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# Perceptions of Reproductive Health Services of Young African American Mothers with Low Literacy

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Walden University
2020

Abstract

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MSW, Chicago State University, 2007

BSW, University of Saint Francis in Joliet, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work

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# Abstract

As they begin to shift decision-making from their parents to themselves, many African American adolescent girls embracing motherhood and living with low literacy seek reproductive health services at federally qualified health centers (FQHCs). Emerging adult African American mothers engaged in reproductive health services at urban FQHCs are provided services based on the centers' promulgated health policies. Although FQHC staff assess for health literacy levels, they often do not design organizational processes to support reproductive health mothers with literacy challenges and diverse learning styles, and little is known about how young African American mothers with low literacy experience FQHCs' reproductive health services. Guided by the life course theory, research questions were centered on emerging adult African American mothers' lived experience of low literacy and formed perceptions when developing reproductive life goals when engaged in reproductive health care services within an FQHC setting. A phenomenological approach was used with semi structured interviews conducted with 10 participants recruited through purposeful sampling. Emerging themes were captured through rigorous coding, member checking, and triangulation and included familial roots, literacy development, reproductive engagement and choice, familial belief systems, and reproductive health and life plan. Lessons learned from this study will help social workers, and other health professionals recognize the importance of understanding the multigenerational practices and historical literacy development of reproductive health mothers, and their ability to receive and process information based on learning style, to help foster positive health outcome throughout the life course.

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# Dedication

This dissertation is dedicated to the memory of my father, James Earl Anderson Sr. He was a superhero with infinite compassion and love. He inspired me to rise above all obstacles and pursue the highest level of academic achievement. Although he is no longer here to celebrate this significant milestone in my life, this dissertation is for him.

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# Chapter 1: Introduction to the Study

## Introduction

The social determinants of health (SDOH) are foundational environmental constructs that formulate the lived experiences of all societal populations (Braveman & Gottlieb, 2014; Greenfield & Jensen, 2010). The Centers for Disease Control and Prevention (2018) noted that the SDOH are influenced by the place in which people are born, raised, and reside in as well as by social and human capital. The place where people call home can affect how their lives are defined, with some populations thriving and others experiencing disparities, or perhaps coexisting between both worlds. Brady and Johnson (2014) suggest that in order to understand how a person lives, the life course perspective should be used to conceptualize specific events that take place before and after birth. For example, low literacy throughout the life course can contribute to how members of marginalized populations function and process information. According to the National Assessment of Adult Literacy, an individual’s ability to receive, process, and apply information varies across the U.S. population (Kutner, Greenberg, & Baer, 2006). In 2019, according to the U.S. Department of Education, well over 26 million Americans experienced some form of low literacy, of which African Americans account for 20% of that population (Mamedova & Pawlowski, 2019). The lived experiences of a lower level of literacy among African Americans may pose a challenge for individuals seeking to engage health systems for reproductive health care services.

Public health social workers and other health professionals engaged in the delivery of health care services are attentive to the lived experiences of and importance of place for marginalized populations living in urban communities. For public health social workers working with emerging adult women seeking to engage in reproductive health care services (hereafter referred to reproductive health mothers) at a federally qualified health center (FQHC), it is essential to first consider how SDOH such as low literacy pose unique barriers for those accessing care. Yee and Simon (2014) described low literacy as a social problem that has influenced nearly 80 million U.S. residents' ability to process and receive information. Mothers account for 54% of individuals scoring at below basic literacy (Kutner et al., 2006). Literacy deficits among mothers may challenge societal efforts to address health disparities.

Over the last decade, health policy has evolved to identify and improve barriers to reproductive health access, such as the social stigma related to health literacy, in the United States. The Patient Protection and Affordable Care Act of 2010 (ACA) led to health systems recognizing literacy as a barrier to achieving optimal health and wellness. For the first time in U.S. history, the ACA created a universal template for healthcare systems across the country, to inform healthcare administrators on how to effectively assess an individual's health literacy level before delivering services (Cantor, Monheit, DeLia, & Lloyd, 2012). This type of workflow shift in healthcare engagement has changed how public health social workers and other health professionals prioritize SDOH before attempting to deliver inclusive health services to marginalized populations with literacy deficits.  Whereas, promogulated rules provided guidance on the development of screening tools, clear communication strategies that incorporated plain language and infographic based educational material aligning with all levels of literacy (Koh et al., 2012). Health systems such as FQHC are designed to provide innovative and comprehensive patient-centered medical care and develop integrative health strategies that address all the needs of individuals residing in marginalized communities (National Association of Community Health Centers, 2018).

