropriate for this study. One example, I consistently applied IRB approved ethical guidelines to recruit and interview participants, and during data analysis. I used a research journal and established and maintained audit trails to a keep record of the study process to establish study validity and to demonstrate quality research. Audit trails provide detailed step-by-step reports of each stage of the research process, thus enabling future researchers to repeat this study in similar settings on similar study groups or populations (Miles et al., 2014). The interested readers wanting to learn more about the quality of this study may gain insight from reviewing the research journal of this study, where I recorded how I maintained objectivity and essential steps I used to address possible researcher biases.

Confirmability

I defined clearly, applied thoroughly, and ensured my research is operationally sound throughout the study process to achieve confirmability. The rationale for providing clarity of the study methodology was to ensure readers with different interpretations can differentiate how I arrived at my study conclusions. NVivo's query tools helped in facilitating the process of abridging and organizing the extensive qualitative data and auditing findings (Yahmady et al., 2013). I maintained audit trails to track the comprehensive background of the data and the motivation and rationale for all methodological decisions taken throughout the study. The technique of audit trails, as emphasized in Miles et al. (2014), is to document, organize and track throughout the data process. Audit trails afforded me the opportunity to summarize my thoughts and rationale, thus ensuring the level of confidence of the research findings based on the participants' narratives.

Results

I interviewed each study participant privately on the date specified and schedule at the agreed-upon venue. Once I completed transcribing and analyzing the data of my first recorded interview, I knew it was vital to include examples of verbatim sentences and spoken words accurately as narrated by the study participants during the interview process. During the transcription and analysis process, it became evident that majority of the participants provided similar responses to the interview questions. During the transcription process, I gave particular attention to sound and intonation expressed by participants' capturing all the details conveyed during the interview processes. Getting the story behind the participant's account of their experience contributed rich information on the detailed narrative.

Also, I used field notes to capture and record nonverbal communication and behaviors of participants during the interview process, including eye contact, facial expressions, gestures, and pauses. Initially, I sought to present the data using the ten interview questions (IQs) in which study participants responded. After participants' responses presented close similarities between emerging themes, I continued with my data analysis and used themes instead. In this study, I sought to present the voices of first-time pregnant minority women as they narrated the personal account of each unique experience of prenatal access disparities. I used the six themes and 14 subthemes that emerged from analyzing participant responses to interview questions . Themes were selected and refined based on the relationship between phrase, statement, and word as they emerged during data analysis in NVivo 12.

Five participants responded to interview questions IQ9, and one participant responded to interview questions IQ10. All five responses to IQ9 emerged as coherent patterns supplementing the other eight interview questions in which I integrated them into the main IQ they addressed. Only one participant responded to IQ10. Otherwise, there is no distinction between the results for IQs 9 and 10 from participants' responses.

Research Question 1: Prenatal Access Disparities Experienced by First-Time Pregnant Minority Women

The first research question was: How do the experiences of women, minority and underserved, of childbearing age as they seek health care affect their ability to achieve positive pregnancy outcomes (defined as term vaginal delivery, appropriate birth weight for infant and pregnancy weights for mother, and to avoid postpartum depression and infant mortality? Expecting to generate quality responses, I ensure that all participants enrolled in this study had (a) sought and used prenatal services, (b) a clear understanding of what health access disparities mean, and (c) had experienced the phenomenon of access disparities in PNC. To achieve this goal, I developed four interview questions (IQs) that generated responses by study participants:

> IQ1. Tell me about the various forms of prenatal health services you sought and used since you suspected or found out you are pregnant.
>
> IQ2. What do you understand by health prenatal/access disparities?
>
> IQ3. Can you describe to me an instance(s) when you experienced prenatal/access disparities or when you felt you were being treated differently in the process of seeking prenatal services?
>
> IQ9. Is there anything else you want to share with me concerning your PNC service experiences in relation to prenatal/access disparities?

Data analysis showed all participant responses to RQ1 held comparable meaning. All participants reported experiencing one or more forms of access disparities in the process of seeking PNC. Three emerging themes from participant responses to RQ1: (i) types of PNC services, (ii) meaning of health access disparities, and (iii) types of prenatal access disparities, including five subthemes (i) access to obstetrical disparities, (ii) care quality disparities, (iii) patient information access disparities, (iv) health literacy disparities, and (v) waiting time disparities.

Theme 1: Types of PNC services. Although participants admitted challenges in accessing PNC services, they used at least one or more types of PNC services since becoming pregnant before data collection time. When asked to tell me the kinds of prenatal services they had used since becoming pregnant, some participants did not quickly grasp the term "prenatal services." However, after providing a short explanation of types of prenatal services, all participants reported various kinds of care they had used, including obstetric, STI screening, and family planning services. Also, several late trimester services or delayed entry into PNC were reported because of the lack of education or insurance coverage, public or pregnancy-related coverage, ambivalence about or unintended pregnancy, negative perception of health care providers, and behavioral constructs (i.e., prenatal initiation, alcohol, and tobacco use). Tiffany shared the PNC she used after finding out she was pregnant. She reported:

> . . . I tried to attend regular PNC visits during pregnancy to monitor the health of my baby. I first used state-funded insurance when I was 9-weeks pregnant. During these appointments, the nurses checked my vital signs and such, and they gave me

> wellness questions to fill out. Occasionally, during these visits, they would do ultrasounds or blood work. At one point, during my prenatal appointment, the doctor prescribed me prenatal vitamins.

In a similar account, Tamica shared that with limited access to private transportation, she ensured that she attended the recommended prenatal appointments. She had learned about the importance of maternal care in receipt of adequate essential services and outcomes, and wanted to avert any risks:

> I must admit that it was not easy for me to attend all recommended care because I had no car, I'm unemployed and single being 2-months pregnant . . . but because I wanted to learn more about my pregnancy, I tried not to miss any recommended PNC services with limited state-funded health insurance. I wanted to understand if I am missing anything or if there are important things to know or do being pregnant. I think I attended all my prenatal visits. During these visits, the doctor is in and out, and I normally do not learn anything new even though I ask questions about this and that.

Whereas variations were reported in the number of PNC services used by individual participants, data analysis indicated that each used one or more types of PNC services. For instance, when asked to explain prenatal services she used after becoming pregnant, Tess stated, "I used the community health services in the past 2-months after I found out I was pregnant." The doctor there sometimes was a baby doctor; otherwise, just a regular doctor checking my blood pressure but not always doing ultrasounds. Similarly, Terri stated, "I have used PNC services at the community center because this what I could afford since I am not working. I went for pregnancy checkups and was recommended resources like birthing classes."

Theme 2: Meaning of health access disparities. After asking study participants to share the types of prenatal services they used since becoming pregnant, it was vital for me to elicit their understanding of health access disparities. The rationale was to understand participants' perception of what health disparities informed their views about their experience of prenatal access disparities. Their responses elicited varied phrases, statements and words without any ambiguity of the meaning of health access disparities. When asked what health access disparities meant to her, Tori stated:

> It means having not the same kind of health access and health care as everyone else or someone with more privilege, you get lesser care, and when you're rich you get better care as if you are not valued as a person. I will never have access to a private doctor or specialists because of access disparities. The way it is….is that with no private insurance there is limited access to a medical team, you may not have access to certain doctors or specialists because of your public or free insurance. Some doctors don't take certain types of insurance. Therefore, your access to better health care or better services like seeing a specialist doesn't exist because of the types of insurance. That's the types of disparities I experienced.

Likewise, Terri's response suggests a clear grasp in her description of health access disparities:

> . . . well, health care access disparities to me is not having the same or equal access to quality care no matter where you're from or the color of your skin or

> how you speak. I know that it is not equal health services given to everyone the same, some get better and others not so much because of your race and when you speak, they think you are stupid or don't understand. This is what I go through, my experiences.

Compared to other participants, such as Tess, Tonya responded with much confidence in her precise response, giving the impression that she knew what health access disparities were. She replied: "To me, this is the unfair treatment or the differences in access or availability of care, services, or facilities in a certain setting."

Responses from other study participants, including Tiffany, Tandy, Tina, Tanya, Terri, Tommy, and Tamica, provided similar insights. Similar views on health access disparities surrounded inequalities in quality care or access to quality care. Interestingly, Taylor and Tammy explained that their understanding of health access disparities unconventionally as tragic. Taylor, when asked what health access disparities mean to her, she felt they just don't care if she existed, and Tammy spelled out in no uncertain terms, "they just don't like me, they don't like our kind" in response to the question directly. Tori reported:

> To me . . . health access disparities . . . mean . . . not having equal opportunity or opportunities to proper care when needed. Everyone do not get the same good treatment in care that they should which I think is determined by the providers based on the policy you tend to have. The environment and community where all patients, all people who need care are not treated the same, even with the same diagnosis. All of this is determined by your zip code because better treatment and

> care comes when you have money or better insurance. For example, Black and Brown people don't get the same opportunities in life like White people do. When you have free insurance, it's like you are a nobody. Even though I work, I can't afford the type of good insurance to get to the best quality care; we are treated poorly and unfair.

Like Tori's response, Toya reported:

> I know first-hand what health access disparities is like to not have access to the best health care, the doctors, or quality of care. Access disparities means second class health care services, which is long wait, being skipped and not being valued to get the best treatment or even simple information about how to keep yourself healthy and even for necessary and timely treatment. I used to have private insurance with my job and will now have to rely on public health insurance because my job has made changes to their health insurance policy for employees, and I will only have supplemented insurance because I can't afford the increase. Another point I am trying to make is, why should we find out late that something is wrong with our pregnancy or have babies that are underweight because no one is teaching us anything?

Theme 3: Types of prenatal access disparities. Statements, phrases, and words supporting recent first-time pregnant minority women accounts of their experience unequal access to PNC services compared to other counterparts emerged from most participants. More than 91% (11/12) of all study participants reported they experienced one or more types of disparities. Only one participant, Toya a 30-year-old, married woman who reported a middle household income status did not believe she was treated indifferently compared to similar care seekers. However, she reported she started using public health insurance, and can see a difference, which was a negative experience. Participants reported several types of access disparities, including disparities in access to obstetrical and diagnosis services, gaps in care quality, disparities in patient information access, and disparities in waiting time.

Disparities in access to specialized services and diagnoses services. More than 50% (6/12) of the total study participants reported having failed to obtain some form of necessary specialized care or diagnoses they needed in the process of seeking prenatal services. Taylor shared her frustration regarding her failure to access specialty care, such as obstetric care during pregnancy, which she attributed to disparities. She shared that she did not always have access to an obstetrician or the same obstetrician who knew or had seen and treated her previously. That disparity in access to specialized care contributed to her maternal weight gain. She showed signs of frustration in her facial expressions, in her tone, and body language when she spoke of not seeing a specialist for over six weeks after an ultrasound result indicated a complication with her pregnancy. Taylor stated:

> I don’t know how to begin to tell you of my frustration or if I can find the words to tell you what I experienced when I went to see doctors during my pregnancy. I have a strong belief that it was because I did not have insurance as well as my skin color:
>
> The results from my ultrasound showed that my baby was not developing well, that the baby’s lung is underdeveloped, and her head was not proportionate with

> the rest of her body. I was given specific instructions to see a neonatal pulmonologist. Inopportunely, the appointment was delayed between 4 - 5 weeks. If I had private insurance, I would not have had to wait for this long. This only happen to people like me who rely on public health insurance and have no choice but to take what they give me or see who they say to see when they say to see them.

Tamica, a 26-year-old woman, reported an incidence of unequal access to specialty PNC and diagnoses services similar to that of Taylor. Tamica recounted that when she visited for one of her prenatal appointments in the second trimester, the doctor indicated that she had protein in her urine and higher than usual blood pressure. She was given specific instructions to see an obstetrician immediately but was never told why and became overwhelmed and stressed by the information. Infuriatingly, she could not see a recommended specialist immediately because of the availability schedule. She viewed this as access disparity in specialized care. During the interview, Tamica responded fervently, when discussing her account of these events:

> I always feel less than when I go in for my doctor visits or appointments because I believe I am always treated different, with the long waits or not scheduled for my recommended follow up appointments timely. Let me share this one experience because it bothers me to this day, and I will continue to tell everyone I know. During one of my regular prenatal visits, the doctor told me I may have preeclampsia, and I never understood what that meant or how this could have cause me and the life of my baby. Overwhelmed with the news, I asked the doctor

> to explain preeclampsia. and what does it mean for me and my baby? He responded that I needed to see a specialist who will determine the appropriate care for me . . .. I was never given an appointment to see the specialist after waiting to speak with the receptionist and was told I will be called the next day with an appointment date and time for the specialist's appointment. Unfortunately, after calling the following day and the day after, which took 3-weeks when I finally got a chance to see the specialist. I have lost all interest in the health care system due to the treatment of people like me who not understand certain risks about being pregnant and not being able to afford proper health insurance.

Similar to Taylor and Tiffany's experiences, four pregnant minority women (i.e., Tori, Tandy, Tommy, and Tanya) reported some form of unequal access to PNC, specialty care, and diagnoses services. Notably, Tori and Tanya said that they were recommended to see specialists for different prenatal reasons primary care providers (PCPs), could not order recommended tests because the type of health insurance did not cover those services. Tori shared that it was frustrating to learn that the type of specialist she needed to see was unobtainable purely because her insurance could not cover or found unnecessary, such expenses.

Similarly, Tanya shared that she was diagnosed with a medical condition that required urgent surgery, but she had to wait for approval from state-funded health insurance to determine if treatment and procedure were necessary or emergent, which took 8-days. Frustratingly, Tanya stated that "If I had private insurance, I would have had same-day treatment and attention. I would have been able to see the specialist the same day." She added further that variations in access to specialized PNC based on the type of insurance a person has are ridiculous when it comes to a person's health, and there should be no compromise."

Disparities in quality care. Several participants reported that the quality of care they received from the health care team, including doctors, nurses, and other providers varied from individuals from the front desk receptionist to discharge. Participants perceived care quality in terms of the receipt of care when they seek care at health care facilities. Some patients reported feelings of being undervalued or unimportant at some point during their prenatal visits, others reported a sense of disingenuousness from the staff and health care members.

Tandy shared an experience she viewed as receiving low-quality care compared to similar care seekers:

> . . . having public health insurance puts you at the bottom of the totem pole because you are viewed as not being able to afford private insurance, and in this instance, you can't get certain appointments or specialist. The best appointments of the day are given to those with private insurance, which means that you are given appointments at inconvenient times, such as early morning or late evening. What I witness is that a Black and Brown pregnant woman who has been waiting for hours in waiting room do not have a right to ask the receptionist question about their appointments. I have waited for my prenatal checkup appointment 2.5 hours past my scheduled time. I have not been treated nicely when asked about the long wait and White women have been given the respect when asking the

> same question. I decided to move to the appointment desk to ask what was going on. I have witnessed these instances too many times to count from other pregnant women who looks like me being treated as if I am a bother to them or invisible or insignificant and unimportant.

Related to the experience of disparities in quality of care in receipt of seeking PNC services by different patients as reported by Terri, several other participants recounted scenarios of receiving less quality care compared to other care seekers. Tammy shared that the doctors she saw during pregnancy always seemed less patient and examined her quickly, never gave her any information, and she never replied to her concerns. To Tammy, this was a disparity in quality of care:

> . . . I must admit that I felt less than like I was nothing, and I always noted how other pregnant patients had longer time with the doctor than me, which bothered me a lot. Why wouldn't this bother me when my appointment is sometimes less than 10 minutes, and other pregnant women appointments are at least 30 or more minutes with the doctor. I know I am not paranoid because I checked the time because I couldn't believe what was happening. The doctors I had seen were less than interested in spending time answering any questions I had, or they never once asked if I had any questions or concerns for them during my prenatal visits. They always seem very dismissive and disrespectful in such a way in being less attentive during my examination and focused more on my records than me. I would say in my experience I have been treated poorly many times by these doctors.

For Tandy, it was her experience she recollected that they will call her to reschedule her appointment or having gone to her appointment to be told her appointment was canceled or the long waiting times in the waiting rooms for her prenatal visits without any explanations which she viewed as disparities in quality of care.

Disparities in patient information access. Five participants (i.e., Tina, Toya, Tanya, Tommy, and Terri), about 42%, believed that their process of seeking PNC involved disparities about access to information. These pregnant minority women reported that members of the health care team, including doctors and nurses, were unwilling to share critical health information about their health status. Tina, a 29- year-old woman who developed diabetes during her pregnancy was never referred to an endocrinologist or given any information regarding her diabetes or how it would affect her unborn baby which she viewed as disparities in patient information access:

> … going to the doctor means seeing someone who knows what the heck they are doing, and you want to trust them, but how would you feel if you weren’t given the information you needed to keep you and your baby healthy? This is how they do us, we are nobody to them, and we don’t matter… but because of my skin color. I prefer to get the information I needed to help me with the important things I need to know. I want to be able to rely on the quality of information the doctors and nurses give me each time. For example, my family friend went through something similar when she was pregnant and told me some things that happened with her baby. . .. They didn’t even give me an explanation on what was going on, or what it means for my baby. I wasn’t told who to see, what I needed to do to

> reverse the diabetes thing but that I must schedule my next appointment. No one cared, not the nurse not the doctor, no one. I was disappointed because these doctors are supposed to inform us when something is not right; I shouldn't have to rely on friends to tell me these things. She had a large baby because she developed diabetes during pregnancy; it continued after she had the baby, she never had diabetes before just like me; this was news to me…. And to think I could use this bit of information; I want a healthy baby just like everyone else.

Terri, a 23-year-old woman without high school education and reported low-income household shared that accessing her health information online is not always possible, and she is limited in accessing her information:

> I do not own a computer, and this means I must sometimes go to family or a friend to have access, even so, what does this all mean? If they did not explain to me any results or what these numbers are, then I still don't know what they are talking about…. I'm not in the medical or health field. Therefore, "getting the information online doesn't mean a thing to me if I don't understand the important patient information online. I don't get any updates or information when I go to my appointments; the doctors and nurses don't talk to me about much. You would think they would be interesting' in knowing how I am managing with my pregnancy; all they care about is to run in and out the room without even a discussion, some of them don't even make eye contact. The nurses are no better, they tell you to go the patient portal and access the information from the appointment. Every prenatal visit I go to, I always asked the doctors to share with

> me while I am in the examination room to tell me my test results, but they basically told me to go online. Sometimes you feel too ashamed to say I don't understand, or I have a problem with computers, I just go along with it and never speak up for myself. I don't know if something is wrong unless they tell me and make recommendations. But when you don't have the education like they expect you to do, it's like they look down on you. I believe everyone should have equal access to their health information, and they should help to make sure we do. Terri views these issues as disparities in patient information access.

Disparities in waiting times. During interviews, I asked participants to share incidences where they felt that they experienced access disparities in the process of seeking PNC services. Four participants viewed differences in waiting times as a type of access disparities. These participants reported their waiting time to be oppressively longer than that of similar pregnant care seekers during their scheduled doctor's visits. They felt it was unfair for patients with appointments to arrive 15 minutes early to accommodate the doctor and wait for more than an hour, and more upsetting to see those who come in after being called first to see the doctor. These four pregnant minority women knew that disproportionate waiting times were a type of access disparity they faced in the process of seeking PNC services. Tina reported that:

> . . . they make you sit in the waiting room and wait for long hours; we are pregnant women…it's sad to see how they could treat anyone like that … it hurts me because we must sit there and take it. Some days you are not feeling your best, morning sickness or just plain depressed, so to sit there an hour or more and wait

> for your scheduled appointment, it’s not like I just walked in off the street. When you are waiting for the same doctor, you see other pregnant women who come in long after you are going in before you seen by the same doctor makes no damn sense. The receptionist become’ short with you when ask you voice your concern; they are not interested to hear you or to give you an answer . . . it’s frustrating because all you are asking for is for them to communicate with us, our time is important too. No one tells you anything, not even the nurses, yet you see others coming after you, and they are called in before to see the doctor, it’s upsetting and painful to see that you are treated differently because of your skin color. This is not a onetime thing, it happens every time I go for my doctor’s appointment, yet you can’t say anything about it. Listen, some people get priority or special treatment over me –cause as I’m waiting, they come in, check-in, and are immediately taken back there to see the doctor. Something need to change, and we needed to be treated the same, no matter where you come from or live. I see how they treat me and others like me, and I don’t mean being pregnant, I mean my skin color, our skin color.