Since the 20th century, FQHCs have led the nation in combating the war on poverty and have continued to advocate for unspoken voices, and within the last decade their leaders have recognized the importance of meeting the rigorous standards of the promogulated rules in the ACA. Reproductive health services have evolved in FQHCs to not only serve pregnant and parenting mothers but also to utilize public health social workers to provide health awareness and education to simplify complex family planning language (Wood et al., 2014). Yet, even with this defined structure, FQHCs have not effectively addressed literacy levels among reproductive health mothers residing in urban communities. Public health social workers and other health professionals have begun to understand the complexity of issues that reproductive health mothers with low literacy encounter when making informed decisions about their health, such as a lack of needed comprehension skills to decode wordy health material (Keim-Malpass, Letzkus, & Kennedy, 2015; Koh et al., 2012).

The available literature does not provide a comprehensive strategy to improve low literacy of emerging adult (18-25 years old) African American mothers attending FQHCs that engage in care for reproductive health and life goal planning. The expectations placed on FQHCs must be reconsidered by reevaluating how to properly address the adverse lived experiences of mothers with literacy deficits. In the present study, I identified gaps in the ACA legislation mandate on health literacy. I did so by exploring the perceptions and lived experience of emerging adult African American mothers with low literary who were engaged in care at an urban FQHC. I wanted to conceptualize participants' familial and lived experiences and determine how they process, receive, and utilize health education received. The study results may inform public health social workers on how to engage with healthcare administrators and federal government officials to ensure that promulgated rules address more than literacy deficits and are inclusive of policy rhetoric that includes diverse learning styles. The study results have social implications in that they may lead public health social workers, other health professionals, and healthcare administrators to develop thoughtful workflows that address low literacy from a systematic perspective. In this chapter, I provide the background, problem, purpose, research questions, and theoretical framework of the study, followed by an overview of the phenomenological qualitative approach I used to investigate the study phenomenon. The key terms, assumptions, scope and delimitations, limitations, and significance of the study are also included.

## Background

Achieving equitable health and wellness can be an unfamiliar journey for emerging adult African American mothers. Emerging adults with lived experiences of low literacy are engaged in the process of discerning the reproductive health method that aligns with their respective lifestyle (Betz et al., 2014). Low literacy has complicated some mothers' access to reproductive health services. However, relying on key aspects of the ACA, public health social workers working in urban settings now can assess patients' health literacy levels (Keim-Malpass et al., 2015).

The ACA has created a pathway for FQHCs to serve as pioneers to address low literacy. However, the legislation's promulgated rules lack consideration of how an individual's learning style (e.g., verbal or visual learner) may be a barrier to accessing reproductive health services. Examination of how a culture learns to read must be reviewed before health care systems can begin to address literacy challenges. According to Jarrett, Hamilton, and Coba-Rodriguez (2015), many African American families use a skills-based approach to learning and utilize repetition to learn how to read, as opposed to Whites who often utilize an entertainment approach to promote comprehension by exposure individuals to the external environment. If how individuals learn is based on race, regulated health laws mandating health systems to address low health literacy levels have indirectly created unanticipated barriers for marginalized populations to comprehend and apply the concepts related to reproductive health information received. Conceptualizing how the lived experience of low literacy among African Americans mothers is a barrier to care requires an in-depth exploration of mothers' historical connections (Willis, 2015).

Explanation of this phenomenon, through a public health social work lens, could improve the engagement of marginalized reproductive health mothers in developing health and life goal plans that translate into long-term health and wellness goals. Perhaps the development of plain health language and simplified medical terminology can bridge the gap of comprehension and low literacy experienced by emerging adult African

American mothers (Koh et al., 2012; Marquez & Ladd, 2019). Decision aid tools, a method to transcribe complex clinical information in either an audio or visual format, could perhaps abridge medical terminologies to account for individuals living with low literacy and comprehension challenges (Bennett, Switzer, Aguirre, Evans, & Barg, 2006; Delanoë et al., 2016; Matsagnis & Golden, 2015). Utilization of a web-based decision aid tool has shown some level of success among reproductive health mothers, as it expands existing knowledge and provides awareness of how to make informed decisions about family planning health options (Peate et al., 2017). The use of health promotion resources is seen as a vehicle to engage emerging adults, and based on current health policy standards, there is a need to use similar strategies to assist reproductive health mothers in developing reproductive plans based on learning style rather than on what public health social workers and other health professional think is the best choice due to literacy deficits (Mendes, Plaza, & Wallerstein, 2014;  Roter et al., 2015).