Similar to Tina’s response, Tess referenced incidences during her prenatal appointment visits when she waited longer to see her provider than her pregnant White counterparts who came in much later, laughed and joked with the receptionists and did not have to wait:

> . . . I can share many incidences of not being treated equally during my prenatal visits; I almost dread the time when I must go for my appointments. I know it is

going to be a long wait, and to watch other pregnant women go in before me, these women are never Black or Brown women. This is hard to swallow because of the unequal treatment I faced when I went to see doctors during my pregnancy. I'm not one to hold my tongue; I complain cause I have a scheduled appointment… it bugs me to be waiting an hour or more to see the doctor when you see pregnant women who look like you, then it becomes upsetting, and there is no way you can sit there and say nothing. I am not the only one to have complained about it . . .. There was not one time I can remember when I went for my prenatal check-up and was seen within 45 minutes of my appointment. It was unbearable those days in my second trimester it seems to have gotten worst, that I had to wait for hours. Treat others how you would want to be treated. I hated seeing others come in long after I did and was seen before I did …. I could see if this was a onetime thing …. it happened every time I went in for my prenatal visits. There was no way you could not be mindful of the differences, and the fact that other patients who came after me would see the same doctor, yet before me, is what made the whole experience difference.' This is never right, and it is unfair to treat pregnant women differently for whatever reason. This is still a painful experience for me, and they wonder why some people get stressed out. As for me, I like to point this out to them when I go for my appointments; I want them to realize that I can see what they are doing to people like me because I am not the right color.

Summary of Results for Research Question 1

The first research question addressed (a) the types of PNC services first-time pregnant minority women used after becoming pregnant before data collection time, (b) what health care access disparities meant to first-time pregnant minority women who participated in this study, and (c) the types of access disparities recently experienced. All participants reported that they had sought and used PNC services.

Though participants used different phrases, statements, or words to describe health care access disparities, there remains no significant variation in their responses. Participants demonstrated to have a shared understanding of the meaning of health care access disparities. Although some participants responded precisely, others contributed detailed explanations equal to a full paragraph. Meanwhile, other participants appearing to have no exact words, directly communicated about situations they believe they experienced disparities to articulate their meaning of health care access.

Most first-time pregnant minority pregnant women I enrolled in this study perceived seeking PNC services experienced one or more access disparities. More than 92% (11/12) of the participants reported incidents in which their perception represents the unequal treatment compared to other counterparts. Only one participant, Toya, a 30-year old married pregnant woman, stated that she could speak on both sides of the coin because she was not treated differently in any way when she had her private insurance compared to other counterparts. However, she now realizes the differences recently in wait time, access to patient information now that she has used the state-funded health insurance.

Disparities in access to specialized services and diagnoses, disparities in quality care, disparities in patient information access, and disparities in waiting time represent the types of access disparities reported by first-time pregnant minority women recruited in this study.

More than 58% (7/12) of the total study participants reported needing essential care and were not a recipient of some form of specialized care or diagnoses they required in the process of seeking prenatal services. Similarly, several participants reiterated that the quality of care they received from obstetricians, nurse practitioners, nurses, and other health care providers varied from the time of arrival to discharge.

Also, four participants (33%) believed that in their process of seeking PNC involved disparities pertaining to access to health information. These first-time pregnant minority women reported obstetricians, and nurses were reluctant to provide pertinent health information about their health compared to other patients. Lastly, four participants reported differences in waiting times as a type of access disparities. These participants described their waiting time to be unreasonably longer than their other counterparts during their prenatal visits. They felt appointment times were mostly not on schedule and felt rushed during actual inpatient visits.

Research Question 2: Circumstances Leading to Prenatal Access Disparities Among First-Time Pregnant Minority Women

Research question 2 (RQ2) focused on participants’ shared views relating to factors surrounding prenatal access disparities reported in their responses to research question 1 (RQ1). To obtain responses needed to answer RQ2, I asked all participants the following three interview questions (IQs).

- IQ4: In your opinion, what led to differences in treatment or the disparities you experienced in the process of seeking prenatal services?
- IQ5: How, if at all, did your status of being a Black/African or Hispanic/Latino American contributed to the different forms of prenatal/access disparities you experienced?
- IQ6: How, if at all, did your SES contribute to the different forms of prenatal/access disparities you experienced?

Analysis of responses to RQ2 highlighted participant's perception to be the primary causes of the access disparities they experienced in the process of seeking PNC services. The themes and subthemes emerging from participant responses to the three IQs that addressed RQ2: What are the self-reported health disparities in first-time pregnant minority women as they seek PNC for the first time? Themes: Cause of prenatal access disparities. Subthemes: (i) Racial/ethnic discrimination, (2) health insurance types, (iii) income status, and (iv) SES.

Theme 4: Causes of prenatal access disparities. More than a few subthemes emerged out of participant responses to RQ2, including racial/ethnic discrimination, health insurance types, income status, and SES. But for precise analysis and representation of results, I refined all subthemes under one theme: causes of prenatal access disparities. Over 92% (11/12) of the total study participants attributed prenatal access disparities they experience to at least one source. Only one participant stated she had experienced no prenatal access disparities experience when she had private insurance added and some indifferences with public insurance.

Racial/ethnic discrimination. Most of the participants perceived and reported racial/ethnic discrimination as the primary cause of prenatal access disparities. Profoundly, phrases and words reflected racial/ethnic discrimination were most referenced in participant responses to IQ4. About 75% (9/12) of the total participants attributed the prenatal access disparities they reported to racial/ethnic discrimination. Participants who were less forthcoming to mention amenably that racial/ethnic discrimination contributed significantly to disparities used different ways to share their experiences and views. Tommy recounted the unequal treatment she experienced at her prenatal visit from the moment she entered by the receptionist of her doctor's office as nothing short of racial/ethnic discrimination. She responded:

> . . . It's obvious that when you arrive for your prenatal visit, some patients received a nice welcome and others pretend as if you don't exist . . . like, when White patients enter, the receptionists begin to talk with them and respond to their million questions. What I witness over and over is that patients like me, who look like me, don't get the same welcome from the receptionist…they behave snooty and hardly want to provide you any information when you ask them . . . something as simple as where is the bathroom. Whenever I'm here for my prenatal appointment or any other person of my race, they behaved basically like they didn't have time for us or as if we were just plain bothering them with our questions.

In a similar response, Tina, a 24-year old pregnant minority woman, attributed the information access disparities when she went to one of her prenatal visits; she experienced racial/ethnic discrimination. She responded:

> Being ignored or insulted or spoken down to because you asked a question is frustrating to be treated like a nobody because of my race. I rely on the information given by the doctors and nurses and want to be understood, considered, and respected. If I ask you if you can clarify or simply ask the nurse to clarify something I do not understand before I leave the doctor’s office, it should not turn into a federal case. When I leave and call back into the doctor’s office, I will be on hold the entire day or transferred from one person to the next. I have witnessed nurses and doctors sharing with White pregnant women important patient information than they with Black and Brown pregnant women. For example, once I was in the doctor’s office for my prenatal visit, I could hear the doctor explaining and answering questions of a White pregnant woman before he came into the examination room to see me, even though he was more than an hour late he used my time for someone else. The nurses even spend time talking with the White pregnant women and refuse to give the same attention to my kind, cause’ we are minorities. I’m so sick of this…the racial discrimination. Why give them all that time, and if women like me who don’t have the answers, ask you questions about our pregnancy, we are hurried off or ignored. We have a living human inside of us, and we want to make sure our baby is doing well just like anybody else.

Similarly, Terri, a 23-year old single unemployed, pregnant woman spoke of a time, the obstetrician ordered an ultrasound of both legs because of swelling … I can remember her saying this is important I get this done as soon as possible. I was never told why I needed this ultrasound by the nurse, and it's not from lack of asking. I waited another 35 minutes in the waiting room to get a scheduled appointment for the ultrasound. Nothing was clarified, I did not know what the ultrasound was meant for legs, and no one would tell me … I know the ultrasounds I have for my belly is to see how my baby is doing. Such racial discrimination to not be told as I can see doctors talking to White pregnant women about their test results, I can see them smiling and talking and hear the doctor giving suggestions. I don't know anything about pregnancy; I feel alone and abandoned by the health care system. Sometimes I'd like to think or say they are just overworked or overwhelmed. This truly hurts my feelings, I have actually cried once waiting in the waiting room, and not one person from the staff to the nurse or doctor asked if I was ok, not one. One week following my appointment and ultrasound tests, no one thought I needed to know the result of the test . . . they didn't explain to me what was going on (I learned from the x-ray tech why I needed the ultrasound), but no one would tell me the results other than everything is fine. I was disappointed because I see doctors and nurses and staff continue to interact with White pregnant women, and I am not given the same treatment ever. It bothered me to watch White pregnant women get all the information about their pregnancy, but not for us Black and Brown woman.

Likewise, Tiffany associated the care quality disparities she experienced during her hospital visits for prenatal appointments to racial/ethnic discrimination. She responded:

> This seems like a recurrent dream, going to my prenatal appointment and never seeing the same doctors consistently. It always seems like someone new or some kind of intern. The doctors I saw, although I made my appointments for my visits, just like for all other patients, I always received one 10-minute visit or less, and other pregnant women who didn't look like me received at least 30 minutes with the doctor. I mean …. the rooms are thin, and you can hear the doctor–patient interacting because you have nothing else to do but to listen since you sit in the cold room for ten minutes or more waiting, and others are not, for the doctor to come in. Once I asked the doctor a question, one in particular she would always turn her back to me and walk out of the room while answering me….the appointments lasted less than 10 minutes, it always bothered me to see how other pregnant women whose appointments were before mine would be in the rooms for 30 or more minutes with the doctor and mine was always well below 10 minutes . . . . I believe that this particular doctor was a major racist who I never wanted to see again, especially not when I'm pregnant.

Tanya made it clear about what contributed to the prenatal access disparities she experienced; her response inferred that racial/ethnic discrimination played a central role:

> This was no doubt because of my background, my culture, my color . . . the way I speak, I not dumb, you know. I know lately, some people believe we don't belong

> here, I can hear the whispers and mocking. This is no different when I go for my prenatal visits, especially the girl at the front desk, they despise us as people who don't know anything, they don't treat us the same as people with their same skin color, they look at us differently, I speak English very well yet they talk to me as if I'm a little child who can't read or write. There is little interaction between us and the staff, the nurses and doctors or some of them ask me cultural questions as if I don't care to come in or believe in seeing a doctor because of my culture. I missed a few appointments because I just couldn't get there, and they just assume. Right now, what I see is that they don't care about us unless you are White, so because of the way I look and speak, they immediately think I just want everything for free and have a bunch of kids and get free care and food and not work. The doctors don't care to talk to me; I am shy, but I do ask questions I know they can understand, but they just discriminate against me, and the nurses are just as bad giving me everything to read in Spanish language even though I am speaking to them in English. I know it's because of where I am from and the current climate in this country and being pregnant, so I am here to take what they are supposed to get, that's disparities.

In a similar response, Tiffany cited racial/ethnic discrimination as the cause for the disparities in accessing PNC services she experienced, "I mean. . . as I explained before, I think the problem was with my race and the fact that I had moved to the United States."

Health insurance types. In their responses, most of the participants believed and reported that that the type of insurance they had at the time of seeking PNC contributed significantly to the access disparities. Participants inferred that the quality of care, access to specialized diagnoses, patient information access, and waiting times varied considerably depending on the type of health insurance, public or private. Terri stated:

> When you have public health or state-funded insurance, they see you as a person less than them, needing assistance which is taking from their pockets or taking from them. It's as if you cannot afford to take care of yourself and that the state must take care of you using taxpayer's money, and they feel you do not deserve to use the taxpayers' money. So, if you are getting help from the state, then you don't want to work and looking for handout. It just may be that I am looking for some help to get back on my feet because I have fall on hard times, or it could just be illness or anything else. But to treat me like I am a nobody is just difficult and unforgiving.

Tommy, another participant who attributed the disparities she encountered in the process of seeking PNC to the type of health insurance she had maintained:

> When you have state-funded insurance, they don't see you as they see someone else with private insurance or insurance from their job or spouse. I know this has contributed to the quality of care I received each time I come to my appointment. What is the difference here, it's not like I come to see the doctor and they don't get paid…they are not seeing me for free? You can talk to them nicely on the phone when they don't know who you are, but once you are in from of them and they quickly learn the type of insurance you have, their behavior changes, from

> rude to ruder. Can I just tell you that you get the worst appointments times, either way too early or way too late? One time I got an appointment for the exact time when the doctor goes for lunch…I didn't know at the time until I got there 15 minutes early and saw the doctor leaving the exact time, I had my scheduled appointment. I asked the receptionist if the doctor was leaving for the day when she said rudely, "if she was, I would have told you so." It doesn't matter when you get to schedule your appointments; the best times are given to those with better insurance, when you have public or state-funded health insurance, we get weird hours. For example, it's always early morning, late evening, or during lunch hours when all nurses and doctors are out on lunch, and you end up waiting for hours. Not to mention, you will still be waiting also in the cold examining room.
>
> Tandy, a 35-year-old married woman who is unemployed referred to her insurance type:

State-funded or public health insurance as the primary cause of the disparities in access to specialized care and diagnostic services she experienced. Tamica responded:

> ….. the type of insurance you have means exactly how you will be treated because it determines which services you can access and what you cannot access. Depending on the health insurance you have, it will not be able to see some specialists. You are limited in accessing certain doctors and hospitals as well as procedures unless you have private insurance. For example, with state-funded insurance, you cannot see doctors who don't take your kind of insurance. It's simple; you will never have access to better doctors, health care, resources or

> better service because of the type of insurance . . .. so, if you have been referred to see a specialist or have certain tests, it will not happen, at least not with my insurance. Everything else requires authorization before gaining access to specialized care, which means this takes a long time. For others with private insurance, they get to choose the doctor and the hospital they want when they want.

Toya was disappointed with her transition from private insurance to semiprivate, and for the first time, had to use public health insurance. She reported previously she never had any issues before when she had the private insurance, and she could go to any doctor within the network and had the best doctors and services and but now it is such a drastic change. I now have long waiting times, and I'm not seen as often as I would like, neither do I get to choose the doctor. This first doctor I saw did not spend 10 minutes with me; she never answered my questions and told me I can access everything from the visit online from the patient portal. I am happy I can still pay for my medications, and I cannot wait to go back to private insurance and not a moment too soon. The way they treat you is terrible, not even to spend time to go over tests or answer specific questions. Tamica reported she could not access some of her prescriptions because she was low on cash with little money to pay out of pocket, and the state-funded health insurance did not cover certain prescriptions. She asserted:

> . . . I'm just saying, the type of health insurance you have can contribute to health access disparities. The health insurance limits the types of services, doctors, and procedures you can get when you visit the hospital. I had this stressful experience

> when I had no money to pay for a medication I needed, public health insurance covered some medications, and I tried to seek other kind of state help to help pay for my expensive medication. This is my experience of not having the right insurance to get you the medications you need…. which is sad.

Income status. Nearly all study participants felt that their status of having limited education and being a minority contributed significantly to what they viewed as inequalities in the process of seeking PNC services. Some participants reported that sometimes it felt as though being a minority meant that you didn't deserve to have anything good in life. A few believed that even with a degree, the pay scale was still inadequate, and the inequalities in pay were apparent. All study participants reported feeling that because they are minorities that they were viewed as less important than other people, which added to prenatal access disparities in some indirect ways, nonetheless, contributing factors. For instance, we live in the worst neighborhoods, go to the worst schools, and therefore have the lowest-paying jobs. Less than 50% of the participants believe that their immigration status contributed to communication challenges because of the language barrier. These contributing factors determined the type of insurance available to them and their SES, all of which are contributing and influencing factors directly underpinned the disparities in the process of accessing PNC services among this population.

Tandy responded with frustration in her voice and sad facial expressions that as a minority pregnant woman with low household income and being unemployed she only had access to less experienced doctors and nurses:

At this point, you cannot access a specialist; you cannot choose the doctor you want easily being in a low household income bracket. You do not have the freedom of choice to see a doctor who you like and when you like. You get what you get; you never see the same doctors because it is the state-run center, and you are given the kind of doctors they give you…and for the prenatal visits, you will see the nurse practitioner but not an obstetrician or a gynecologist. You are lucky if you see the same doctor for the rest of your pregnancy, this is because you cannot afford to see a good doctor, so you must be grateful for what they give you because they don't consider you to be important. This disparity bothered me because health care should be a rite of passage for everyone equally. No one should be treated less significantly than anyone when it comes to your health, and everyone should have the same access to health care services, but unfortunately, that's not the case.

Toya, a 30-year-old married pregnant woman who obtained care using private health insurance, attributed the inequalities she encountered in accessing PNC services to her skin color and background. She responded:

. . . sometimes I think it would matter that you have private insurance, you are employed and educated…overall what they see is your color, which contributed to access disparities. When you don't understand much about the health care system or understand your rights, you face discrimination of all sorts. It is important to know even the basics of your rights because it helped go a long way. When I looked at how badly I have been treated as a patient, I never voiced my complaints or do anything because I didn't know my rights.

Tiffany’s emotional response and a shaky voice said that as an immigrant, and being around nonimmigrants, she was always treated indifferently, even lately it has gotten worse, which she perceived to have caused the disparities she experienced in accessing care services. She stated that:

> . . . I know, I think our status, the fact that we are Hispanics, the fact that I am an immigrant these people know we come here for a better life, that we are here running from even worse situations, and evidently anything goes. I hear the mocking or, some saying, they should go back to their country because they believe we come here not to work and get everything for free and just have babies so the state can take care of them for free. These are the ridiculous stereotypes that is imposed on every one of us, no matter what we have achieved or earn in life or contribute to society.

Socioeconomic status. In the process of analyzing responses to RQ2, it was evident that some participants felt and shared the experience that their low SES contributed to PNC access disparities. The low SES of participants reported influencing factors, including education status, employment status, and immigration status, which determined their household income status. Fifty percent (6/12) of the minority pregnant women are unemployed, and about 66% (8/12) of the total study participants reported low household income status. Participants stated that employment status and household income determined the insurance type one can afford (public or private) access to the best doctors and prescriptions. Almost all participants believe that in America, the zip code you are born in can determine your future, your job, and your problems.

Taylor felt that if she had a better income, she would have a better option of choosing an ideal private insurance and not using state-provided insurance, viewed widely as the insurance for the poor, underprivileged, or the lazy people who don't want to work. She responded:

> If I had better income, there is no doubt; I would get my own private insurance, which would enable me to see whichever doctors I wanted to or choose which specialist to see, especially being pregnant. I would be treated better; I could see caring staff members who would give me better care and discuss with me the important things I need to know about my pregnancy to have a healthy baby. There is nothing like a good-paying job that provides employees great health benefits as opposed to public health insurance, where you receive less quality of care.

Terri noted that minorities live in low SES conditions, which an influencing factor determining the type of health care and insurance available to them. State-funded health generally covers basic minimum care and do no cover some medications of specialized services or procedures. She shared:

> ….. that because I had no job, I had to rely on state-funded insurance for pregnant women, which is not only limited, but you are allowed what you have because of your status. Because of my low household income, I was denied access to quality care services or access to personalized care or let me just say a specialist enjoyed by those who can afford the luxury of private insurance or private doctors or specialists with access to tests and procedures and advanced treatments.

Tommy, another participant who perceived the low SES of minority women as an influencing factor contributing to access disparities in PNC services. She responded:

> It significantly contributed because it played an enormous role in the type of insurance you have and the doctor you can or cannot see. My household income helped determine the type of doctors I would get to see and in what area I would be able to go to see them…. which means you cannot just go anywhere you want. Come to think of it, not all doctors accept state-funded or public health insurance, and they are the best doctors. For example, because I have public health insurance, I could not get prescribed prenatal vitamins with public health insurance.

Summary of Results for Research Question 2

The second research question (RQ2) was designed to explore first-time pregnant minority women’s perceptions on what led to access disparities in PNC services experienced by this population. The aim was to elicit participants to share their assessments on factors that influenced prenatal access disparities they reported in their responses to RQ1. Eleven of 12 participants response referred to one or more reasons of access disparities. Only one participant felt access disparities did not impede her PNC services, did not respond to RQ2. Whereas several subthemes emerged from the analysis of participant responses to RQ2, including racial/ethnic discrimination, health insurance types, income status, and SES, I was able to refine the themes into one major theme – contributor to prenatal access disparities.