## Problem Statement

African American mothers with lived experiences of low literacy rely on wordy health educational material to make reproductive health choices over the course of their lifespan (Bennett et al., 2006; Delanoë et al., 2016; Matsaganis & Golden, 2015). Previous research indicates that other modes of communication can be used to address health literacy challenges among African American women. Mittal (2014), for instance, suggests that, by setting time aside and helping an individual to create a well thought-out reproductive health plan, health care professions can help patients to achieve desired health and wellness outcomes. Mandated health policies have shifted how FQHCs incorporate health literacy screening into practice by using validated screening assessment, for example the Rapid Estimate of Adult Literacy in Medicine scale. The scale is a method that can assist low literacy African American reproductive health mothers to recognize their literacy challenges, which may in turn help public health social workers to tailor family planning services, materials, and messaging based on linguistic level (Wood et al., 2014). In addition, there are health systems that use empowerment techniques and computerized systems as a means of improving communication gaps to address health literacy deficits among African American reproductive health mothers (Mendes et al., 2014; Roter et al., 2015). Still, there is a need to explore how the lived experiences of low literacy among emerging adult African American reproductive health mothers create challenges when engaged in reproductive health planning with public health social workers and other health professionals. Researching this phenomenon may expand the social work literature concerning low literacy challenges among reproductive health populations residing in urban communities. Findings may also provide a platform for advocacy by informing health administrators and federal government officials of the need to revise promulgated regulations to focus not only on health literacy but also on low literacy in general.

## Purpose of the Study

The purpose of this phenomenological study was to explore how the lived experiences of low literacy among emerging adult African American reproductive health mothers may create unforeseen barriers when engaged by public health social workers to develop reproductive health and life goals. Understanding these experiences may help public health social workers and other health professionals working at FQHCs to reframe how they engage with marginalized mothers seeking reproductive health services in urban settings. Study findings may clarify how FQHCs, which have as a goal providing innovative patient-centered services, can serve as a global catalyst to improve literacy deficits among African American reproductive health mothers across the United States. Placing value on a mother's reproductive rights and the development of a meaningful health and life goals may lead to positive health and wellness throughout the lifespan.

## Research Questions

1. How do lived experiences of low literacy affect emerging adult African American reproductive mothers engaged in reproductive health care services within an FQHC setting?
2. How do lived experiences, throughout the life course of emerging adult African American reproductive mothers, create challenges during the development of a personalized reproductive health plan?

## Theoretical Framework

I used the life course theory to gain insight on how an individual's personal life and reproductive development is formed based on societal and familial belief systems (Elder, Johnson, & Crosnoe, 2003). Researchers studying reproductive health populations often employ the life course theory to help public health professionals conceptualize how social and medical circumstances have contributed to both positive or adverse health outcomes among marginalized populations (Callahan et al., 2015). The life course is influenced by environmental constructs, multigenerational belief systems, personal motivation, and capacity to transition to the next phase in the lifespan. The life course perspective provides fundamental concepts associated with low literacy among emerging adult African American mothers and reveals barriers formed by actualized lived experiences. The life course theory also provides guidance to the public to conceptualize the challenges of individuals living with low literacy to unveil how effective health systems engage African American reproductive health mothers with low literacy. Furthermore, understanding the learning style of an individual should also be prioritized when engaging this population in selecting family planning methods, especially when historical challenges have prevented them from understanding the importance of setting long-term goals (Sethi, Lomte, & Shinde, 2017).

## Nature of the Study

In this study, I explored the lived experiences of low literacy among emerging adult African American mothers engaged in reproductive health services to develop a health and life plan. Use of a phenomenological qualitative approach helped with the formal engagement of reproductive health mothers. In using this approach, I conducted in-person interviews to collect participants’ verbal stories describing how their lived experiences of low literacy created barriers when engaged in reproductive health planning services in an urban FQHC setting. I recruited study participants with a flyer I distributed at a local partner agency. The partner agency has close ties to urban community members, works closely with urban FQHC, and provides case management services to emerging adult African American mothers in the reproductive phase of the lifespan. The goal of the agency is to help marginalized women to achieve their desired life plans and access tangible resources (Halfon, Larson, Lu, Tullis, & Russ, 2014). I used purposeful sampling to select study participants who had verbally expressed their interest and desire to share their lived experiences with me (Palinkas et al., 2015). Interested participants were contacted by phone and provided with detailed information on how to participate in the study. Once the individual agreed to participate, they signed an informed consent form to be interviewed. All interviews were recorded and transcribed to assist in gathering rich data. A template and thematic analysis were used to capture concepts and constructs based on participants' responses. I used observational field notes to capture verbal and nonverbal communication cues that took place throughout the interview process. Reflection of analyzed data helped to define emerging themes related to the phenomenon, which in the future may help public health social workers to collaborate with health policy experts to develop political rhetoric that is unconsciously biased. Furthermore, obtained themes can also aid in the development of critical concepts that predicate reframing of the ACA regulated rules to be more inclusive of all literacy challenges, not just health literacy, and to develop thought-based health educational resources for print and electronic platforms that are designed to incorporate messaging tailored to all phases of the lifespan (Begun, 2015; Matsaganis, & Golden, 2015).

## Definitions

The following terms are used throughout the study:

*Emerging adult*: A young adult who transitions from the adolescence phase of the lifespan to adulthood and is between 18 to 30 years of age (Bitter & Plane, 2012).

*Health literacy*: How an individual access, engages, and understands health information received to ensure positive health outcomes (World Health Organization, 2018a).

*Health policy*: Policies that determine the overall health and well-being of the society (World Health Organization, 2018b).

*Life course or lifespan:* How a person's trajectory of life is defined by environmental and human agency constructs (Elder, 1998).

*Low literacy*: A person's inability to comprehend, articulate, or receive verbal and nonverbal information when required to make informed decisions (McNaughton, Jacobson, & Kripalani, 2014; Paasche-Orlow, Parker, Gazmararian, Nielsen-Bohlman, & Rudd, 2005).

*Public health social worker*: A master's-level social worker who practices in the public health sector and utilizes research-based approach processes to assist individuals in achieving their optimal health and wellness (Addy, Browne, Blake, & Bailey, 2015).

*Reproductive health plan*: A tool that is used to guide the development of health and life goals during the reproductive phase (14-44 years of age) of the lifespan (Stern, Bodin, Grandahl, Segeblad, & Axe, 2015).

## Assumptions

An initial assumption was that African American reproductive health mothers who had lived experiences of low literacy encountered challenges when required to understand medical rhetoric and health education reading material. In that low literacy among African American women engaged in reproductive health care services were not guided into developing meaningful health plans. The next assumption was that based on the generational beliefs of the maternal side of an emerging adult African American reproductive health mother’s family played a vital role in the selection of family planning choices that met their individual lifestyle needs. Examples of generational beliefs include such sayings as “Do not have sex!” or that you should not have sexual intercourse until you are older or married. It is assumed that the study’s method of using semi-structured interviews helped capture the perceptions of participants and lead to the collection of rich data and robust themes (DeJonckeheere & Vaughn, 2019). By using this type of interview, approach forged a trusting relationship with the study participant’s and allowed for honest sharing of their lived experiences of low literacy. It was also assumed that the perceptions shared by study participants concerning their engagement in the health care system formed negative perceptions of public health social workers and other health professionals. I assumed that utilization of the life course theory, would yield results from the study that were applicable to other African American reproductive health mothers receiving care at other urban FQHC located in other regions of the country. Lastly, I assumed that study results would have implications for social change in the social work field to improve health policies and health care systems that align with promogulated policies which are defined by the federal government are designed to improve the SDOH and health disparities among marginalized populations.

## Scope and Delimitations

The goal of the phenomenological qualitative study explored how the lived experiences of low literacy among emerging adult African American reproductive mothers, create unspoken challenges when engaging public health social workers in the development of long-term health and life goals; it did not explore other women of color, such as Whites and Hispanics. The study's criteria only sought to explore the perceptions of African American reproductive health mothers who delivered a child within the last two years and excluded women that acknowledged they were currently pregnant. Confirmation of age and motherhood status was self-reported by study participants.

Data were collected through in-person individual semi-structured interviews in Chicago, IL at the local library. All study participants were actively enrolled in case management services at the partner agency and had been assessed for health literacy, received care at a FQHC located within an urban community, and were recruited using purposeful sampling.

## Limitations

Use of a phenomenological approach posed several limitations for this study. Limitations in generalizability was due to the lack of transferability of this study, as participants were emerging adult African American reproductive health mothers receiving care in an urban community. This study did not focus on other races, such as Whites and Hispanics; other age groups in the reproductive phase of the lifespan; and did account for rural or tribal community areas.  I also limited recruitment to the partner agency that provided case management services to mothers lacking tangible resources. In addition, to receiving services from the partner agency, study participants attended different FQHC's for reproductive health care services, hence the variance of engagement with the public health social worker and other health professionals.