Most participants perceived and reported racial/ethnic discrimination as the major contributor to access disparities. Phrases, statements, and words representing racial/ethnic discrimination were the most referenced in participant responses to IQ4. Approximately 92% (11/12) of participants attributed the access disparities they reported to racial/ethnic discrimination. In contrast, some of the participants appeared less candid in admitting openly that racial/ethnic discrimination contributed to the disparities they experienced but expressed their views by referring to skin color. In addition to racial/ethnic discrimination, several participants voiced that the type of insurance or insurance status at the time of seeking PNC contributed significantly to the access disparities. Participants stated that disparities in access to quality care, access to specialized care and diagnoses, patient information access, and waiting times varied considerably based on whether one had public or private insurance.

Data analysis showed that most study participants felt their status of being pregnant minority women contributed to what they viewed as health inequalities in the process of seeking PNC services. Some participants reported that sometimes they felt that being a woman makes them feel invisible or that their health is less important. Other participants shared that being a minority woman added to access disparities in indirect ways. For instance, racial/ethnic status contributed to health information challenges, which determined the type of available insurance, income, education, and SES which, directly influenced disparities in the process of accessing PNC services among this population.

Lastly, analyzing responses to RQ2 revealed that some participant’s perceptions that their low SES contributed to their experience of prenatal access disparities. The low SES of participants were influenced by several factors, including marital and employment status, which determined their household income levels. Fifty percent 6/12) of all the participants were unemployed, and approximately 75% (9/12) of the study participants reported low household income status. Participants communicated that household income and employment status determined the insurance type they had, and the quality of treatment received from HCPs.

Analyzing responses to RQ2 revealed five subthemes (e.g., racial/ethnic discrimination, health insurance types, income status, education status, and SES) that emerged from participant responses were not exclusive. For instance, racial/ethnic status influenced the low SES reported by first-time pregnant minority women, in determining the kind of insurance obtainable to this population. Similarly, income status contributed to obtaining affordable insurance that led to access disparities in PNC services among the population of focus in this study.

Research Question 3: Effects of Access Disparities on the Experience of Seeking Prenatal Services Among First-Time Pregnant Women

Research question 3 (RQ3) aimed at exploring how access disparities affected the participants' overall experience in the process of seeking PNC services. To generate participant responses needed to address RQ3, I asked participants the following interview questions (IQs):

> IQ7. How, if at all, did the access disparities you experienced affect your feelings and decisions towards seeking subsequent PNC?
>
> IQ8. How, if at all, did access disparities affect your overall experience of seeking PNC services?

IQ9. Is there anything else you want to share with me concerning your PNC service experiences in relation to prenatal/access disparities?

Analyzing responses to RQ3 revealed that pregnant minority women who participated in this study felt that overall access disparities had a negative effect on their experience of seeking PNC services. All participants reported at least one negative aspect in which access disparities affected their PNC-seeking process.

How have the experiences of health disparity affected the health-related outcomes in first-time pregnant minority women as they seek PNC for the first time?

Emergent theme and subthemes for research question 3

RQ3. How do access disparities affect the overall experience and perceptions of recent first-time pregnant minority women towards seeking prenatal services? Theme: Negative experience in seeking PNC services.

Theme 5: Effects of access disparities. Five subthemes (i.e., feeling undervalued, emotional distress, changing providers, skipping appointments, missing care, and loss of trust in the HCPs) emerged from participant responses to RQ3. To explain in more comprehensive terms the analysis and presentation of results, I refined the five subthemes under one major theme: consequences of access disparities from personal experience of seeking prenatal services.

Feeling undervalued. Participants perceived disparities in accessing PNC services as a discriminatory treatment that makes you feel undervalued or insignificant. In their responses to RQ3, four participants reported that the access disparities they experienced diminished their sense of value resulting in an unwelcomed feeling to the providers. Notably, Tammy responded:

> . . . I felt like I didn’t matter to anyone whenever I went for my prenatal visits, the reception at from the time I entered the facility throughout prenatal examination felt cold and disappointing. Personally, the staff were unpleasant and uncaring; they behaved as if I was a bother to them, which suggested you were not welcome. I felt unloved and alone, and most of all, I didn’t feel respected …. I never expected to feel so less than, as if I didn’t matter, which made me sad, I sometimes cried. The look I was given as if you don’t belong here or you are just looking for a handout always stayed in the back of my mind. It made me question who I am, and if I was as insignificant as they made me feel, and yeah, maybe, I’m nothing then.

Tina shared her annoyance and disappointment with the whole health care team and thought they had the role of helping others in my position, and treating some kindly and others like trash. I felt unworthy and unwanted, and I hated feeling this way and deserved better treatment:

> . . . so why treat some so nicely and others with disregard. It’s very obvious that anyone can see what they’re doing, I’m not blind. To think they treat me like this every time I come here…. I’m ignored and taken for a fool. I sit and wait; I’m spoken to like I’m a nobody, and this saddens me.
>
> No one wants to feel like they are less than, you know, when someone looks down on you like you are nothing, it affects your self-confidence, and you start feeling like crap. This is how they all treated me, from the staff, nurses, and

> doctors. I would never treat anyone they made me to feel, and why would anyone go out of their way to make someone feel unwelcome and rejected. All I think about is changing location, finding a different provider or facility.

Emotional distress. Other participants perceived disparities in accessing PNC services to cause them emotional distress with reluctance in going to their regular prenatal visits during pregnancy. When asked to share her overall experience with the challenges of seeking care in the presence of access disparities, Tommy was emotional in her response. She expressed:

> . . . I never wanted to go to my second prenatal appointment or any more after that but knew I had to because I didn't have anywhere else to go. It was too much to sit around for hours waiting to see a doctor or nurse …. feeling as if I was a burden or something. I have scheduled appointments one after the other, so there was no reason to treat me any different when you know I'm coming every month. I was worried of and had anxiety every time I had to go for my prenatal appointments, and I hated feeling this way. Being in this health care place didn't seem anyone cared about me or what I was going through because of the way there were treating me truly hurt me. You try to be nice and greet them politely, but they will not treat you as you did, instead they treat you like you are a nobody. It's hurtful that after being disregarded, a White patient shows up and is given the royal treatment. Yeah, it's emotionally upsetting and nasty like you shouldn't exist.

Tanya, a 35-year-old married, unemployed woman, shared a similar view to that of

Tommy concerning the effect access disparities had on her experience of seeking PNC services. She reported:

> . . . you have to visit the doctor because you are pregnant, they know you are pregnant, and it just seems like they want to upset you. It's like you are taking, taking, taking, and you don't deserve anything, they make you feel like a complete nobody, or you are second class. . .. that's how they make me feel as if I am the bottom and they are on top. They don't treat other patients who do not look like me this way; they get top treatment, respectful greeting, and fun conversations. They don't have to wait like me. . .. waiting like two hours or so. I am haunted by the treatment I have to endure when I go for my prenatal visits, and I don't care to come, but what other choices do I have? I don't want this feeling, especially since I'm pregnant. I didn't expect any form of discrimination or to be disrespected. I'm not stupid, you know, I know if it wasn't for my skin color, I wouldn't be treated this awful. This is so very hurtful and distressful, an emotional Tandy reflected.

Changing providers. Several participants emphasized in their responses that the access disparities they encountered in the process of seeking PNC services provoked them to change providers reluctantly. Participants conveyed that the decision to change providers was not their first choice because having a doctor that knows you or knows your case is important or even at the same facility because at least they have your information. The decision to change was not decided on frivolously but was given the same consideration of the balance of a stable relationship with providers and the benefit of a healthy mindset, although very challenging. The participants who felt they had no other choice but to change providers reported that it was in their best interest to avoid an unpleasant atmosphere, especially since I'm pregnant. Terri, who perceived that her PNC resulted in quality disparities, which she attributed to the doctor's behavior towards her, she had to change doctor in her second trimester. She reported:

> . . . discussions about her behavior towards me was met with disregard or downplaying my concerns. So, I decided to change doctors in my second trimester because I needed to keep my sanity, let me tell you, her behavior was deeply disturbing. I changed the facility because I realized it was not working out; nothing was going to change. I just couldn't deal with it; do I continue to miss appointments or just stop going altogether. Yeah, it was misery. How do you find someone you can truly trust and who you feel cares about you enough to treat you as a person? They gave me a hard time for changing, but I had stopped going to my scheduled appointments, I think I missed one or two visits with this doctor. I didn't want to feel put down or low like I'm not doing anything right, as if I'm stupid. Just respect me, and that's all I ask, it's not that hard. I just couldn't end up being depressed while I'm pregnant too.

Toya and Tina were two other study participants who reported that their experience of access disparities in the process of seeking PNC resulted in a change in providers. Toya stated:

> . . . how I did this was to choose the days I knew that particular provider did not come to the facility. This didn't happen by choice; it was because you usually

> never get to see the same doctor all the time, it might be two months or so before you might see the same doctor based on the appointment days you were given. So, I looked into this further, so the days I knew the doctor would come into the facility, I made sure I wasn't available, so I would be scheduled opposite dates.
>
> Tina reported a similar response when she replied that, "you know. . . I wanted to just move away and go live with my boyfriend, so I wouldn't have to see these people again. I asked for a transfer to another doctor because I was not happy with how the staff treated me at my prenatal visits, I was refused immediately, so I decided to take the early morning appointment times to offset this issue, but it was basically the same. You really don't want to change doctors because they have your record and know about you and your medical history and would seem like to know what's going on with you sooner. However, staying with this doctor would've made me emotionally unstable, and I'm already struggling with the thought of pregnancy right now, and I didn't need the added stress.

Skipping appointments. Participants also reported that the indifference in treatment by HCPs influenced their decisions to skip recommended appointments because of past experience and interactions with said providers. At least three study participants referenced in their responses that they missed one or more of their prenatal appointments intentionally because they were treated poorly by their providers in previous visits and did not want a repeat of the same experience. Tori indicated that if I skipped an appointment because I couldn't stand to be belittled when I didn't get a recommended prescription or follow up with a particular test, then so be it. I needed to feel a real human connection or have a meaningful conversation, which shows me that you, as a doctor, are genuine in treating me with care and not just a paycheck at the end of the week. Am I a person or just another number at the end of a folder…? I can't get an answer from you at all about the concerns I have with my pregnancy, being extremely scared, yet you have not inquired about how I am doing or managing. Do you even know if I can afford the prescription or if I'm in a stable relationship with support? Then…. it is not worth it to go for appointments where providers treat you so low. She responded:

. . . I do not wish to see someone who undervalues my existence or treat me so badly that it affects my self-confidence and my wellbeing while I am pregnant. You can't treat a person less than and expect them to want to be around you…even if they rely on you partly by no choice of theirs and when they think you are nothing. . . they treat you like nothing. So, if I am not dying, I feel better about not going, and I know where to go if I have an emergency.

Similarly, Tandy disclosed that she skipped several appointments, though not back to back, and not because she does not value health, but she could not get passed what she perceived as an ugly and unwarranted treatment by her HCPs. She shared:

Though I am not proud of skipping my appointments intentionally, I felt I had no choice, and I will not lose my sanity over being treated badly because of my skin color. . . I'm not blind; you have one set of behavior for one group and another set of the other. I dreaded the doctors' appointment, I felt a pit in my stomach every prenatal visit, and I became understandably paranoid and felt unsafe that somehow because of the way they treated me there was no reason for me to go back. I could no longer trust doctors, and though I value health, I hated going to my prenatal appointments. It was always a tense visit; they never regarded me as a person with feelings who wanted the same things they want in life, a happy, healthy life, and family. It became hard to keep going to the appointments where they show you that you are not valued.

Loss of trust in the providers. Some study participants felt that the major effect access disparities had on their experience of seeking PNC services was the loss of trust in providers. Participants indicated that they had confidence and trust in HCPs providers but have changed their opinions when they had their prenatal visits. Tandy admitted that she had high expectations about HCPs until she became pregnant and started seeking PNC using public insurance:

> The disparities I lived seeking PNC, made me distrust the health care team, from the nurses to doctors. I never expected our interactions to be so horrible, but it's worse than that; I have zero trust in the providers when I experienced access disparities early in my pregnancy. I am convinced that disparities in access to specialized care contributed to a negative health outcome. The lack of communication and trusting patient-provider relationship make me think negatively about nurses and doctors. The doctors never cared about me, they never explained anything to me or even a followed up much less answered my call. I cannot even understand how being pregnant and having concerns would not have been a high priority for the doctors who are to ensure their patients remain healthy. I felt like the nurse and doctors showed no compassion and don't care about the health outcomes of some patients. Patients that look like me were taken less seriously, and the doctors performed their job as an obligation. There was just a lack of compassion.

Similarly, Toya indicated that access disparities left a negative effect on her perception towards HCPs. She reported:

> The inequalities in accessing PNC gave me a very negative impression of nurses' and doctors' treatment toward certain patients. There was a time I never thought I would say this, but there was variance in how doctors treated minority patients than their White counterparts, but it was upsetting not to mention. You know there is a lack of promoting equality and not treating people the same way. I have had experience with both types of insurance, and let me just say, when you have public insurance, they disrespect and degrade you like you are just poor and rely on others for a handout. The insurance is there for a reason, and you get qualified for it, it's not a handout. The idea of being treated because of how you look. . . whether it's your race or your ethnicity or the way you speak should not determine the type of care you receive from the professional health care team. I continue to be truly disappointed and feel I can't trust the health care team, and this made me become my own advocate. I feel they were not there for me, and they will never be there for me. Bottom line is. . . the ultimate trust I had in HCPs is gone.

Summary of Results for Research Question 3

Research question three (RQ3) addressed the influence of access disparities in the process and experience of seeking prenatal and essential services among first-time pregnant minority women residing in the BCBC. In response to RQ3, participants shared their insights about the influences of access disparities have had on their experience of seeking PNC services. Collectively, first-time pregnant minority women's participation in this study felt that access disparities had a negative effect on their experience of seeking prenatal or essential care services. Five subthemes (i.e., feeling undervalued, emotional distress, changing providers, skipping appointments, and loss of trust in providers) emerged from participant's responses to RQ3. To explain in more comprehensive terms the analysis and presentation of results, I refined the five subthemes under one major theme: effects of access disparities from personal experience of seeking PNC services.

The participants who reported disparities in accessing PNC services in their view collectively believe discriminatory treatment that makes the victim feel undervalued or unimportant. In their responses to RQ3, four participants referenced that the access disparities they experienced diminished their sense of wellbeing and felt ignored, undeserving, and unwelcome to the providers. To reiterate this negative perception, other participants reported that access disparities made them emotional, and they dreaded their regular prenatal visits during pregnancy.

Similarly, some study participants felt that the major effect access disparities had on their experience of seeking PNC services was a loss of trust in providers. Participants indicated that they had a lot of confidence and respect for providers until they needed PNC services. Also, several participants highlighted in their responses that the access disparities they encountered in the process of seeking PNC services forced them to change providers prematurely and obligatorily. Participants reported that the decision to change providers was raw because they understand very well the benefits of having a continuous relationship with providers but had no choice. Although it is not what they wanted to happen, the participants who changed providers believed that it was in their best interest to avoid what they viewed as unequal treatment and distressing recurrent experience.

Also, some participants reported that the inequalities in treatment by the HCPs influenced their decisions to skip their prenatal appointments because of their negative experience. Three study participants referenced in their responses that they missed one or more of their doctor’s appointments intentionally because they were treated poorly in their previous visits and were reluctant to repeat the same negative.

Summary

The purpose of this chapter was to provide an analysis of the unique experience of first-time pregnant minority women in relation to the phenomenon of access disparities in PNC as recounted in response to research questions that underpinned this study. To understand further the study phenomenon, access disparities in first-time pregnant minority women, I created three research questions that underpinned this study. I recruited 12 study participants who met the eligibility criteria listed in Appendix B. The 12 participants responded to the interview questions that shaped the data used in this study. Here outlines subthemes, themes, and key findings that emerged from analysis of participants’ responses to research questions. Subthemes: (i) Disparities in access to specialized services and diagnoses, (ii) disparities in care quality, (iii) disparities in patient information access, (iv) disparities in waiting times, (v) racial/ethnic discrimination, (vi) health insurance types, (vii) income status, and (vii) SES. Themes: (i) feeling undervalued, (2) causes of prenatal access disparities, (iii) emotional distress, (iv) changing providers, (v) skipping appointments, and (vi) loss of trust in providers. Key findings: (i) types of PNC services, (ii) meaning of health access disparities, (iii) types of prenatal access disparities, (iv) causes of prenatal access disparities, (v) effects of access disparities (vi) all (100%) participants used one or more forms of PNC services, (vii) all participants understood the meaning of health care access disparities, (viii) more than 92% reported access disparities in PNC services, (ix) more than 60% failed to access needed specialized care or diagnostic services, (x) more than 90% attributed access disparities to racial/ethnic discrimination, insurance types, income status, and SES.

RQ1 was designed to produce inclusive participant responses surrounding access disparities first-time pregnant minority women experienced in the process of seeking PNC services. All participants reported they had sought and used prenatal or essential care after becoming pregnant and had experienced access disparities during this time. Seemingly, all participants confirmed or acknowledged understanding the meaning of health access disparities. Themes that emerged from participant responses to RQ1 were, (1) types of PNC services, (2) meaning of health access disparities, and (3) types of prenatal access disparities, including access to specialized services and diagnoses disparities, quality care disparities, patient information access disparities, and waiting time disparities. All first-time pregnant minority pregnant women who participated in this study reported having experienced one or more types of access disparities in the process of seeking PNC. Analysis of participant responses to RQ1 showed several participants reported experiencing comparable access disparities.

RQ2 was designed to explore first-time pregnant minority women' perceptions of what factors influenced access disparities in PNC services experienced by this population. Analyzed responses to RQ2 emphasized areas study participants perceived to be the main influences of the access disparities they experienced in the process of seeking and using PNC services. Almost all participants responded highlighted one or more influences of access disparities. One of 12 participants felt her experience with PNC services did and did not involve access disparities was the sole participant who responded to RQ2 as experiencing disparities after a change in insurance status. Racial/ethnic discrimination, health insurance status, income status, and SES were the subthemes that emerged from the analysis of participant responses to RQ2. To explain in more comprehensive terms the analysis and presentation of results, I refined the five subthemes under one major theme: causes of prenatal access disparities.

RQ3 was designed to explore how access disparities affected study participants' overall experience in the process of seeking PNC services. In response to RQ3, participants shared their perceptions of the influence access disparities had on their experience of seeking PNC services. In general, first-time pregnant minority women who participated in this study felt that access disparities had a negative influence on their experience of seeking PNC services. Five subthemes (i.e., feeling undervalued, emotional distress, changing providers, skipping appointments, and loss of trust in providers) emerged from participant responses to RQ3. To explain in more comprehensive terms the analysis and presentation of results, I refined the five subthemes under one major theme, "effects of access disparities from personal experience of seeking prenatal services."

Chapter 4 presented an analysis of responses from participants of the three research questions that underpinned this study and a description of study results relating to the phenomenon of access disparities in PNC from the accounts of events experienced by first-time pregnant minority women. Also included in this chapter is a summary of data collection and data analysis procedures and descriptions surrounding evidence of quality in this research. Chapter 5 provided a brief summary of the study's purpose, an interpretation of the study results, limitation of the study, recommendations, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to (a) identify what SES, provider’s perception of their race-ethnicity, knowledge, and care-seeking factors influenced first-time pregnant minority women’s access disparity in the use of health care, (b) explore what first-time pregnancy health disparity may be unique to this population, and (c) understand how access disparities affected participants’ overall experience of seeking PNC services. Earlier studies on pregnant minority women’s health focused on maternal and child mortality, which left health needs and challenges of first-time pregnant women less known (Parekh et al., 2018). Hence, the information generated in this study potentially fills a gap in the literature on access disparities in the prenatal health of first-time pregnant minority women.

Furthermore, the results of my study may provide valuable insights about minority childbearing pregnant women’s perception of their experiences of health disparities (Kennard, 2016), attain good access to care and ongoing care, and find providers who meet their needs, which will reduce the health disparity gap. Thus, the information can be used to maximize and support their achievement in navigating the health care system to prevent delayed treatment and gaps in care and improve their quality of life not only for themselves but for their family and this population.

The study findings that emerged from analyzing participant responses were generated through conducting in-depth, face-to-face semistructured interviews with 12 first-time pregnant minority women who volunteered to participate in this study. I used semistructured narrative inquiry questions (see Appendix D) designed to produce answers from participants in response to the three research questions that underpinned this study. I compared the results to findings of the literature review in Chapter 2 to gain insight into whether this study added or failed to add new knowledge to the existing body of knowledge on the phenomenon of access disparities in PNC of first-time pregnant minority women. The ANFHSU (Andersen, 1968, 1995; Andersen & Newman, 1973, 2005) provided the theoretical lens I used to analyze and interpret findings from this narrative study.

The main findings that emerged from the analysis of participants' responses revealed participants were treated unequally in the process of seeking PNC services when compared to their White counterparts. Participants' perception of the differences in treatment as types of access disparities were factors influenced primarily by racial-ethnic discrimination, health insurance status, income status, and SES. There was an overwhelming consensus among first-time pregnant minority women who participated in this study who believed that access disparities adversely affected their experience of seeking prenatal or essential health services. In this chapter, I discussed the interpretation of the findings from this study, limitations of this study, recommendations and suggestions for future research, and implications for social change. The chapter ends with the conclusions and remarks about my personal experiences as the researcher in this study.

Interpretation of Findings

In this section is the interpretation of study findings on the topic of experiences of prenatal access disparities experienced by first-time pregnant minority women. Upon review of the literature, it became evident that earlier studies of minority pregnant women's health focused largely on maternal-child mortality populations, whereas the unique health needs and challenges of first-time pregnant minority women minority remained less known (Parekh et al., 2018). Findings from this study potentially fill a gap in the literature on access disparities in first-time pregnant minority women in the process of seeking health care services for the first-time. The three RQs that underpinned this study were as follows: How do the experiences of women, minority and underserved, of childbearing age as they seek PNC affect their ability to achieve positive pregnancy outcomes (defined as term vaginal delivery, appropriate birth weight for infant and pregnancy weights for mother, and to avoid postpartum depression and infant mortality)? What are the self-reported access disparities in first-time pregnant minority women as they seek PNC for the first time? And, how has access disparities affect the overall experience and perceptions of first-time pregnant minority women towards seeking PNC services? Because most participants provided similar responses to the three RQs, I interpreted the result to reflect the themes that emerged from the RQs from the lens of the ANFHSU and the context of relevant literature reviewed in Chapter 2.

Research Question 1 Findings and Relevant Literature Reviewed

The following three themes emerged from participant responses to interview questions (IQs) generated data to address RQ1:

- Types of PNC services.
- Meaning of health access disparities.
- Types of prenatal access disparities.

Participants admitted to using several types of PNC during the gestational period before data collection, including obstetric care and family planning services. Whereas some participants reported more than others, of the 12 participants in this study reported, none reported complete underuse of needed prenatal or essential care services. These results support the findings of Bellis et al. (2014), Bellis et al. (2015), Osler et al. (2013), and Manning et al. (2010), and support the increasing emphasis on the significance of early life development to adult health outcomes. The commitment of first-time pregnant minority women seeking and using PNC services may partly be a result of their increased understanding of the benefits associated with using recommended prenatal and essential care on the future health of both mother and child.

Most participants obtained PNC services using Medicaid for pregnant women, which is in line with the findings of Parekh et al. (2018) that there is evidence of commitment at the local, state, and federal levels to improve access to adequate PNC, of the assumption that early continual PNC would result in positive effect on birth outcomes, including the reduction of low infant birth weight, infant mortality and morbidity rates for the low-income population through prenatal health-promoting programs. However, Gold and Kennedy (1985), Parekh et al. (2018), and March of Dimes (2013) suggested that if a substantial number of women continue late enrollment in PNC or essential services the expansions may negate promoting significantly early use of PNC programs. Approximately 92% (11 of 12) of participants can be attributed to Medicaid-covered pregnancy health, a state health insurance program provided to residents of MA who meet specific criteria by measuring their family income to the poverty level.

Although there is no consensus on the precise definition of health disparities, Healthy People 2020 (2014) defined health disparities as the difference in health because of the economic disadvantage including the lack of resources and opportunities that adversely affect groups of people based on their racial or ethnic group, SES and or geographic location and the subsequent inability to afford goods, services, and influence, or other "characteristics historically linked to discrimination or exclusion" (p. 1). Similarly, participants used varied phrases, sentences, or words to simplify what health care access disparities meant to them, resulting in no discrepancies between Healthy People 2020 definition of health disparities and the meaning given by study participants. For instance, participant Tammy described health disparities as the inequality in health care provided to different groups of people because of the way they look or where they live, their race or ethnic background, and income status. Congruently, Tori reiterated,

> from experience it is the unequal or differences in the care and services available to people like me, or adequate clinics or health centers and nice nurses and doctors for us… it doesn't matter that we don't have the means or not rich.

Participants referred to inequalities frequently in access to care or services in their description of their perception of health disparities. Tess shared,

> because we live in these neighborhoods, it seems like they have forgotten us, we don’t get the best care, we don’t have the best nurses and doctors… not even get to see a specialist unless we are dying, yeah…. Talk about unfair.

Participants’ perceptions of the meaning of health access disparities reflected the four major indicators of measuring health access (e.g., health insurance, adequate service, available HCPs, timeliness emphasized by Healthy People 2020 (2015). Further, equitable access to health care, means where all Americans can secure an adequate level of care without excessive burdens. A person’s ability to access health services has a profound effect on every aspect of his or her health (Healthy People 2020, 2015). Moreover, Tamica reiterated the significance of the component of coverage and quality service in measuring access to care when she expressed that, “we need a society without discrimination, where all patients are given equal care, no matter the color of your skin, if you are rich or poor, where you come from or live, or how you speak.”

Tommy, in her explanation of the meaning placed on health care access, similarly emphasized the need for HCPs to remove all forms of inequality in care services to ensure that everyone in receipt of care are afforded equal opportunity to quality health care access and services, and the availability of quality health care facilities and HCPs no matter where you live or your ability to pay.

The literature indicated the prevalence of worse health care disparities are densely concentrated among minority populations including such as Blacks, African Americans, Hispanics, Latinos, Indian Americans, and immigrants when compared to their White counterparts (Gadson et al., 2017; James et al., 2009; S. Lee et al., 2015). Study results indicated that greater than 95% of first-time pregnant minority women who voluntarily participated in this study reported experiencing access disparities in the process of seeking PNC services. Several participants reported incidences of receiving indifferent or unequal treatment compared to other care seekers seeking similar treatment, and in their perception, contributed to access disparities that negatively affected their care experience. These results are supported by findings of Gadson et al. (2017), James et al. (2009), and S. Lee et al. (2015) who argued that minority populations such as African Americans, Latino Americans, Indian Americans, and immigrants disproportionately experience disparities in access to health care services in the United States that contribute to their adverse health outcomes. Results from this study are also supported by Bloom (2011), Durkin et al. (2015), Parekh et al. (2018), and Roman et al.'s (2017) findings suggested that pregnant minority women and or low-income families, and/or those from various background experience disparities in access to care in the United States.

More than 92% (11/12) of the participants reported incidences of access disparities, including disparities in access to specialized services and diagnoses, quality of care, access to patient information, and waiting time disparities. Notably, greater than 50% (7/12) of the study participants failed to access adequate PNC and the assumption of early continual PNC, support the findings of Durkin et al. (2015), that despite policy and program interventions at local, state, federal levels to improve the availability of access to healthcare, some population subgroups in the United States continue to experience disparities in access to PNC services. Traub et al. (2016) suggested that improvements in national outcomes require a comprehensive intervention approach that addresses clinical factors and socioeconomic determinants to better foster coordinated care. Thus, Traub et al. (2016) findings explain why first-time pregnant minority women experienced disparities in PNC services despite having access to insurance and providers.

This study revealed that the quality of care provided showed indifferences of participants' experiences in receipt of seeking PNC. Participants shared that they were treated differently from the time of their prenatal appointment, including staff, nurse practitioners, and doctors. Several researchers (Smith et al., 2015; Miller et al., 2017) indicated that minority individuals experience prejudice that made them vulnerable to being treated differently in the process of seeking care. Similar studies showed disparate treatments for similar care or treatment and wide divergence in general health status among racial-ethnic groups (J. Lee, 2015; Arce, Goldstein, Mitani, Lenihan & Winkelmayer, 2013). In a study conducted by Parekh et al. (2018) showed that pregnant minority women who had public health insurance experienced poorer treatment and often poor engagement from HCPs, confirming the findings of this study.

Also, almost 70% of the participants experienced disparities in access to patient information in the process of seeking prenatal or essential care services. Terri, a 23-year-old woman, who holds less than high school education, explained that the current emphasis of accessing patient information online, including test-results limited her full access to patient information. These results reflect the findings of Liddell et al. (2018), consistent variations in access to health information among minority individuals. Whereas educated Americans had higher odds of using the internet to seek information compared to less well-educated who had no computer access had less access to healthful information (DesRoches et al., 2010; J. Lee, 2015). Participants experienced similar cases of information-access disparities in this study, which magnified the findings of several other cases. Also, the findings of disparities in access to patient information support results of Prey, Restaino, and Vawdrey (2014) and J. Lee (2015), that minority patients had less access to their patient information when compared to their nonminority counterparts.

Almost 90% of participants experienced variations in waiting times for their prenatal or essential care appointments. Even with scheduled appointments prior to their visits, participants reported they waited unreasonably longer than other nonminority care seekers during their prenatal visits. Participants report was consistent with Prentice, Davies, and Pizer’s (2014) study indicating structural inequalities in waiting time during physician visits. In relation to findings of this study, Taylor and Francis (2018) noted that minority pregnant women reported long wait times, and rushed visits varied from one patient to another, which they report as disparities in care. Similarly, Hernandez and Rossel’s (2015) study indicated that a lack of consistency in waiting time reflects a negative influence on the meaning patients’ place on the health care system and their desire to seek needed care. Also, findings of Parekh et al. (2018) showed that the common belief that adequate health insurance coverage improves health care use but may be ineffective with increased in-office waiting times and rushed visits. In general, results from participant responses to RQ1 reflect the literature reviewed in this, study which supports that prenatal access disparities are major ongoing health challenges experienced by minority populations such as African Americans, Hispanics, Latino Americans, and immigrants. These studies indicated that access disparities play a key role in adverse health outcomes among these population Subgroups. More than 92% (11 of 12) of the study participants admitted that they accessed and used different types of PNC services during which they experienced numerous access disparities.

Research Question 2 Findings and Relevant Literature Review

Research Question 2 (RQ2): What are the self-reported access disparities in first-time pregnant minority women as they seek PNC for the first time?

Study participants reported similar views and opinions about factors influencing access disparities in the process of seeking and using PNC services. More than 92% of the first-time pregnant minority women who participated in this study attributed access disparities in prenatal to one or more influencing factors. No participant reported their care did not involve access disparities. Subthemes that emerged from RQ2 include racial-ethnic discrimination, health insurance status, income status, and SES. In the analysis and presentation of results, I grouped all subthemes under one theme: factors influencing prenatal access disparities.

Although participants highlighted several factors influencing inequalities in access to PNC services, the majority, 11/12 or approximately 92%, reported racial-ethnic discrimination as the primary reason for access disparities. Participants said that they were treated differently or unequally during their prenatal appointments when compared to their White counterparts. These findings expand upon the existing body of knowledge investigated by several researchers (Johnson et al., 2011; Mazul et al., 2017; Parekh et al., 2018; Roman et al., 2017; Vardeman-Winter, 2017; Walker & Chestnut, 2010) of the challenge of persistent health care disparities in the health care system and exclusions along racial-ethnic lines.

Previous studies by (Frieden, 2014; Kirzinger et al., 2018; Martino et al., 2013; Parekh et al., 2018) have found substantial racial/ethnic disparities in almost all health indicators, including access. Similar studies have shown negligible evidence that racial/ethnic disparities in child health remain consistently challenging, comparing Black-White disparities of infant mortality have grown increasingly more significant over time (Kothari et al., 2017; Martin et al., 2009, 2017; Parekh et al., 2018). Participants shared their experience of the feeling of discrimination, or some form of indifferent treatment persisted throughout their prenatal visits. They reported that treatment among patients varied based on our skin color or background. These results are substantiated by study findings of Mazul et al. (2017); Meyer et al. (2016); Yearby (2018) that racial and ethnic backgrounds contribute significantly to health care disparities. Comparable studies by (E. Howell et al., 2016; Hsieh & Ruther, 2017; Kenney et al., 2013) support previous study findings that pregnant minority women are more prone to disparities compared to nonminority pregnant women. These studies directly support the existence of racial/ethnic discrimination experienced by the participants in this study.

Most participants attributed disparities in accessing PNC services as a contributing and influencing factor to the type of insurance in receipt of PNC. Participants maintained that their form of insurance coverage limited the opportunity of the level of access and use of care services. Contrasting views of one participant with private insurance were without restriction in the choice of provider or service use. There is a limitation of state-provided insurance or Medicaid insured during pregnancy afforded to participants in receipt of PNC services from only Medicaid-approved providers. The perception of participants reporting that health insurance restrictions influenced disparities in their access to PNC is consistent with the findings of (Kenney et al., 2013; Hahn, 2013; Heaman's et al., 2015) study, which suggest state-insured patients suffer disproportionately from health disparities when compared with their privately insured or White counterparts. In their study, C. Brown et al. (2019) found that even with the expansion of insurance coverage the differences in outcomes persist among Medicaid patients and privately insured patients, emphasizing the finding that differences in insurance type contributed significantly to access disparities in PNC services reported by participants in this study. Hence, supporting the need for comprehensive interventions addressing the persistent multilayered challenges of health disparities beyond expanding insurance coverage.

Similarly, results from this study indicated that almost all participants attributed access disparities in PNC services to their low-income status. Participants maintained that their low-income status was in relation to incomplete knowledge of the healthcare delivery system, influencing challenges that exacerbated the disparities in access in the receipt of care. Results from the study expand upon existing findings reported by Bloome (2018), Bromley et al. (2012), and Border et al. (2015) that minority pregnant women subgroups in the United States experience greater barriers to care, receive poorer quality of care, and report poorer health outcomes when compared with nonminority pregnant women subgroups. Also, access to care disparities based on income status, as detailed in this study, coincides with results of a pilot study conducted by F. Gonzales et al. (2014), which indicated that minority pregnant women remain as one of the medically underserved population Subgroups in the United States.

The findings on income status as a cause for disparities in access to PNC services magnifies the results that were identified in studies by Kochhar & Cilluffo (2018); Mazul et al. (2017). This report indicated that income inequality was the catalyst to barriers and challenges, including poverty, marginalization, and limited access to social benefits and health services, resulting in adverse health-related outcomes. Also, the finding highlighted that health disparities faced by low-income minority pregnant women in access to care experienced more significant disparities from factors such as discrimination, exclusion, unequal access to education and employment, and lack of adequate and sustainable social support (Sacks et al., 2015).

Further, some participants reported that their SES was the single most factor influencing the challenges of experiencing prenatal access disparities. Almost 65% of the participants confirmed unemployment, and nearly 67% confirmed low-income household status. These participants maintained that their low SES limited their health insurance choice to state-funded or Medicaid, their choice of HCPs and prenatal facilities, and sometimes lack the funds to pay for their prescriptions. These findings from this study are consistent with results from several studies by (Bloome, 2018; Bromley et al., 2012; Border et al., 2015), found that greater disparities in health care access and the poor health outcomes among pregnant minority women are significantly influenced by a high prevalence of socioeconomic inequalities in the United States. Owing to no employment and low income in most cases of pregnant minority women with low SES tend to depend on government programs and resources.

Researchers argued that factors influencing inequalities include low-income status, race/ethnicity, SES, insurance status, and geographical location significantly contribute to prenatal access disparities (Saez & Zucman, 2016). Similarly, substantive findings from RQ2 supported results from several studies (Parekh et al., 2018; Semega et al., 2017; Smith, 2017; Taylor & Nies, 2013; Traub et al., 2015; Vardeman-Winter, 2017) found that health disparities stem from several factors. These factors include racial/ethnic background, SES, geographical location, education levels, insurance status, discrimination, and social support. However, most participants attributed access disparities to racism, prejudices and stereotypes, and marginalization as differences of major factors influencing the barriers and challenges in health access disparities among minority pregnant populations.

Research Question 3 Findings and Relevant Literature Review

Research Question 3 (RQ3): How have access disparities affect the overall experience and perceptions of first-time pregnant minority women towards seeking PNC services?

Several subthemes, including feeling undervalued, emotional distress, changing health care providers, skipping appointments, and loss of trust in providers, emerged from RQ3. For a better analysis of results, I grouped all subthemes under one theme – the effects of access disparities in the process of seeking PNC services. Overall, participants reported that access disparities had a negative impact on their experience of seeking care and prenatal outcomes. These reports are supported by findings from several studies by (Gadson et al., 2017; A. Gavin, Nurius & Logan-Green, 2012; Lobel eta al., 2008; Lorch & Enlow, 2016; Matthew & Brodersen, n.d; Miller et al., 2017; Taylor & Nies, 2013), which found poor health outcomes of minority pregnant women population are a result of low socioeconomic and health care disparities in the United States.

Findings from RQ3 showed some participants who experienced access disparities reported feeling undervalued, disregarded, and insignificant to the HCPs, and others suffered emotional distress, which reflected their care-seeking behaviors. Martinez's et al., 2013) study indicated that socially disadvantaged and marginalized people suffered from physiological resentment and reported poorer health outcomes on average than people who belong to more socially advantaged and inclusive groups. Similarly, access disparities among some participants reported a loss of trust in HCPs and the United States' health care delivery system. Findings from Mazul et al. (2017) study showed greater evidence of negative attitudes towards HCPs and perceived poor quality of care, which reflected lower patient satisfaction among minority pregnant women subgroups.

Other participants indicated that access disparities influenced them to engage in seeking new HCPs frequently, which interrupted their opportunities to enjoy the benefits of establishing a stable doctor-patient relationship. Findings from this study indicated that participants intentionally missed or delayed recommended care to avoid suffering mistreatment related to access disparities. These findings were supported by Mazul et al. (2017) study, which indicated that health care disparities contributed to fewer use of preventive health care services among pregnant minority women when compared to their

White counterparts. The IOMs report of Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care emphasized evidence of discrimination, exclusion, prejudice, and stereotyping by HCPs as contributing to disparities (Coley et al. 2018). This report showed little evidence that minorities commitment and use of recommended routine preventive health service, which further supports the findings of this study. Interpretation and reporting protocol describe the steps used to report the findings of this study through a single researcher's lens.

Theoretical Lens

Andersen developed the original model ANFHSU in 1968 designed to explore why individuals use health care services and have extended the framework through numerous iterations to adopt health outcomes. Further, Andersen's model helped facilitate the process of understanding why families use health care services, define and measure equitable access to health care, and contribute to the development of policy interventions for promoting equal access to health care. Hence, the *need* to explore factors that enable or inhibit access to health care (Andersen, 1968, 1995). ANFHSU proposed the reality of factors that enable or impede an individual's use of health care services and categorized them into three groups: predisposing, enabling, and need factors (Andersen, 1968). ANFHSU provided the lens of analysis to explore access disparities in PNC services experienced first-time pregnant minority women in northeast MA. More than 92% (11/12) of the participants who sought PNC services acknowledged that they experienced one or more forms of access disparities in the process of seeking PNC services. Notably, one participant admitted to not experiencing or noticing access disparities until she started using public insurance.

Study findings reflected the existence of access disparities experienced by study participants in the process of seeking PNC services, which were attributed to several influencing factors such as racial/ethnic discrimination, health insurance status, income status, SES, and education status. The three categories determined by Andersen are predisposing, enabling, and need (perceived and evaluated) factors deduce to enable or impede health care services use. These categories provided valuable insight into the multifaceted layers of access disparities experienced by first-time pregnant minority women in the process of seeking PNC services. Andersen stated inequitable access to care occurs when predisposing (i.e., sociocultural characteristics, attitude and value individuals place on the health care system), enabling (i.e., available resources and knowledge to access health services, income to acquire and sustain quality health insurance, availability of HCPs and facilities, and need (i.e., perceived is the immediate cause of an individual's need for health service use and evaluated is the professional decision in determining health status), and the need for medical attention.

ANFHSU's perception of the existence of factors that enable or impede an individual's use of health care services is consistent with racial/ethnic discrimination and income status predisposing factors. These factors contributed to inequitable access to PNC services among first-time pregnant minority women. Participants argued that the predisposing factor of being racial-ethnic minorities coupled with being pregnant interfered with their process of seeking and using care significantly in the form of racial/ethnic discrimination, which contributed to their experiences of access disparities. Almost all participants believed they were treated indifferently or unequally at their prenatal visits.