Collecting data through individual based in-person interviews created limitations. When interviewing participants, it was challenging to pick up on unfamiliar terms, which caused some frustration when collecting the data and participants were responding to interview questions about their family planning choice, which was consistent across all interviews. This issue was addressed by jotting down terms in observational notes and at the completion of all the interviews and I followed up with participants, and clarified questions were asked to ensure consistency in reported data. An example of an unfamiliar term used frequently was the “three-month shot”, and when asking the participant for clarification they either used the words the shot, Depo, or Depo-Povera Shot. Lastly, the study considered the low literacy levels of participants to gain insight on the challenges regarding the engagement into health care systems but did not factor in barriers that formed their perceptions beyond this phenomenon.

## Significance

With the massive changes in U.S. health policy, there is now less attention focused on the lived experiences of a person and how they learn and process information. On the other hand, there is now more concentration on how to effectively implement health policies that are aimed to improve health outcomes in a short-sided manner. As healthcare transforms the ever-evolving needs of people, public health social workers working in FQHC’s are placed in a unique position to work with marginalized women who lives have need molded by the SDOH (i.e., low literacy) throughout their life course. Pioneers of the social work profession have led numerous grassroot advocacy efforts to inform the masses on how marginalized populations, particularly African American women, basic human rights have been violated by the community, health care systems, and most importantly governmental influencers through policy (Bird, Wright, & Frost; 2016; Healy, 2008). This study adds to the body of the social work literature by providing an understanding of the underpinnings of the public health social work praxis, to describe the lived experiences of low literacy among emerging adult African American reproductive health mothers when developing reproductive health and life goals that may be outside the norm of their generational belief systems. This study guides the development of best practices among FQHCs to employ more public health social workers to utilize unique approaches that help urban African American reproductive health mothers engage in reproductive health services (Browne, Darnell, Savage, & Brown, 2015; Daaleman, Hay, Prentice, & Gwynne, 2014; Gage, 2012; Shera & Bogo, 2001). Thus, the findings from this study may aid in the development of transparent reproductive health policy provisions that support the basic health rights of reproductive health mothers whose personal agency has been shaped by their lived experiences of low literacy and will necessitate the need for positive global social change (Brady & Johnson, 2014; Raine et al., 2016).

## Summary

In Chapter 1, I provided an overview of the transformation of health policy and how it constitutes how healthcare services designed the engagement of marginalized populations into care. The makings of the ACA account for low literacy levels by way of health literacy assessment among, however, there is less attention of how to address an individual’s comprehension and the role race contributes to learning. To guide the work of this study, the selection of the life course theory, instead of the social cognitive theory which suggest the new learning processes can be gained through mimicking others behavior, helped to review the lived experiences of low literacy from an individual's familial background and throughout the course of the life span (Tougas, Hayden, Mcgarth, & Huguet, 2015). This study will further explore unexplainable social constructs that have created barriers to care and how they can be an asset to develop meaningful reproductive health and life goals. In Chapter 2, exploration of the historical foundation of health policy, reproductive health, and literacy among marginalized populations provides an in-depth context on the systemic levels public health social workers must understand to work with reproductive health mothers in FQHC situated in urban communities.

# Chapter 2: Literature Review

## Introduction

An individual's lifespan consists of a myriad of transitional milestones. African American young women have experienced the adolescence phase of the lifespan in which puberty, menstruation, and the need to become responsible for life decisions are necessary for healthy growth and development to transition to the next phase of the lifespan (Bogard, Murry, & Alexander; 2017; Yee & Simon, 2014). Adolescents who embark on motherhood at an early age sometimes are classified as emancipated minors for the purpose of having their own child but are still adolescents in the eyes of the law. Although they are legally responsible for their infant, they remain codependent on their legal guardians concerning general health and other aspects of their life (Huang et al., 2014). Often, reproductive health mothers with lived experiences of low literacy begin their transition into the emerging adult phase of the lifespan facing the unknown challenges of engaging reproductive health services without guardian support. Health systems such as FQHCs are designed to address the SDOH and the complex medical needs of marginalized communities (Bogard et al., 2017; Institute of Medicine, 2013; Lewis et al., 2016; National Association for Community Health Centers, 2018). In the current social work literature there have been studies that looked at health literacy, reproductive health choices, and the engagement is into services. However, there is a need for further exploration in the social work literature regarding how health policy can redress the impact of low literacy on emerging adult African American mothers' ability to engage in reproductive health services to develop meaningful long-term health and life goals.