Similarly, health insurance types, income status, and SES perceived by participants as major reasons influencing their experience of access disparities, which are components of ANFHSU's enabling resources. These components of enabling factors clarified why participants perceived their low SES characterized by unemployment status and low household income contributed to their experience of access disparities in the process of PNC services. For instance, low-income status and SES dictated the type of insurance, available facilities, and choice in HCPs to first-time pregnant minority women. Also, the component of health beliefs as used in the ANFHSU provided insight on why 12 study participants who experienced prenatal access disparities, more than 50% reported they missed the recommended care intentionally as a result of access disparities. The commitment to continue seeking the recommended PNC amidst access disparities reflected the attitude and value first-time pregnant minority women attach health.

ANFHSU not only provided lenses for analysis, but its conceptualization encompassed all facets of this study. More importantly, the model's assumption of the existence of enabling and impeding (i.e., predisposing, enabling, and need) factors that influence an individual to access and use health care services illustrate the disparities in access to PNC, their causes, and the effect these disparities had on participants. This study converged a review of the literature with a landscape lens of interviews with key participants to provide an overview of studies in access disparities.

Limitations of the Study

Limitations of this narrative descriptive study included the participant recruited criteria from the execution of the study as described in chapter one. The design of this study inclusion of Black/African and Hispanic/Latino American women may offer transferability to similar groups, other minority groups and communities yet limitations of this study could also influence transferability and credibility; thus, weakening study findings. Although the findings of this study is highly relevant, there were an inherent limitation on ethnic differences that needed to be highlighted.

First, recruited participants were limited to two minority subgroups inclusive to Black/African American and Hispanic/Latino American women. The characteristics of the participants used in this narrative descriptive study were limited to two subgroups of women to transfer findings to similar populations or settings outside the scope of this study. Other minority groups of women, white or other ethnicities may share similar disparities unique to this type of population. Although health disparity is seen mostly in underserved neighborhoods made up of racial/ethnic groups, barriers unique to this population in accessing PNC or specialized care system of similar minority groups of similar background, other women were excluded from this study. Other racial/ethnic minority groups could have included, e.g., Asian American, Native American, American Indian or immigrant women.

Second limitation is the other women in this setting who received similar care who were non-Hispanic or non-African American such as White women or refugees who shared the same commonality in the receipt of PNC services. Background similarities included SES, low-income, unemployment, and lack of insurance. These other women not included in this study may have responded similarly to the IQs based on similar experiences and more importantly, similar settings. Similarly, these women are in a group as higher need for specialty services because of the pervasive influence of poverty and poor decision making which may be contributing factors to the situation these women are in or the overall problem to access. Addressing other minority groups outside the ones explored in this study could further help to understand from their perspective their experience in the receipt of PNC and specialty services or their engagement with HCPs or other health care staff during their care visits. It would help to understand if factors influencing disparities are systemic or structural among women with low SES or self-identified racial/ethnic characteristics.

Third limitation include systems issue where other groups of women do not have what would be considered good access and good care. These issues may include limited appointment availability, HCP/specialty shortage, constrained financial resources to health care sites, need for policy changes, and limited education about health care sites. Health care organization must prioritize and build capacity and convenient care options and patient services to mobilize patient access opportunities.

Race/ethnicity or culture in the context of health behavior has been defined by HHS (2017) as unique shared values, beliefs, and practices directly or indirectly associated with a health-related behavior or the adoption of the health information. Healthy People 2020 (2014) defined race/ethnicity or culture as the learned and shared beliefs and values of a designated or specific group transmitted intergenerationally which influence thoughts and actions. The current study followed the rigorous methods to achieve the findings interpreted with reference to relevant theoretical and policy perspectives, in order to derive recommendations for research and practice.

Recommendations

I am confident that there is a strong need for a new qualitative review employing gold standard methods to capture the critical assessment of minority pregnant women beyond Blacks/African American and Hispanic/Latino American pregnant women in receipt of PNC services. The limitations of the present study led to several recommendations for future researchers.

First, the study participants consisted of a limited recruitment, within a limited geographic area, and two specific subgroups. Future researchers may consider focusing priorities conducting a similar study using wider national participant recruitment, in a different geographic area or location, and incorporating a wider subgroup of racial/ethnic minority pregnant women to provide further transferability of the results. This study presents the opportunity for future qualitative research to be conducted prioritizing emphasis on other minority pregnant women in the receipt of PNC focused on timely obstetrical care and extended specialized care services may bring about substantive inquiries and impart further understanding of factors influencing prenatal disparities and implement strategic policy intervention to address prenatal disparities. If replicating this study, future researchers should consider expounding the questions related to factors influencing access disparities on their newborn.

Extending the areas of the research to the patterns of HCS and systems issues may help highlight other issues of a fractured HCS. Health care systems issues domain should focus on limited appointment availability, HCP/specialty shortage, constrained financial resources for health care/specialty sites, policy changes, and limited education about health care sites. Health care organization must prioritize and build capacity and convenient care options and patient services to mobilize patient access opportunities. Access to health services means "the timely use of personal health services" to achieve optimal health outcomes. Requiring three distinct steps include (a) gaining entry into the HCS (usually through insurance coverage), (b) ease in accessing a location offering PNC or specialty care services (availability), and (c) finding an HCP who patient trusts, can engage and communicate with (doctor-patient relationship). Access to health care affects the overall physical, social, and mental health status and quality of life (Healthy People 2020, 2015).

Due to the narrative descriptive design of this study, participants' limited responses within the defined scope of this study could benefit from new studies focused on areas that emerged that were beyond the purpose and scope of this study. I would recommend the long-term monitoring of the health outcome of first-time racial/ethnic minority postpartum mothers and their one-year-old newborn who experienced access disparities to establish the long-term effects of access disparities on health outcomes for this population.

Implications

This study provided first-time pregnant minority women an opportunity to voice their interpretation of their experiences on access disparities in the domain of PNC. This study added new knowledge to the existing body of knowledge of PNC services of the pregnant minority populations in the United States. Dissemination of the information generated in this study and the study findings could contribute meaningfully to the gap in the literature on first-time pregnant minority women in the receipt of health care access for the first time, unambiguously the domain of PNC services.

Potential Positive Social Change Implications

The potential for positive social change contributions of this study may involve increased awareness of the challenge in PNC services such as access disparities in first-time pregnant minority women experience in the United States. The findings of this study will be made available to the study population, HCPs and health institutions, community leaders, advocacy groups, and the general public when published to generate transparency of the access challenges in prenatal health among minority pregnant women. To increase awareness of the findings of this study, I will remit to discuss and interpret the substantive results of this study at research forums, including conferences and workshops at the national and international levels.

I will work with research and private and public organizations committed to addressing health disparities and promoting health equity among pregnant minority women. Hopefully, the results of my study may provide valuable insights that will be used by policymakers to design, develop, and implement evidence-based sustainable policy and program interventions tailored to address the specific health needs of minority pregnant women. As a result, these policy interventions will help to maximize and support their achievement in navigating the health care system to prevent delayed treatment and gaps in care and improve prenatal health outcomes for minority pregnant women in the United States.

Theoretical Implications

This study supported the use of Andersen and Newman's (1995) predisposing, enabling and needs factor in identifying and understanding health care disparities and interventions. Andersen's framework helped guide the research to underscore factors that influenced health care disparity. The study also implied that the ANFHSU not only provided in-depth look at health care behaviors of participants, but also their perceived health status. Participants perceived their predisposing characteristics, i.e., education, occupation, ethnicity, social interaction, and culture would not meet their needs of their care-seeking behavior and the kind and amount of treatment that would be provided after presenting to an HCP. Other research did not show the use of Andersen's extended phase, outcomes, which is a potential implication of the present study. The study does, however, imply that the extended phase of Andersen and Newman's framework may provide illustrative value for researchers studying this and similar issues.

Recommendations for Action

The results of this study are congruent with previously published literature by (Callaghan, 2012; Creanga et al., 2014; D'Angelo, Bryan, & Kurz, 2016; Docherty & Johnston, 2015; Gabbe et al., 2017; F. Gonzales et al., 2014; G. Gonzales et al., 2019; E.

Howell et al., 2016; Lu et al., 2015) emphasize that pregnant minority women are a marginalized and medically underserved subgroup and suffers disproportionately from health care disparities in the United States. Given the collective awareness of the significance of early life development in relation to the overall health outcomes in adult populations, urgent policy and program intervention to address PNC needs of pregnant minority women subgroups in the United States is strongly recommended. For this to occur, there is a need to generate awareness among scholars, researchers, health care providers, and policymakers of the sweeping health challenges prominently faced by pregnant minority women subgroup population.

Implications for Future Research

I propose it would be useful for the Department of Health and Human Services through agencies such as AHRQ and NIH to create incentives that attract researchers to investigate in the area of health of pregnant minority women. There is a need to strengthen existing policy, mobilize new policy, and maximize program interventions in response to access disparities in health care facilities across the United States.

The primary goal of public health stakeholders' is to reduce health disparity across cultural lines in the United Sates. The HHS (2016) released a report in 1985 documenting the existing health disparity among minorities which they called "an affront both to our ideals and to the ongoing genius of American medicine" (p. 12). The national stakeholder strategy in achieving health equity provided an all-encompassing path for eliminating health disparities through two key components using cooperative and strategic actions. These actions include the blueprint for guided action at the local, state, and national levels and targeted initiatives reinforced by public and private sector partners. Other program strategies designed to bridge the gaps among impacted communities imposed a critical step toward bringing individuals and organizations within the health arena collectively with other individuals and organizations with similar influences in health. Together negotiation and policy decision-making toward achieving health equity has the potential to achieve sustainability.

For researchers, the study implies the undeterred need to view with a critical lens and understand the fundamental factors influencing the existential health care disparities. Qualitative research may revive and awaken the existential issues by those experiencing the problem and their attitudes towards specific stakeholders in health care and public health policy, as with this study. Qualitative researchers share the understanding that is their role to distinguish their population and potential barriers, such as health and health care disparity, and socioeconomic factors that may influence behaviors. This study in addition, promotes awareness to researchers of the need for strategic action to solutions to remove prenatal disparities among minority women. It is required for the health care sector to preserve the transparency in health care initiatives, increase the transparency of the actions taken to improve health disparity, including the strategic development, actions and monitoring of health statistics, especially, among minority subgroup population.

The Offices of the Institute for Minority (2017) in conjunction with the AQHR, observed policy approaches concurrently with public health issues, and reported that effective strategy to earn the public’s trust is to increase transparency of data and metrics to illustrate quality indexes. Hence, researchers should be transparent in their data collection methods to the public to equally increase public trust in research. Transparency necessitates accountability throughout the health care system. Therefore, it is recommended that individuals, community organizers, health care providers, and stakeholders' partner with researchers to improve population health outcomes. Finally, these practices are likely to strengthen the relationship among researchers, minority communities, and HCPs.

I hope the dissemination of the results of this study will foster the interest of future researchers to undertake similar appraisal of pregnant minority women in the United States and in countries such as Canada and other European countries. The development of researchers' interest in investigating health needs and challenges of pregnant minority women will help to not only bridge the current literature gap but to close the gap central to health outcomes of this vulnerable population.

Implications for Practice

An integrated community action is vital to influence societal change and remove health care disparities (CDC, 2013), and all stakeholders should work to serve as an integrated stakeholder. The study results revealed several recommended functions that nursing practice could serve in reducing health care disparities. In accordance with the national stakeholder strategic action in achieving health equity is to increase transparency, strengthen and broaden leadership, improve health outcomes, improve cultural and linguistic competencies and health-related workplace diversity, and improve data availability, diffusion, and use of research and evaluation health outcomes for racial, ethnic, and underserved population.

Health care providers should undergo a mandatory sensitivity training to identify and minimize the negative impact associated with prenatal disparities among minority groups. A health care management system should implement a reporting system of health outcomes to understand the underlying causes of access disparities and find reliable solutions to mitigate the problem. Staff may also benefit from an incentive program for those who show a commitment to promote equitable care.

The role of nursing practice is to serve the community through nurse-led quality improvement initiatives aimed at providing information and education about common health issues for first-time pregnant women. Nurses could inform racial/ethnic minority pregnant women in underserved and vulnerable populations of the importance of early and timely PNC visits and risk factors of perinatal complications. The CDC (2019) released a report containing data from 2011 to 2015, showing Black women experienced 42.8% or 3.3 times as high pregnancy-related deaths for every 100,000 live births when compared to their White counterparts. The study further revealed that 700 women die from pregnancy-related complications annually.

The results of the present study suggested Blacks/African American and Hispanic/Latino American pregnant women in the receipt of PNC are treated differently than non-minority pregnant women, receive less-significant amount of care, and are less likely to receive consistency care or specialized care. Nurse-led health communication enhance and improve health service experience through coordinated health education, communications, and interactions. Previous researchers have similarly indicated encouraging benefits from nurse-supported PNC initiatives (Picklesimer, Billings, Hale, Blackhurst, & Covington-Kolb, 2012; Tenenbaum Potter, 2017). The findings supported community-based participatory action has the potential to promote the connection between educational attainment and long-term health benefits.

Knowledge transfer generated by research support health care information and program intervention related to health disparities and health equity. Community-based participation could build capacity of the PNC system that indirectly reduces costs at all levels, reduce unexpected hospital visits when preventative measures is in place. Further, potential findings could foster positive change in nursing practice. As a practice discipline, nursing may benefit from this research because it could provide nurses with insight into some of the barriers these women face in accessing and navigating healthcare and healthcare services. The information from such research could be implemented at all levels of nursing practice to remove barriers for this population.

Implications for Policymakers

Having the ability to identify a social change issue and understanding the values influencing specific populations, provides the opportunity for public policy reform (Dye, 1972). Thus, this study provides several indications of the needs of first-time pregnant minority women regarding PNC disparity and health care reforms by policymakers. These implications may be especially salient for reducing health care disparities as policymakers take actions to revise the ACA. The existential problem of PNC disparities persistently affecting the same subgroups or populations were used to derive policy implications from the present study. The perception of first-time pregnant minority women health needs as identified from this study generated salient themes, became the first steps of stakeholder's responsibility the underserved and vulnerable populations. Circumstances diverting attention from the current issue of PNC and access disparities can impact any component of the policy process.

Steps in policy reform process must be valued and accurately documented, confirm routine analysis of alternative strategic solutions until the health disparity goals are met. Quality health care and health services should remain a prioritizing focus for the nation, as the present study indicates persistent health care disparities with devastating effects for the population under study. The problem should provide the impetus for unlimited coordination with stakeholders, such as the minority women examined in the present study. Stakeholders with in-depth knowledge and experience in the problem, such as pregnant minority women from underserved populations, as active representatives in policymaking can limit interferences impeding positive change. Hence, building capacity at all levels of decision making can promote community solutions.

Policy-based participation on the needs identified from this study with stakeholders, community leaders, and hospital agencies would bridge the gap to achieve population health goals (IOM, 2015). An implication from this study is integrating policy revisions that mandate enhanced partnerships that include stakeholders at all levels and open venues to address issues of PNC disparities. Stakeholders at all levels can provide valuable insight to policymakers and help shape the policy that place value on their lives. Stakeholders at all levels have the potential opportunity for soliciting community input to integrate valuable information and prevent nuances of political biases, from interfering with policy faced by minority populations. Policymakers could use this information to expand coordination, collaboration, and to target policy demands on funding priorities and involvement in research and services. This study can also inform future policy strategies based on the theoretical perspectives of Andersen & Newman.

Policymakers major implication should focus major emphasis from the issues in this study including preventing financial obstacles to care through the delivery of insurance or other payment sources. Increase the capacity of the PNC system including department of health clinics, the network of private physicians providing care for low-income and Medicaid-enrolled (Roman, Raffo, Zhu, Meghea, 2014), outpatient departments, and community health centers, low-income community-based obstetrics clinic (IOM, 2017), and similar point of care settings. Improve institutional practices for easier accessibility, adequate and acceptable care by low income and underserved populations (Picklesimer et al., 2012). Identify women in need of PNC by mobilizing a variety of approaches, including hotlines, canvassing communities using outreach or paraprofessional workers, cross-agency referrals, and the providing incentives (Shah, Revere & Toy, 2018). Provide social support to encourage continuity in PNC visits and to increase the likelihood of healthy pregnancies and the smooth transition into parenthood (Heaman et al., 2015).

Knowledge transfer generated by research extends to decision making about policies and program intervention related to health disparities and health equity. Lastly, I hope sincerely that the findings and insights generated by this narrative descriptive research on access disparities in PNC services experienced by pregnant minority women will elicit action that will result in sustainable positive social change in the form of enhanced health care outcomes for the study population.

Conclusion

Minorities are considered the largest underserved population who are at the greatest risk for deaths in childbirth and infant mortality (CDC, 2013). This study was conducted to explore first-time pregnant minority women's account of access disparities in the process of seeking PNC. Data was collected from direct sources, the pregnant women, living in the northeast region of the country. Andersen and Newman's (1968) framework of health service utilization were used to understand the factors and characteristics of minority pregnant women with possible health care disparities qualified as low socioeconomic status and explanation for the policy implications including stakeholders at all levels. It was found that some factors counted, including race/ethnicity, SES, residency, availability of services, income, education, and employment may have presented as barriers to PNC access influencing health care disparities (Dutta, 2018; Howell, & Zeitlin, 2017; Petersen, Davis, Goodman, et al., 2019).

Enhancing equal access to health services were important to the participants in this study, yet most participants encountered unequal or limited treatment to essential services during their pregnancy. Some participants either could not afford comprehensive insurance or basic insurance plan. Public health professionals are in the position to potentially foster the communication between all stakeholders to provide resources to establish equitable access at all levels of health services. Alarmingly, there seems to be gaps in care services in the health care delivery system for minorities, especially when the health care system confirms deficiencies of resources even with the amendment to the ACA. Essential care should be easily accessible and not challenging to these women in the receipt of PNC. PHPs are catalyst to opening the dialogue to mobilize interventions which would save lives and reduce burden to these women.

Participants understood the value of health care and the importance of PNC which they could not personally afford. One of the primary barriers to PNC service was affordability. Racial/ethnic status was also a contributing barrier preventing most from quality care access and as noted from the participants. Congress, legislators and community leaders are essential part of the process addressing how health disparities impact the health of the individual, their family and the community, especially, the underserved minority women subgroup population. Scholars and HCPs have an equal role to bring awareness and voice to policymakers, to gain acknowledgment and establish a path to integrate services to community by broadening outreach capabilities to build capacity.

Interviews also revealed that the participants valued equal treatment in quality care services by specialty HCPs who value them equally and provide quality care for everyone equally. HCPs have the benefit in having a voice in policy-making decision affecting communities' health. The participants from this study were eager to stretch their voice to the challenges and expect to have an influence on addressing PNC disparities. Fully understanding the influencing factors surrounding health care disparities is most vital to designing targeted, effective, and sustainable policy reform. Researchers, scholars, and PHPs have an empowering role to help minority pregnant women through the barriers predisposing them to PNC disparity. Those in the role may develop programs to educate and advocate grounded on the needs of the minority pregnant women and advocate the needs to health care policymakers and legislators. Other HCPs and community leaders can identify from this study and assess the health care needs and appraise what type of actions are required for improving the health of these women. Also, they may communicate these actions to HHS (2014) and other legislators for policy support. Partnering with health care system agencies as a stakeholder will facilitate the implementation of improved programs.

A community participatory approach that engages diverse stakeholders may help to reduce health disparities. There is a significant relationship between an individual's behavior, health behaviors, and health behavior outcomes (Shepherd et al., 2014), which suggest that maximizing resources can empower individuals to become well informed, which can improve statistical outcomes and improved health for the underserved communities (HHS, 2017). As a lifelong learner, I feel strongly about the goal to empower individuals through education and providing equal opportunities to end all health care disparities at the local, national and global levels. I believe in lending support to empower individuals, strengthen communities, and provide opportunities that will help to bridge the divide and disparities gap. Empowering individuals to make an actionable difference in the lives of others can enable that individual to make a positive difference to empower others at an individual or community level.

In this study, I disclose the voices of the pregnant minority women who feel undervalued by HCPs in the receipt of PNC. I acknowledged and brought the health care needs and concerns to the forefront. I will unremittingly push the findings to legislators, community leaders, HCPs, and PHPs with a personal goal to respond to the unnecessary burden for those negatively affected by the challenges of PNC access in relation to health disparities. Mobilizing strategies, invigorating organizations and communities, and including diverse stakeholders will help facilitate accountability and call to action to address health care disparities, which would thrust the underserved communities within the goal of health equity across racial and cultural lines in the United States. The more strategies and more organizations and communities involved in facilitating accountability and addressing health care disparities, the more likely underserved communities will experience a better quality of life and thrive.

References

Aday, L. A. & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research*, *9*(3), 208–20. Retrieved from https://www.hsr.org

Aday, L. A. & Andersen, R. M. (1981). Equity to access to medical care: A conceptual and empirical overview. *Medical Care, 19*(supplement), 4-27. doi:10.1097/00005650-198112001-00004

Agency for Healthcare Research and Quality. (2015). *The 2014 national healthcare quality and disparities report.* Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf

Agency for Healthcare Research and Quality. (2016). *Access and disparities in access to health care*. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/access.html

Agency for Healthcare Research and Quality. (2017). *Perinatal Care*. Retrieved from https://www.ahrq.gov/pqmp/measures/perinatal-care.html

Andersen, R.M. (1968) A behavioral model of families' use of health services. *Research Series No 25*. Chicago, IL: Centre for Health Administration Studies.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health Society Behavior, 36*(3),1-10. doi: 10.2307/2137284

Andersen, R. M., Davidson, P. L. & Baumeister, S. E. (2015). *Improving access to care in: Changing the U.S. health care system.* San Francisco, CA: Jossey Bass.

Andersen, R. & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly Health Society, 51*(1), 95–124. doi:10.2307/3349613

Andersen, R. M, & Newman, J. F. (2005). Societal and individual determinants of medical care use in the United States. *Milbank Quarterly, 83*(4). doi:10.1111/j.1468-0009.2005.00428.x

Anderson, C. B., & Metzger, S. A. (2012). Slavery, the civil war era, and African American representation in U.S. history: An analysis of four states' academic standards. *Theory & Research in Social Education, 39*(3), 393–415. doi:10.1080/00933104.2011.10473460

Arce, C. M., Goldstein, B. A., Mitani, A. A., Lenihan, C. R. & Winkelmayer, W.C. (2013). Differences in access to kidney transplantation between Hispanic and Non-Hispanic Whites by geographic location in the United States. *Clinical Journal of the American Society of Nephrology, 8*(12);2149–57. doi:10.2215/CJN.01560213.

Babitsch, B., Gohl, D. & von Lengerke, T. (2012). Re-revisiting Andersen's Behavioral Model of Health Services Use: A systematic review of studies from 1998–2011. *Psychosocial Medicine, 9*(11). doi:10.3205/psm000089

Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice*, *25*(2), 127–131, doi:10.1093/fampra/cmn003

Bandura, A. (1986). *Social foundation of thought and action: Social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Barr, D. A. (2014). *Health disparities in the United States: social class, race, ethnicity, and health* (2nd ed.). Baltimore, MD: Johns Hopkins UP, 2014. Print

Bartick, M. C., Jegier, B. J., Green, B. D., Schwarz, E. B., Reinhold, A. G., & Stuebe, A. M. (n.d.). Disparities in breastfeeding: impact on maternal and child health outcomes and costs. *Journal of Pediatrics, 181*, 49. doi:10.1016/j.jpeds.2016.10.028

Beck, A. F., Sandel, M. T., Ryan, P. H. & Kahn, R.S. (2017). Mapping neighborhood health geomarkers to clinical care decisions to promote equity in child health. *Health Affairs (Millwood), 36*(6), 999–1005. doi:10.1377/hlthaff.2016.1425

Beckham, A. J., Urrutia, R. P., Sahadeo, L., Corbie-Smith, G., & Nicholson, W. (2015). 'We know but we don't really know': Diet, physical activity and cardiovascular disease prevention knowledge and beliefs among underserved pregnant women. *Maternal and Child Health Journal, 19*(8), 1791-1801. doi:10.1007/s10995-015-1693-2

Bellis, M. A., Hughes, K., Leckenby, N., Jones, L., Baban, A., Kachaeva, M., Povilaitis, R., Pudule, I., Qirjako, G., Ulukol, B., Raleva, M., & Terzic, N. (2014). Adverse childhood experiences and associations with health-harming behaviours in young adults: Surveys in eight eastern European countries. *Bulletin of the World Health Organization*, *92*(9), 641–655. doi:10.2471/BLT.13.129247

Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2014). Adverse childhood experiences: Retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public*

Health, 36(1), 81–91. doi:10.1093/pubmed/fdt038

Bellis, M. A., Hughes, K. & Leckenby, N., Hughes, K., & Harrison, D. (2015). Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: A national survey. *Journal of Public Health, 37*, 445–454. doi:10.1093/pubmed/fdu065

Benfer, E. A. (2015). Health justice: A framework (and Call to Action) for the elimination of health inequity and social injustice. *American University Law Review, 65*(2), 275. Retrieved from https://www.wcl.american.edu

Beng, T. S., Guan, N. C., Seang, L. K., Pathmawathi, S., Ming, M. F., Jane, L. E., … Loong, L. C. (2014). The experiences of suffering of palliative care patients in Malaysia: A thematic analysis. *American Journal of Hospice and Palliative Medicine*, *31*(1), 45–56. doi:10.1177/1049909112458721

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC Medical Research Methodology*, *16*, 21. doi:10.1186/s12874-016-0114-6

Berkowitz, S. A., Traore, C. Y., Singer, D. E., & Atlas, S. J. (2015). Evaluating area-based socioeconomic status indicators for monitoring disparities within health care systems: Results from a primary care network. *Health Services Research, 50*(2), 398-417. doi:10.1111/1475-6773.12229

Berger, R. (2015). Now I see it, now I don’t: Researcher’s position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234.

doi:10.1177/1468794112468475

Bideshi, D., & Kposowa, A. J. (2012). African immigrants and capital conversion in the U.S labor market: Comparisons by race and national origin. *Western Journal of Black Studies, 36*(3), 181-200. Retrieved from http://search.proquest.com/docview/1346355395?accountid=14872

Black, M. M., Walker, S. P., Fernald, L. C. H., Andersen, C. T., DiGirolamo, A. M., Lu, C., ... Grantham-McGregor, S. (2017). Early childhood development coming of age: science through the life course. *The Lancet*, *389*(10064), 77-90. doi:10.1016/S0140-6736(16)31389-7

Blakemore, E. (2017). *The brutal history of Anti-Latino discrimination in America. A&E Television Networks*. Retrieved from https://www.history.com/news/the-brutal-history-of-anti-latino-discrimination-in-america

Blanas, D., Nichols, K., Bekele, M., Shankar, H., Bekele, S., Jandorf, L., … Perumalswami, P. (2015). Adapting the Andersen Model to a Francophone West African immigrant population: Hepatitis B screening and linkage to care in New York City. *Journal of Community Health, 40*(1), 175–184. doi:10.1007/s10900-014-9916-9

Bloom, T. L. (2011). The greatest asset: Addressing maternal-child health disparities in the United States. *Western Journal of Nursing Research, 33*(4), 483–485. doi:10.1177/0193945910396429

Bloome, D., Dyer, S., & Zhou, X. (2018). Educational inequality, educational expansion, and intergenerational income persistence in the United States. *American*

Sociological Review, *83*(6), 1215. doi:10.1177/0003122418809374

Bondarenko, D. M. (2017). Pre-slave trade and pre-colonial Africa in the historical consciousness of African Americans and African migrants in the USA. *Africa Review, 9*(1), 82–97. doi:10.1080/09744053.2016.1239713

Borders, A. E., Wolfe, K., Qadir, S., Kim, K. Y., Holl, J., & Grobman, W. (2015). Racial/ethnic differences in self-reported and biologic measures of chronic stress in pregnancy. *Journal of Perinatology, 35*(8), 580–584. doi:10.1038/jp.2015.18

Boslaugh, S. E. (2019). *Health disparities*. Salem Press Encyclopedia. Thousand Oaks, California.

Bower, B. (2004). Immigration blues: Born in the USA: Mental-health deficit. *Science News*, *166*(25–26), 387–8. doi:10.2307/4015677

Bower, B. (1998). Immigrants go from health to worse. *Science News*. *154* (12), 180. doi:10.2307/4010766

Bradbury-Jones, C., Taylor, J., & Herber, O. (2014). How theory is used and articulated in qualitative research: Development of a new typology. *Social Science & Medicine, 120,* 135-141. doi:10.1016/j.socscimed.2014.09.014

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(2)*, 77–101. doi:10.1191/1478088706qp063oa

Bromley, E., Nunes, A. & Phipps, M. G. (2012). Disparities in pregnancy healthcare utilization between Hispanic and non-Hispanic White women in Rhode Island. *Maternal and Child Health Journal, 16*(8), 1576-1582. doi:10.1007/s10995-011-0850-5

Brown, A. F., Ma, G. X., Miranda, J., Eng, E., Castille, D., Brockie, T., … Trinh-Shevrin, C. (2019). Structural interventions to reduce and eliminate health disparities. *American Journal of Public Health*, *109*, S72–S78. doi:10.2105/AJPH.2018.304844

Brown, C., Barner, J., Bohman, T. & Richards, K. (2009). A multivariate test of an expanded Andersen Health Care Utilization Model for complementary and alternative medicine (CAM) use in African Americans. *Journal of Alternative & Complementary Medicine, 15*(8), 911–919. doi:10.1089/acm.2008.0561

Brown, C. C., Moore, J. E., Felix, H. C. Stewart, M. K., Bird, T. M., Lowery, C. L. & Tilford, J. M. (2019). Association of state Medicaid expansion status with low birth weight and preterm birth. *Journal of American Medical Association, 321*(16):1598–1609. doi:10.1001/jama.2019.3678

Bullock, A. (2015). Getting to the roots: Early life intervention and adult health. *American Journal of Psychiatry, (2),* 108. doi:10.1176/appi.ajp.2014.14111394

Burmeister, E. & Aitken, L. (2012). Sample size: How many is enough? *Journal of Australian Critical Care, 25*(4), 271-274. doi:10.1016/j.aucc.2012.07.002

Caine, V., Steeves, P., Clandinin, D. J., Estefan, A., Huber, J. & Murphy, M. S. (2018). Social justice practice: A narrative inquiry perspective. *Education, Citizenship & Social Justice, 13*(2), 133–143. doi:10.1177/1746197917710235

Caldwell, J. T., Ford, C. L., Wallace, S. P., May. C. & Wang, M. C. & Takahashi, L. M. (2016). “Intersection of living in a rural versus urban area and race/ethnicity in explaining access to health care in the United States.” *American Journal of Public*

Health 106, 8: 1463-1469. doi:10.2105/AJPH.2016.303212

Callaghan, W. M. (2012). Overview of maternal mortality in the United States. *Seminars in Perinatology, 36*(1), 2-6. doi:10.1053/j.semperi.2011.09.002

Campbell, F., Conti, G., Heckman, J. J., Moon, S. H., Pinto, R., Pungello, E., & Pan, Y. (2014). Early childhood investments substantially boost adult health. *Science (New York, N.Y.)*, *343*(6178), 1478–1485. doi:10.1126/science.1248429

Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement framework. *The Qualitative Report, 21*(5), 811-831. Retrieved from https://nsuworks.nova.edu/tqr/vol21/iss5/2

Centers for Disease Control and Prevention. (2013). Conclusion and future directions: CDC health disparities and inequalities report — United States, 2013. *Morbidity and Mortality Weekly Report,* 62(03);184-186. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a32.htm

Center for Disease Control and Prevention (CDC) (2014). *Reproductive health: Infant mortality*. Retrieved from http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm

Centers for Diseases Prevention and Preparedness. (2014). *Social determinants of health*. Retrieved from http://www.cdc.gov/socialdeterminants/Definitions.html.

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine, 28*(11), 1504–1510. doi:10.1007/s11606-013-2441-1

Chase, S. E. (2005). *Narrative inquiry: Multiple lenses, approaches, voices*. In N. K.

Denzin, & Y. S. Lincoln (Eds.), The Sage Handbook of Qualitative Research: Third Edition (pp. 651-679). London, Thousand Oaks, CA, and New Delhi: Sage.

Chavez, T. E. (2002). *Spain and the independence of the United States. An intrinsic gift*. Albuquerque: University of New Mexico Press.

Chedid, R. A. & Phillips, K. P. (2019). Best practices for the design, implementation and evaluation of prenatal health programs. *Child Maternal Health Journal, 23*: 109-119. doi:10.1007/s10995-018-2600-4

Chen, J., Vargas-Bustamante, A., Mortensen, K., & Ortega, A. N. (2016). Racial and ethnic disparities in health care access and utilization under the Affordable Care Act. *Medical care*, *54*(2), 140–146. doi:10.1097/MLR.0000000000000467

Chen, Z. & Gotway Crawford, C. A. (2012). The role of geographic scale in testing the income inequality hypothesis as an explanation of health disparities**.** *Social Science & Medicine, 75*(6), 1022-1031. doi:10.1016/j.socscimed.2012.04.032

Chisholm, H. (1911). "*Alaska & history*". Encyclopædia Britannica. 1 (11th ed.). Cambridge University Press. p. 477.

Cobb, J. A., & Stevens, F. G. (2017). These unequal states: Corporate organization and income inequality in the United States. *Administrative Science Quarterly*, *62*(2), 304–340. doi:10.1177/0001839216673823

Cohen, R. A., Zammitti, E. P., Martinez, M. E. (2017). *Health insurance coverage: Early release of estimates from the national health interview survey, 2017*, (Rockville, MD: National Center for Health Statistics). Retrieved from https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

Colen, C. G., Ramey, D. M., Cooksey, E. C., & Williams, D. R. (2018). Racial disparities in health among nonpoor African Americans and Hispanics: The role of acute and chronic discrimination. *Social Science & Medicine, 199*, 167–180. doi:10.1016/j.socscimed.2017.04.051

Coley, S. L., & Aronson, R. E. (2013). Exploring birth outcome disparities and the impact of prenatal care utilization among North Carolina teen mothers. *Women's Health Issues, 23*, e287–e294. doi:10.1016/j.whi.2013.06.004

Coley, S. L., Zapata, J. Y., Schwei, R. J., Mihalovic, G. E., Matabele, M. N., Jacobs, E. A., & Anderson, C. K. (2018). More Than a "Number": Perspectives of Prenatal Care Quality from Mothers of Color and Providers. *Women's health issues: official publication of the Jacobs Institute of Women's Health*, *28*(2), 158–164. doi:10.1016/j.whi.2017.10.014

Collins, A. (2006). Perinatal outcomes among US minority populations. *The Journal for Nurse Practitioners, 2*(3), 165–169. doi:10.1016/j.nurpra.2006.01.008

Connelly, L. M. (2016). Understanding research. Trustworthiness in qualitative research. *MEDSURG Nursing, 25*(6), 435–436. Retrieved from https://medsnj.com

Connelly, F. M. & Clandinin, D. J. (2006). *Narrative inquiry*. In J. L. Green, G. Camilli, P. Elmore (Eds.), Handbook of complementary methods in education research (3rd ed., pp. 477 - 487). Mahwah, NJ: Lawrence Erlbaum.

Consumer Financial Protection Bureau (2017). "*Consumer experiences with debt collection: Findings from the CFPB's survey of consumer views on debt*." Retrieved from https://www.consumerfinance.gov/data-research/research-reports/consumer-experiences-debt-collection-findings-cfpbs-survey-consumer-views-debt/

Council on Foreign Relations (2014). *African immigrants to the United States*. Retrieved from http://blogs.cfr.org/campbell/2014/10/23/african-immigrants-to-the-u-s/.

Cowley, S., Whittaker, K., Malone, M., Donetto, S., Grigulis, A., & Maben, J. (2015). Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: A narrative review of the literature. *International Journal of Nursing Studies, 52*(1), 465–480. doi:10.1016/j.ijnurstu.2014.07.013

Coxon, K., Sandall, J. & Fulop, N. (2015). How do pregnancy and birth experiences influence planned place of birth in future pregnancies? Findings from a longitudinal, narrative study. *Birth, 42*(2),141–148, doi:10.1111/birt.12149

Creanga, A. A., Berg, C. J., Ko, J. Y., Farr, S. L., Tong, V. T., Bruce, F. C., & Callaghan, W. M. (2014). Maternal mortality and morbidity in the United States: Where are we now? *Journal of women's health (2002)*, *23*(1), 3–9. doi:10.1089/jwh.2013.4617

Creanga, A. A., Berg, C. J., Syverson, C., Seed, K, Bruce, F. C. & Callaghan, W. M. (2015). Pregnancy-related mortality in the United States, 2006– 2010. *Obstetrics & Gynecology, 125*(1), 5–12. doi:10.1097/AOG.0000000000000564

Creswell, J. W. (2009). *Designing a qualitative study: Qualitative, quantitative and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

D'Angelo, K. A., Bryan, J. K. & Kurz, B. (2016). Women's experiences with prenatal care: A mixed-methods study exploring the influence of the social determinants of health. *Journal of Health Disparities Research and Practice, 9*(3), 127-149. Retrieved from https://digitalscholarship.unlv.edu/jhdrp/vol9/iss3/9

D'Anna-Hernandez, K., & Riviera, K. D. (2014). Understanding and alleviating cultural stressors and health disparities in the perinatal outcomes of Mexican American Women. *Zero to Three, 34*(4), 37. Retrieved from https://www.zerotothree.org

Das, A., & Sarkar, M. (2014). Pregnancy-related health information-seeking behaviors among rural pregnant women in India: Validating the Wilson model in the Indian context. *The Yale Journal of Biology and Medicine*, *87*(3), 251–262. Retrieved from https://medicine.yale.edu/yjbm/

De León, A. (2015). Our America: A Hispanic history of the United States, by Felipe Fernández-Armesto. *Southwestern Historical Quarterly, 118*(3), 317-318. doi:10.1353/swh.2015.0019.

DesRoches, C., Campbell, E., Vogeli, C., Zheng, J., Rao, S. & Shields, A., et al. (2010). Electronic health records' limited successes suggest more targeted uses. *Health Affair, 29*(4):639–46. doi:10.1377/hlthaff.2009.1086.

Deurzen, I. V., Ingen, E. V., Oorschot, W. J. (2015). Income inequality and depression: The role of social comparisons and coping resources**.** *European Sociological Review, 31*(4), 477-489. doi:10.1093/esr/jcv007

Dikko, M. (2016). Establishing construct validity and reliability: Pilot testing of a qualitative interview for research in Takaful (Islamic insurance). *The Qualitative Report, 21*(3), 521- 528. Retrieved from https://nsuworks.nova.edu/tqr/vol21/iss3/6

Docherty, A., & Johnston, A. L. (2015). Prenatal care in Oregon and Washington: Policy and utilization for vulnerable women. *Nursing Research, 64*(2), 117–127. doi:10.1097/NNR.0000000000000073

Doody, O. & Noonan, M. (2013). Preparing and conducting interviews to collect data. *Nurse Researcher, 20*(5), 28-32. doi:10.7748/nr2013.05.20.5.28.e327

Douthit, N., Kiv, S., Dwolatzky, T. & Biswas, S. (2015). Exposing some important barriers to health care access in the rural USA. *Public Health,129*(6):611–20. doi:10.1016/j.puhe.2015.04.001

Durkin, M. S., Maenner, M. J., Benedict, R. E., Van Naarden Braun, K., Christensen, D., Kirby, R. S., … Yeargin, A. M. (2015). The role of socio□economic status and perinatal factors in racial disparities in the risk of cerebral palsy. *Developmental Medicine & Child Neurology, 57*(9), 835–843. doi:10.1111/dmcn.12746

Dye, B. A., Duran, D. G., Murray, D. M., Creswell, J. W., Richard, P., Farhat, T., … Engelgau, M. M. (2019). The Importance of evaluating health disparities research. *American Journal of Public Health*, *109*(S1), S34–S40. doi:10.2105/AJPH.2018.304808

Edmonds, B. T., Mogul, M. & Shea, J. A. (2015). Understanding low income African American women’s expectations, preferences, and priorities in prenatal care. *Family Community Health, 38*(2), 149–157. doi:10.1097/FCH.0000000000000066.

Evans, R. G. & Stoddart, G. L. (1990). "Producing health, consuming health care". *Social*

Science Medicine, 31(12): 1347–63. doi:10.1016/0277-9536(90)90074-3

Erving, C. L., Thomas, C. S., & Frazier, C. (2019). Is the Black-White mental health paradox consistent across gender and psychiatric disorders? *American Journal of Epidemiology*, *188*(2), 314–322. doi:10.1093/aje/kwy224

Everett, B. G., Kominiarek, M. A., Mollborn, S., Adkins, D. E. & Hughes, T. L. (2018). Sexual orientation disparities in pregnancy and infant outcomes. *Maternal and Child Health Journal,* 1-10. doi:10.1007/s10995-018-2595-x

Finer, L. B. & Zolna, M. R. (2014). Shifts in intended and unintended pregnancies in the United States, 2001-2008. *American Journal of Public Health,104*(1), 43–8. doi:10.2105/AJPH.2013.301416

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*(4-5), 583-90. doi:10.1080/10503300902798375.

Flores. A. (2017). *How the U.S. Hispanic population is changing*. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2017/09/18/how-the-u-s-hispanic-population-is-changing

Fortin, M., Cao, Z., & Fleury, M.-J. (2018). A typology of satisfaction with mental health services based on Andersen's behavioral model. *Social Psychiatry and Psychiatric Epidemiology*: *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services.* doi:10.1007/s00127-018-1498-x

Fusch. P. I & Ness, R. L. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416. Retrieved from http://www.nova.edu/ssss/QR/QR20/9/fusch1.pdf

Gabbe, P. T., Reno, R., Clutter, C., Schottke, T. F., Price, T., Calhoun, K., … Lynch, C. D. (2017). Improving maternal and infant child health outcomes with community-based pregnancy support groups: Outcomes from Moms2B Ohio. *Maternal and Child Health Journal, 21*(5), 1130–1138. doi:10.1007/s10995-016-2211-x

Gadson, A., Akpovi, E., & Mehta, P. K. (2017). Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Seminars in Perinatology, 41*(5), 308–317. doi:10.1053/j.semperi.2017.04.008

Ganle, J. K. (2016). Ethnic disparities in utilisation of maternal health care services in Ghana: Evidence from the 2007 Ghana maternal health survey. *Ethnicity & Health, 21*(1), 85–101. doi:10.1080/13557858.2015.1015499

Garfield, R, Damico, A., & Orgera, K. (2018). *The coverage gap: Uninsured poor adults in states that do not expand Medicaid* (Washington, DC: Kaiser Family Foundation). Retrieved from https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

Gavin, N. I., Adams, E. K., Hartmann, K. E., Benedict, M. B. & Chireau, M. (2004). Racial and ethnic disparities in the use of pregnancy-related health care among Medicaid pregnant women. *Maternal Child Health Journal, 8*(3):113-26. doi:10.1023/B:MACI.0000037645.63379.62

Gavin, A. R., Nurius, P., & Logan-Green, P. (2012). Mediators of adverse birth outcomes among socially disadvantaged women. *Journal of Women's Health, 21*(6), 634–

641. doi:10.1089/jwh.2011.2766

Gilstein, J. (2018). *Narrative inquiry*. Salem Press Encyclopedia.

Gonzales, G. & Blewett. L. A. (2014). National and state-specific health insurance disparities for adults in same-sex relationships. *American Journal of Public Health, 104*(2), 95-104. doi:10.2105/AJPH.2013.301577

Gonzales, G., Quinones, N. & Attanasio, L. (2019). Health and access to care among reproductive-age women by sexual orientation and pregnancy status. *Women's Health Issues, 29*(1), 8–16. doi:10.1016/j.whi.2018.10.006

Gonzales, F. A., Le, H. N. & Perry, D. F. (2014). Using an optimality index to understand perinatal health disparities: A pilot study with Latina immigrants. *Journal of Transcultural Nursing*, *25*(3), 265–272. doi:10.1177/1043659614522302

Graham, M., Uesugi, K., & Olson, C. (2016). Barriers to weight-related health behaviours: A qualitative comparison of the socioecological conditions between pregnant and post-partum low-income women. *Maternal and Child Nutrition, 12*(2), 349-361. doi:10.1111/mcn.12135

Green, H. E. (2014). Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher, 21*(6), 34–38. doi:10.7748/nr.21.6.34.e1252

Groenewald, T. 2008. *Memos and memoing* (Vol 2: pp. 505-6). In Given, L.M. (Ed) 2008. *The SAGE encyclopedia of qualitative research methods*. Los Angeles, Thousand Oaks, Calif.: SAGE Publications.

Guendelman, S. (1991). "Health care users residing on the Mexican border. What factors determine choice of the U.S. or Mexican health system?" *Medical Care*, *29* (5):

419–29. doi:10.1097/00005650-199105000-00003.

Guerra-Reyes, L., & Hamilton, L. J. (2017). Racial disparities in birth care: Exploring the perceived role of African American women providing midwifery care and birth support in the United States. *Women and Birth, 30*, 9–16. doi:10.1016/j.wombi.2016.06.004

Guest, G., Bunce, A. & Johnson, L. (2006) How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. doi:10.1177/1525822X05279903

Hadi, M. A., & Jose Closs, S. (2016). Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy. *International Journal of Clinical Pharmacy*, (3), 641. doi:10.1007/s11096-015-0237-6

Hahn, Y. (2013). The effect of Medicaid physician fees on take-up of public health insurance among children in poverty. *Journal of Health Economics, 32*(2), 452–462. doi:10.1016/j.jhealeco.2013.01.003

Hall, K. S., Dalton, V., & Johnson, T. R. B. (2014). Social disparities in women's health service use in the United States: a population-based analysis. *Annals of Epidemiology, 24*(2), 135–143. doi:10.1016/j.annepidem.2013.10.018

Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G. & Brodie, M. (2016). *The burden of medical debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey,*(Washington, D.C.: Kaiser Family Foundation). http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/.

Han, W., & Redlich, A. (2018). Racial/ethnic disparities in community behavioral health service usage: A comparison of mental health court and traditional court defendants. *Criminal Justice and Behavior, 45*(2), 173-194. doi:10.1177/0093854817739045

Harding, J. (2013). *Qualitative data analysis: From start to finish*. Thousand Oaks, CA: Sage Publications.

Healthy People 2020. (2014). *Disparities*. Retrieved from http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx

Healthy People 2020. (2015). *Maternal. Infant, and child health*. Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/maternalinfant-and-child-health.

Heaman, M. I., Sword, W., Elliott, L., Moffatt, M., Helewa, M. E., Morris, H., Gregory, P. Tjaden, L. & Cook, C. (2015). Barriers and facilitators related to use of prenatal care by inner-city women: perceptions of health care providers. *BMC Pregnancy & Childbirth, 15*(1), 1-13. dx.doi:10.1186/s12884-015-0431-5.

Hilal, A. H. & Alabri, S. S. (2013). Using NVivo for data analysis in qualitative research. *International Interdisciplinary Journal of Education, 2*(2). Retrieved from http://iijoe.org/v2/IIJOE_06_02_02_2013.pdf

Hill, C. V., Lynne-Landsman, S. D., & Boyce, C. A. (2012). Maternal and child health disparities: Considering the influence of fathers. *American Journal of Public Health, 102*(2), S164–S165. doi:10.2105/AJPH.2012.300792

Horvath, S., Gurven, M., Levine, M. E., Trumble, B. C., Kaplan, H., Allayee, H., . . .

Assimes, T. L. (2016). "An epigenetic clock analysis of race/ethnicity, sex, and coronary heart disease". *Genome Biology*, *17*(1): 171. doi:10.1186/s13059-016-10300.

Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A. & Milgrom. J. (2014). Non-psychotic mental disorders in the perinatal period. *Lancet, 384* (9956), 1775-1788. doi:10.1016/S0140-6736(14)61276-9

Howell, E. A., Egorova, N., Balbierz, A., J. Zeitlin, J. & Hebert, P. L. (2016). Black-white differences in severe maternal morbidity and site of care. *American Journal of Obstetrics & Gynecology, 214*(1), 122 e121–122.e127. doi:10.1016/j.ajog.2015.08.019

Howell, E. A., & Zeitlin, J. (2017). Improving hospital quality to reduce disparities in severe maternal morbidity and mortality. *Seminars in Perinatology, 41*(5), 266–272. doi:10.1053/j.semperi.2017.04.002

Hsieh, N. & Ruther, M. (2017). Despite increased insurance coverage, nonwhite sexual minorities still experience disparities in access to care. *Health Affairs, 36*(10), 1786-1794. doi:10.1377/hlthaff.2017.0455.

Hughes, M. C., Baker, T. A., Kim, H., & Valdes, E. G. (2019). Health behaviors and related disparities of insured adults with a health care provider in the United States, 2015–2016. *Preventive Medicine, 120,* 42–49. doi:10.1016/j.ypmed.2019.01.004

Institute of Medicine. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Retrieved from, http://iom.nationalacademies.org/reports/2002/unequal-treatment-confrontingracial-and-ethnic-disparities-in-health-care.aspx.

Irvine, A., Drew, P., & Sainsbury, R. (2013). 'Am I not answering your questions properly? 'Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research, 13*(1), 87-106. doi:10.1177/1468794112439086

James, C. S. A., Thomas, M., Ranji, U., Lillie-Blanton, M., & Wyn, R. (2009). *Putting women's health care disparities on the map: Examining racial and ethnic disparities at the state level.* Kaiser Family Foundation. Retrieved from, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf.

Jeffries, N., Zaslavsky, A. M., Diez Roux, A. V., Creswell, J. W., Palmer, R. C., Gregorich, S. E., Reschovsky, J. D., Graubard, B. I., Choi, K., Pfeiffer, R. M., Zhang, X. & Breen, N. (2019). Methodological approaches to understanding causes of health disparities. *American Journal of Public Health, 109*(1), 28–33. doi:10.2105/AJPH. 2018.304843

Johnson, A. A., Wesley, B. D. & El-Khorazaty, M. N., Utter, J. M., Bhaskar, B., Hatcher, B. J., . . . Laryea, H. A. (2011). African American and Latino patient versus provider perceptions of determinants of prenatal care initiation. *Maternal Child Health Journal, 15*(1): 27-34. doi:10.1007/s10995- 011-0864-z

Johnson, K., Posner, S., Bierman, J., Cordero, J., Atrash, H., Parker, C., . . . Curtis, M. (2006). Recommendations to improve preconception health and health care—United States: A report of the CDC/ATSDR preconception care work group and the select panel on preconception care. *Morbidity and Mortality Weekly Report, 55(*6). Retrieved from http://www.cdc.gov/mmwr/pdf/rr/rr5506.pdf

Kaiser Family Foundation and Asian & Pacific Islander American Health Forum (APIAHF). (2009). *Race, ethnicity and health care: Fact sheet. Health coverage and access to care among Asian Americans, Native Hawaiians and Pacific Islanders.* Menlo Park, CA: The Henry J. Kaiser Family Foundation. Putting women's health care disparities on the map: Examining racial and ethnic disparities at the state level. Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Kaiser Family Foundation. (2018). *Beyond health care: The role of social determinants in promoting health and health equity*, (Washington, DC: Kaiser Family Foundation). Retrieved from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Kennard, D. K. (2016). Health literacy concepts in nursing education. *Nursing Education Perspectives (National League for Nursing)*, *37*(2), 118–119. doi:10.5480/14-1350

Kenney, G. M., Coyer, C., & Anderson, N. (2013). *Racial and ethnic differences in access to care and service use for children with coverage through Medicaid and the Children's Health Insurance Program*. Washington, DC: The Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/412781-Racial-and-EthnicDifferences-in-Access-to-Care-and-Service-Use-for-Children.pdf

Keyes, C. L. M. (2009). The Black–White paradox in health: Flourishing in the face of social inequality and discrimination. *Journal of Personality*, *77*(6), 1677–1706. doi:10.1111/j.1467-6494.2009.00597.x

Kim, H. K., Niederdeppe, J., Guillory, J., Graham, M., Olson, C., & Gay, G. (2015). Determinants of pregnant women's online self-regulatory activities for appropriate gestational weight gain. *Health Communication, 30*(9), 922-932. doi:10.1080/10410236.2014.905900

Kirzinger, A., Hamel, L., Muñana, C., & Brodie. M. (2018). *Kaiser health tracking poll – March 2018: Non-group enrollees*, (Washington, D.C.: Kaiser Family Foundation, April 2018). Retrieved from https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/.

Kochhar, R. & Fry, R. (2014). *Wealth inequality has widened along racial, ethnic lines since end of great recession*. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2014/12/12/racial-wealth-gaps-great-recession/

Kochhar, R. & Cilluffo, A. (2018). *Key findings on the rise in income inequality within America's racial and ethnic groups*. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2018/07/12/key-findings-on-the-rise-in-income-inequality-within-americas-racial-and-ethnic-groups/

Kochhar, R., Fry, R & Taylor, P. (2011). "*Wealth gaps rise to record highs between Whites, Blacks, Hispanics.*" Pew Research Center. Social and Demographic Trends. Retrieved from https://www.pewsocialtrends.org

Kothari, C. L., Romph, C., Bautista, T., & Lenz, D. (2017). Perinatal periods of risk analysis: Disentangling race and socioeconomic status to inform a Black infant mortality community action initiative. *Maternal and Child Health Journal*, *21*(1), 49. doi:10.1007/s10995-017-2383-z

Kusow, A. (2014). "African immigrants in the United States: Implications for affirmative action." *Sociology Mind, 4,* 74-83. doi:10.4236/sm.2014.41010.

Lacy. E. C. (2001). Changing race: Latinos, the census, and the history of ethnicity in the United States (review), *Hispanic American Historical Review, 81*(3), 774-775. doi:10.1215/00182168-81-3-4-774

LaVeist, T. A., & Isaac, L. A. (2013). *Race, ethnicity, and health. [electronic resource]: a public health reader*. San Francisco: Jossey-Bass, 2012, c2013.

Lee, J. (2015). The impact of health information technology on disparity of process of care. *International Journal for Equity in Health*, *14*, 34. doi:10.1186/s12939-015-0161-3

Lee, S. H., Nurmatov, U. B., Nwaru, B. I., Mukherjee, M., Grant, L., & Pagliari, C. (2015). Effectiveness of mHealth interventions for maternal, newborn and child health in low- and middle-income countries: Systematic review and meta-analysis. *Journal of Global Health*, *6*(1), 010401. doi:10.7189/jogh.06.010401

Liddell, J. L., Burnette, C. E., Roh, S., & Lee, Y. S. (2018). Healthcare barriers and supports for American Indian women with cancer. *Social Work in Health Care, 57*(8), 656–673. doi:10.1080/00981389.2018.1474837

Lieberson, S. & Waters, M. C. (1988). From many strands: Ethnic and racial groups in contemporary America. New York, New York, Russell Sage Foundation, 1988.

Lincoln, Y. & Guba, G. (2002). *Ensuring trustworthiness. In a A. Bryan & R. Burgess (eds).* Qualitative Research. London: Sage.

Lind, J. N., Perrine, C. G., Li, R., Scanlon, K. S. & Grummer-Strawn, L. M. (2014). Racial disparities in access to maternity care practices that support breastfeeding — United States, 2011. *Morbidity and Mortality Weekly Report, 63*(33), 725-728. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6333a2.htm

Lix, L., Finlayson, G., Yogendran, M., Bond, R., Bodnarchuk, J. & Soodeen, R. (2005). "*Primary prevention: An examination of data capabilities in Manitoba*." Winnipeg, MB: Manitoba Centre for Health Policy.

Lo, T. K. T., Parkinson, L., Cunich, M., & Byles, J. (2016). Factors associated with the health care cost in older Australian women with arthritis: an application of the Andersen's Behavioural Model of Health Services Use. *Public Health, 134*, 64–71. doi:10.1016/j.puhe.2015.11.018

Lobel, M., Cannella, D.L., Graham, J. E., DeVincent, C., Schneider, J. & Meyer, B. A. (2008). Pregnancy-specific stress, prenatal health behaviors, and birth outcomes. *Health Psychology, 27*(5), 604-61. doi:10.1037/a0013242

Lorch, S. A. (2017). Perinatal legislative policies and health outcomes. *Seminars in Perinatology, 41*(6), 375–384. doi:10.1053/j.semperi.2017.07.006

Lorch, S. A & Enlow, E. (2016). The role of social determinants in explaining racial/ethnic disparities in perinatal outcomes. *Pediatric Resource, 79*(1–2), 141–147. dx.doi:10.1038/ pr.2015.199

Louis-Jacques, A., Deubel, T. F., Taylor, M., & Stuebe, A. M. (n.d.). Racial and ethnic disparities in US breastfeeding and implications for maternal and child health outcomes. *Seminars in Perinatology, 41*(5), 299–307. doi:10.1053/j.semperi.2017.04.007

Lu, M. C., Highsmith, K., de la Cruz, D., & Atrash, H. K. (2015). Putting the "M" back in maternal child health bureau: reducing maternal mortality and morbidity. *Maternal Child Health Journal, 19*: 1435. doi:10.1007/s10995-015-1665-6

Manski, R., Grindlay, K., Burns, B., Holt, K., & Grossman, D. (2014). Reproductive health access among deployed U.S. servicewomen: A qualitative study. *Military Medicine, 179*(6), 645–652. doi:10.7205/MILMED-D-13-00302

Manning, M., Homel, R., & Smith, C. (2010). A meta-analysis of the effects of early developmental prevention programs in at-risk populations on non-health outcomes in adolescence. *Children and Youth Services Review, 32*(4), 506-519. doi:10.1016/j.childyouth.2009.11.003

March of Dimes. (2013). *Early entry into prenatal care toolkit: Overcoming barriers and improving access to care [Pamphlet]*. New York: March of Dimes.

March of Dimes. (2016). *PeriStats*. Retrieved from http://www.marchofdimes.com/peristats/calculations.aspx?reg=&top=&id=62013

Markus, H. & Conner, A. (2013). *Clash!: 8 cultural conflicts that make us who we are.* New York, NY: Hudson Street Press.

Marshall, B., Cardon, P., Poddar, A. & Fontenot, R. (2013). Does sample size matter in qualitative research?: A review of qualitative interviews in IS research. *Journal of*

Computer Information Systems, 54:1, 11-22, doi:10.1080/08874417.2013.11645667

Martin, J. A. (2012). *Facts are important. Prenatal care is important to healthy pregnancies*. American College of Obstetrician and Gynecologists*,* Washington D.C. Retrieved from https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/20120221FactsareImportant.pdf?dmc=1

Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K. & Mathews, T. J. (2017). Births: Final data for 2015. *National Vital Statistics Report, 66*(1) 1. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf

Martin, J. A., Hamilton, B. E., Sutton, P. D., Ventura, S. J., Menacker, F., Kirmeyer, S. & Mathews, T. J. (2009). Births: Final data for 2006. *National Vital Statistics Reports, 57*(7). Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf

Martinez, G., Chandra, A., Febo-Vazquez, I., & Mosher, W. (2013). Use of family planning and related medical services among women aged 15-44 in the United States: National survey of family growth, 2006-2010. *National Health Statistics Reports,* (68), 1. Retrieved from https://www.cdc.gov/nchs/data/nhsr/nhsr068.pdf

Martino, S. C., Weinick, R. M., Kanouse, D. E., Brown, J. A., Haviland, A. M., Goldstein, E., Adams, J. L., Hambarsoomian, K., Klein, D. & Elliott, M. N. (2013). “Reporting CAHPS and HEDIS data by race/ethnicity for Medicare beneficiaries,” *Health Services Research, 48*(2), 417–434. doi:10.1111/j.1475-

6773.2012.01452.x.

Matthew, P., & Brodersen, D. M. (n.d.). Income inequality and health outcomes in the United States: An empirical analysis. *Social Science Journal*, *55*(4), 432–442. doi:10.1016/j.soscij.2018.05.001

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Sozialforschung/ Forum: Qualitative Social Research*, *11*(3), 8. doi:10.17169/fqs-11.3.1428

Mazul, M.C., Salm Ward, T.C. & Ngui, E.M. (2017). Anatomy of good prenatal care: perspectives of low income African American women on barriers and facilitators to prenatal care. *Journal of Racial and Ethnic Health Disparities, 4*(1), 79. doi:10.1007/s40615-015-0204-x

Mckinnon, J. D. & Bennett, C. E. (2005). *We the people: Blacks in the United states.* Washington, D.C.: U.S. Census Bureau.

Mealer, M. & Jones, J. (2014). Methodological and ethical issues related to qualitative telephone interviews on sensitive topics. *Nurse Researcher*, *21*(4), 32-37. doi:10.7748/nr2014.03.21.4.32.e1229

Meghea, C. I., Raffo, J. E., VanderMeulen, P., & Roman, L. A. (2014). Moving toward evidence-based federal healthy start program evaluations: Accounting for bias in birth outcomes studies. *American Journal of Public Health, 104*(1), S25–S27. doi:10.2105/AJPH.2013.301276

Mendoza, M. (2014). Our America: A Hispanic history of the United States. *Americas: A*

Quarterly Review of Inter-American Cultural History, 71(1), 157-158. doi:10.1353/tam.2014.0098

Meyer, E., Hennink, M., Rochat, R., Julian, Z., Pinto, M., Zertuche., A. D., Spelke, B., Dott, A. & Cota, P. (2016). Working towards safe motherhood: Delays and barriers to prenatal care for women in rural and peri-urban areas of Georgia. *Maternal Child Health Journal, 20*(7):1358–1365. doi:10.1007/ s10995-016-1997-x

Miles, M. B., Huberman, A. M., & Saldaña, J. (2013). *Qualitative Data Analysis: A Methods Sourcebook*. SAGE Publications, Inc.

Miller, G. E., Culhane, J., Grobman, W., Simhan, H., Williamson, D. E., Adam, E. K., … Borders, A. (2017). Mothers' childhood hardship forecasts adverse pregnancy outcomes: Role of inflammatory, lifestyle, and psychosocial pathways. *Brain Behavior and Immunity, 65,* 11–19. doi:10.1016/j.bbi.2017.04.018

National Institute of Health. (2015). *What are health disparities?* Retrieved from http://www.niaid.nih.gov/topics/minorityhealth/Pages/Default.aspx.

Oregon Health Authority. (2012a). *Oregon vital statistics county data book (2000–2010).* Retrieved from http://public.health.oregon.gov/BirthDeathCertificates /VitalStatistics/annualreports/CountyDataBook/ Pages/cdb.aspx

O'Reilly, M. & Parker, N. 2012. 'Unsatisfactory saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, *13*(2), 190–197. doi:10.1177/1468794112446106

Osler, M., Avlund, K. & Mortensen, E. L. (2013). Socio-economic position early in life, cognitive development and cognitive change from young adulthood to middle age, *European Journal of Public Health*, *23*(6), 974-980. doi.10.1093/eurpub/cks140

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. doi:10.1007/s10488-013-0528-y

Parekh, N., Jarlenski, M. & Kelley, D. (2018). "Disparities in access to primary care and emergency department utilization in a large Medicaid program." *Journal of Health Disparities Research and Practice*, *11*(4), 1. Retrieved from https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1727&context=jhdrp

Parekh, N., Jarlenski, M., & Kelley, D. (2018). Prenatal and postpartum care disparities in a large Medicaid program. *Maternal & Child Health Journal*, *22*(3), 429–437. doi:10.1007/s10995-017-2410-0

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Picketty, T. & Saez, E. (2013). Top incomes and the great recession: recent evolutions and policy implications. *Economic Review, 61*(3); 456-478. doi:10.1057/imfer.2013.14

Pitt, L. & Gutierrez, R. A. (1999). *Decline of the Californios: A social history of the*

Spanish-Speaking Californias, 1846-1890. University of California Press; First edition.

Portes, A., Kyle, D. & Eaton, W. W. (1992). "Mental illness and help-seeking behavior among Mariel Cuban and Haitian refugees in south Florida". *Journal of Health Social Behavior*, *33*(4), 283–298. doi:10.2307/2137309. PMID 1464715

Prey, J. E., Restaino, S. & Vawdrey, D. K. (2014). Providing hospital patients with access to their medical records. *American Medical Informatics Association. AMIA ... Annual Symposium proceedings. AMIA Symposium*, *2014*, 1884–1893.

Ramsey, J., & Mayes, B. (2018). Outcomes of community-based prenatal education programs for pregnant women in rural Texas. *Family & Community Health, 41*(3), E1-E4. doi:10.1097/FCH.0000000000000191.

Rigg, K. K., Cook, H. H., & Murphy, J. W. (2014). Expanding the scope and relevance of health interventions: Moving beyond clinical trials and behavior change models. *International Journal of Qualitative Studies on Health and Well-being, 9*. doi:10.3402/qhw.v9.24743

Robert Wood Johnson Foundation. (2018). *Race, racism and health*. Retrieved from https://www.rwjf.org/en/library/collections/racism-and-health.html

Rodriguez, J. A., & Ruiz, V. L. (2000). At loose ends: Twentieth-century Latinos in current United States history textbooks. *Journal of American History, 86*(4), 1689–1699. doi:10.2307/2567584

Rolls, L. & Relf, M. (2006). Bracketing interviews: Addressing methodological challenges in qualitative interviewing in bereavement and palliative care.

Mortality, 11(3), 286-305. doi:10.1080/13576270600774893

Roman, L. A., Gardiner, J. C., Lindsay, J. K., Moore, J. S., Luo, Z., Baer, L. J., Goddeeris, J. H., Shoemaker, A. L., Barton, L. R., Fitzgerald, H. E., & Paneth, N. (2009). Alleviating perinatal depressive symptoms and stress: A nurse-community health worker randomized trial. *Archives of Women's Mental Health, 12*(6), 379–391. doi:10.1007/s00737-009-0083-4

Roman, L. A., Raffo, J. E., Dertz, K., Agee, B., Evans, D., Penninga, K., … VanderMeulen, P. (2017). Understanding perspectives of African American Medicaid-insured women on the process of perinatal care: An opportunity for systems improvement. *Maternal and Child Health Journal, 21*(1), 81–92. doi:10.1007/s10995-017-2372-2

Roman, L., Raffo, J. E., Zhu, Q., & Meghea, C. I. (2014). A statewide Medicaid enhanced prenatal care program. *Journal of the American Medical Association Pediatrics, 168*(3), 220–227. doi:10.1001/jamapediatrics.2013.4347.

Ruiz, V. L. (2006). Nuestra América: Latino history as United States history. *Journal of American History, 93*(3), 655–672. doi:10.2307/4486408

Sacks, R. M., Greene, J., Burke, R., & Owen, E. C. (2015). Mental health care among low-income pregnant women with depressive symptoms: Facilitators and barriers to care access and the effectiveness of financial incentives for increasing care. *Administration and Policy in Mental Health, 42*(4), 484–492. doi:10.1007/s10488-014-0562-4

Saez, E. & Zucman, G. (2016). Wealth inequality in the United States since 1913:

Evidence from capitalized income tax data, *The Quarterly Journal of Economics*, *131*(2), 519–578. doi:10.1093/qje/qjw004

Scherman, A., Tolosa, J. E., & McEvoy, C. (2018). Smoking cessation in pregnancy: A continuing challenge in the United States. *Therapeutic Advances in Drug Safety*, *9*(8), 457-474. doi:10.1177/2042098618775366

Schetter, C. D. & Tanner. T. (2012). Anxiety, depression and stress in pregnancy: Implications for mothers, children, research, and practice. *Current Opinion in Psychiatry, 25*(2), 141-148. doi:10.1097/YCO.0b013e3283503680

Selchau, K., Babuca, M., Bower, K., Castro, Y., Coakley, E., Flores, A., … Shattuck, L. (2017). First trimester prenatal care initiation among Hispanic women along the U.S.-Mexico border. *Maternal and Child Health Journal, 21*(1), 11–18. doi:10.1007/s10995-017-2374-0

Semega, J. L., Fontenot, K. R. & Kollar, M. A. (2017). *Income and poverty in the United States: 2016 current population reports*, (Washington, DC: US Census Bureau). Retrieved from https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60-259.pdf

Shah, J. S., Revere, F. L. & Toy, E. C. (2018). Improving rates of early entry prenatal care in an underserved population. *Maternal Child Health Journal, 22*(12), 1738–1742. doi:10.1007/s10995-018-2569-z

Shelton, C. L., Smith, A. F., & Mort, M. (2014). Opening up the black box: An introduction to qualitative research methods in anaesthesia. *Anaesthesia, 69*(3), 270-280. doi:10.1111/anae.12517

Shonkoff, J. P. (2014). Changing the narrative for early childhood investment. *Journal of American Medical Association of Pediatrics, 168*(2), 105–106. doi:10.1001/jamapediatrics.2013.4212

Smedley, B. D. (2008). Moving beyond access: achieving equity in state health care reform. *Health Affairs, 27*(2). doi:10.1377/hlthaff.27.2.447

Smith, L. S. (2015). When your patient can't read or write. *Nursing, 45*(2), 67–69. doi:10.1097/01.NURSE.0000459800.25582.92

Smith, D. P. & Bradshaw, B. S. (2006). "Rethinking the Hispanic paradox: death rates and life expectancy for US non-Hispanic White and Hispanic populations". *American Journal of Public Health*, *96*(9): 1686–92. doi:10.2105/AJPH.2003.035378.

Sorsa, M. A., Kiikkala, I. & Åstedt-Kurki, P. (2015). Bracketing as a skill in conducting unstructured qualitative interviews. *Nurse Researcher, 22*(4), 8-12. doi: 10.7748/nr.22.4.8.e1317

Strain, L. A. (1990). Physician visits by the elderly: Testing the Andersen-Newman framework. *Canadian Journal of Sociology, 15*(1), 19-37. doi:10.2307/3341171

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226–231. doi:10.4212/cjhp.v68i3.1456

Taylor, Y. J., & Nies, M. A. (2013). Measuring the impact and outcomes of maternal child health federal programs. *Maternal and Child Health Journal, 17*(5), 886-896. doi:10.1007/s10995-012-1067-y

Tesfaye, G., Chojenta, C., Smith, R. & Loxton, D. (2018). Application of the Andersen-Newman model of health care utilization to understand antenatal care use in Kersa District, Eastern Ethiopia. *PLOS ONE, 13*(12), e0208729. doi:10.1371/journal.pone.0208729

Thomas, L. & Isaac, L. A. (2013) eds. *Race, ethnicity, and wealth: a public health reader*. San Francisco: Jossey, 2013. Print.

Tomiak, M., Berthelot, J., Guimond, E. & Mustard, C. (2000). Factors associated with nursing-home entry for elders in Manitoba. *Canada. Journal of Gerontology: Medical Sciences, 55*(5): M279-M287. doi:10.1093/gerona/55.5.M279

Traub, A., Ruetschlin, C., Sullivan, L., Meschede, T., Dietrich, L. & Shapiro, T. (2015). The racial wealth gaps. Why policy matters. *Institute for Assets & Social Policy*. Retrieved from https://www.demos.org/sites/default/files/publications/RacialWealthGap_1.pdf

Trahar, S. (2013). *Contextualizing Narrative Inquiry: Developing Methodological Approaches for Local Contexts*. New York: Routledge, 2013. Print.

True, W. R., Romeis, J. C., Heath, A. C., Flick, L. H., Shaw, L., Eisen, S. A., … Lyons, M. J. (1997). Genetic and environmental contributions to healthcare need and utilization: A twin analysis. *Health Services Research*, *32*(1), 37–53. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070168

Tschudy, M. M., Toomey, S. L., & Cheng, T. L. (2013). Merging systems: Integrating home visitation and the family-centered medical home. *Pediatrics, 132*(2), S74–S81. doi:10.1542/peds.2013-1021E

Tufford, L. & Newman, P. A. (n.d). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96. doi:10.1177/1473325010368316

Turra, C. M. & Goldman, N. (2007). "Socioeconomic differences in mortality among U.S. adults: insights into the Hispanic paradox". *The Journals of Gerontology: Series B*, *62*(3), S184–92. doi:10.1093/geronb/62.3.S184.

U.S. Census Bureau. (2017). *American Community Survey 1-Year Estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages /productview.xhtml?src=bkmk

U.S. Census Bureau. (2017). *Facts for features: Hispanic heritage month 2017*. Retrieved from https://www.census.gov/newsroom/facts-for-features/2017/hispanic-heritage.html

U.S. Census Bureau. (2015). *Projections of the population by sex, Hispanic origin, race for the United States 2015 to 2060.* Retrieved from http://www.census.gov /population/projections/data/national/2014/summarytables.html

U.S. Department of Health and Human Services. (2014). *Healthy People 2020: Access to health care.* Retrieved from http://www.healthypeople.gov/2020/default

U.S. Department of Health and Human Services. (2016). *Strategies for reducing health disparities-Selected CDC sponsored interventions*. Retrieved from https://www.cdc.gov/minorityhealth/strategies2016/index.html

U.S. Department of Health and Human Services. (2017). *Healthy People 2020 leading health indicators: Progress update.* Retrieved from https://www.healthypeople.gov/2020/leading-health-indicators/Healthy-People2020-Leading-Health-Indicators%3A-Progress-Update

Vardeman-Winter, J. (2017). The framing of women and health disparities: A critical look at race, gender, and class from the perspectives of grassroots health communicators. *Health Communication, 32*(5), 629–638. doi:10.1080/10410236.2016.1160318

Walker, L. O. & Chestnut, S. W. (2010). Identifying health disparities and social inequities affecting childbearing women and infants. *Journal of Obstetrics Gynecological Neonatal Nursing, 39*(3), 328-38. http://doi:10.1111/j.1552-6909.2010.01144.x.

Walden University. (2012g). *Institutional review board for ethical standards in research*. Retrieved from http://researchcenter.waldenu.edu/Office-of-Research-Integrityand-Compliance.htm.

Walden University. (2018). *About us*. Retrieved from https://academicguides.waldenu.edu/social-change/about-us/mission

Woods, M., Paulus, T., Atkins, D. P., & Macklin, R. (2016). Advancing qualitative research using qualitative data analysis software (QDAS)? Reviewing potential versus practice in published studies using ATLAS.ti and NVivo, 1994–2013. *Social Science Computer Review*, *34*(5), 597–617. doi:10.1177/0894439315596311

World Health Organization. (WHO). (2015). *World health statistics 2015*. Geneva: WHO, 2012. Print.

World Population Review. (2018). Maryland population 2019. Retrieved from http://worldpopulationreview.com/states/maryland-population/

Yearby, R. (2018). Racial disparities in health status and access to healthcare: The continuation of inequality in the United States due to structural racism. *The American Journal of Economics and Sociology,* 77(3–4), 1113-1152. doi:10.1111/ajes.12230

Zimmermann, K., Carnahan, L. R., Paulsey, E., & Molina, Y. (2016). Health care eligibility and availability and health care reform: Are we addressing rural women's barriers to accessing care? *Journal of Health Care for the Poor and Underserved, 27*(4), 204–219. doi:10.1353/hpu.2016.0177

Appendix A: Study Invitation Flyer

STUDY INVITATION FLYER

Invitation to Participate in a Study on experiences of Health Disparities and Health-related Outcomes: A Perspective from Minority Pregnant Women – IRB Approval # 09-18-19-0078198. This research study is for first-time pregnant Black/African American and non-White Hispanic/Latino American women seeking health care for prenatal or essential care services. The researcher, Lorna Robinson, is a doctoral candidate at Walden University's School of Nursing. She is interested in gaining an understanding of the health access disparities experienced by first-time pregnant Black/African American and non-white Hispanic/Latino American women in the United States. Note: Your participation would be voluntary and have the option to withdraw at any time.

Study Eligibility:

You may qualify for this study if:

1. A woman who self-identifies as Black/African American and non-White Hispanic/Latino American 18 years or older;
2. First-time pregnant Black/African American or non-white Hispanic/Latino American woman and first-time seeking professional health care (i.e., prenatal or essential care;
3. You live in the northeast metropolitan area;
4. You are willing to complete a short demographic survey by email, and short follow up of the study by email or phone;
5. You are willing to share with the researcher your experience of seeking prenatal care in a recorded, private face-to-face interview lasting between 45 to 60 minutes; and
6. You can read, write and understand instructions in basic English language.

Benefits to Participants:

The results of this study will provide information about health care challenges Black/African American and nonwhite Hispanic/Latino American women face in the United States. You will be given a $10 gift card for taking part in this study. Also, water, juice and snacks will be served at the interview venue. To learn more about this study and how you can participate, please contact Lorna Robinson at XXX-XXX-XXXX or by email at XXXXX@XXXXX.

Appendix B: Initial Eligibility Screening Questionnaire

Participant Recruiting goals:

Participants must:

- Be legal Africa American or Hispanic American aged 18 years or older and live in the United States.

- Have sought prenatal care in the past one year.

- Live in northeast MA and able to read, write, and speak at Basic English.

- Be willing to travel to interview venue, sign the participant consent form and complete a recorded face-to-face interview that will last between 30 to 45 minutes.

- Commit to a date and time they will be available for the interview

The following questions will be used to qualify potential participants in the initial phone call screening interview:

1. Obtain caller's name, sex, and age.

2. Are you a legal African American or Hispanic American?

3. How long have you lived in the United States?

4. Are you a resident of the northeast MA?

5. Do you have a child(ren)?

6. Have you sought prenatal care in the past 12 months?

7. Are you willing to complete a short demographic survey and short debrief of the study?

8. Are you willing to freely participate and share with the researcher about your experience of seeking maternal and child health services in a face-to-face interview that will last between 45 to 60 minutes?

9. The face-to-face interviews will be audio recorded. Do you have a problem with this?

10. Are you willing to travel to the interview venue?

11. Are you willing to sign an informed consent, which says that you voluntarily agree to participate fully in the study?

12. When is the best time and date to schedule your interview?

13. How soon are you available to meet with me?

Closing Remarks for Potential Ineligible Participants:

Thank you for your interest in participating in the study and answering the screening questions. The information you have provided, you do not meet the study eligibility requirements. Thank you for your time.

Closing Remarks for Eligible Potential Participants:

Thank you for your interest in participating in the study and answering the screening questions. Based on your answers, you are eligible to take part in this study, and I would like to set up an interview time and date convenient for you.

Do you have any questions for me at this moment?

- So, would you like to participate in this study?

- Can we set your interview? What time and day works best for you? Date of

Interview _______________ Time of Interview _____________ Thank you for agreeing to take part in this study.

Appendix C: Demographic Checklist

Ethnicity: ☐ Black/African American ☐ Non-White Hispanic/Latino

Education level: ☐ Less than high school ☐ High school ☐ Associate degree ☐ Bachelor's degree ☐ Advanced degree

Marital status: ☐ Single ☐ Married ☐ Legally separated ☐ Divorced ☐ Currently living with a partner

Annual household income: ☐ Less than $17,000 ☐ Less than 25,000 ☐ Less than $49,900

Age category: ☐ 18 – 25 ☐ 26 – 35 ☐ 36 – 45 ☐ 46 – 55

Current employment status: ☐ Full-time ☐ Part-time ☐ Unemployed
Type of health insurance: ☐ Private ☐ Public ☐ None

No. of children in a family: ☐ None ☐ 1 or more

No. of times prenatal services used: ☐ 1 – 2 ☐ 3 – 4 ☐ 5 or more

Health care sought in the last year: ☐ Prenatal ☐ Other

Nature of care sought: ☐ Inpatient ☐ Outpatient

What type of health care provider do you use? ☐ Gynecologist ☐ Obstetrician ☐ Primary Care Physician

Do you have a Primary Care Physician? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

Appendix D: Interview Guide/Protocol

Experiences of Prenatal Care Access Disparities among first-time Pregnant Minority Women

Introduction: I stated my name, the title of the study, research purpose, and IRB approval number.

Obtain demographic information of the study participant: I asked participants to briefly tell me about herself, her name, age, highest education level reached, marital status, employment status, where she lives, her nationality, and age. Next, I informed the participant that the interview may last between 30-45 minutes. At this moment, I asked the participant if she has any questions or clarifications before we start the interview. I started administering the interview questions.

Interview Guide/Protocol

IQ1. Tell me about the various forms of prenatal health services you sought and used since you suspected or found out you are pregnant.

IQ2. What do you understand about health care prenatal/access disparities?

IQ3. Can you describe to me an instance(s) when you experienced prenatal/access disparities/difficulties or when you felt you were being treated different in the process of seeking prenatal services?

IQ4. In your opinion, what led to difference in treatment or the disparities you experienced in the process of seeking prenatal services?

IQ5. How, if at all, did your status of being a Black/African or Hispanic/Latino American contribute to the different forms of prenatal/access disparities you experienced?

IQ6. How, if at all, did your social-economic status contribute to the different forms of prenatal/access disparities you experienced?

IQ7. How, if at all, did the access disparities you experienced affect your feelings and decisions towards seeking subsequent prenatal care?

IQ8. How, if at all, did access disparities affect your overall experience of seeking prenatal care services?

IQ9. Is there anything else you want to share with me concerning your prenatal care service experiences in relation to prenatal/access disparities?

IQ10. Do you have any other questions for me relating to this study?

Conclusion: I thanked the participants for participating in the study then provided participants with a description of what will happen next after data collection. Also, at this moment, I explained and assured the participant that the privacy of their collected data is guaranteed.