In this chapter, I review the literature concerning the influence of health policy, for example, the ACA, and how FQHCs can create capacity among public health social workers and other medical professional to assist emerging adult African American mothers challenged with low literacy. I will provide context on how this unique population defines and prioritizes their level of engagement when utilizing reproductive health services to develop reproductive health and life goals. The review of the literature will also provide additional insight on the connection between an individual's lifespan, lived experience of low literacy, and perception of mistrust of healthcare. I begin the chapter by providing an overview of the literature search strategy and theoretical framework.

## Literature Search Strategy

I used Academic Search Complete, Eric, Eric and Education Source Combined, EBSCOhost, Google Scholar, Science Direct, ProQuest Central, PsycARTICLES, PubMed, SAGE Journals, SOCINDEX with Full Text, Taylor and Francis Online, US Department of Health and Human Services, and World Health Organization to locate current and historical literature. For information on the life course theory, I turned to the seminal work of Glen Elder, a behavioral science researcher who asserted the theoretical perspective that human agency and the behaviors developed over the life course (Elder et al., 2003). The key terms *health policy*, *care coordination*, *social work, literacy, African American women*, *reproductive health*, *emerging adults*, and *parenting* were used in database searches and yielded numerous research articles. To accurately identify the urban population of interest, I expanded the search to include *community health centers, the Affordable Care Act of 2010,* and *public health social workers*. The searches yielded 60 scholarly peer-reviewed articles, books, conference presentations, government-based reports, and reputable online resources not extending beyond 2015, unless for historical acknowledgment for the literature review.

## Theoretical Framework

The life course theory served as the theoretical framework to understand how environment and familial influences formed the perceptions of African American women engaging in reproductive health services with lived experience of low literacy. Use of this theoretical framework helped me to understand the first principle, that where and what a person is born into sets the foundation of a person’s life trajectory (Elder, 1998; Elder et al., 2003). For example, if a woman was born into a situation that their mother was not present, this framework would suggest that a similar occurrence would happen in this individual’s life. The second principle accounts for the exposure of adverse experiences that constitute either a positive or adverse health outcome in an individual’s lifespan (Callahan et al., 2015). The third principle foresees that how someone is raised in their environment and the social constructs that exist during that time would create the foundation or direction of personal health choices (Thoits, 2010). Next, the life course theory sees health access and the utilization of services as being based on human agency, or personal choice, that self-reliance is the key to achieving self-efficacy in decision-making related to health and wellness (Hitlin & Johnson, 2015; Shrimali, Luginbuhl, Malin, Flournoy, & Siegel 2014). Lastly, the importance of multigenerational and familiar connections is important to understand why decisions are made and how individuals' partner with others concerning the development of life choice (Elder et al., 2003).

## Literature Review Related to Key Variables and Concepts

### Health Policy

Society is governed by regulated rules that are supposed to create equitable opportunities, access, and support to all populations lacking the capacity to care for themselves, especially mothers affected by SDOH and their children. Throughout history, reproductive health pioneers of women's health and rights have advocated for equitable health policies that are in support of marginalized populations and communities. Over time, numerous health policies have impacted (e.g., Comstock Law, Sheppard-Towne Maternity and Infancy Act, Social Security Act, Temporary Assistance for Needy Families) how women can engage in reproductive health care services. With a keen focus to ensure how marginalized women's rights are respected in health systems, reproductive health pioneers have advocated for regulated laws not to nullify access and for the free choice to use family planning options not to be revised (Mundt, 2017).

In the 1873, U.S. lawmakers enacted the Comstock Law, named after Anthony Comstock, language that made the discussion of reproductive services illegal and known as America's first obscene regulation under the Grant administration (McGarry, 2000). The Comstock Law created the first barrier to stopping women from receiving valuable health education about their reproductive health. Defined regulations also instructed postal offices to thoroughly review mailings for inappropriate language persuading the public engagement in reproductive services (Moon, 2001). Reproductive health services are designed to extend the interval of time between births or stop unwanted and unplanned pregnancies (Stones, Stulberg, & Bello Kottenstette, 2017). By controlling the narrative on health education, this type of health policy ultimately led to mistrust among community members concerning the medical community. In order to avoid being arrested and charged with a federal crime, women avoided receiving education on their reproductive health rights and continued to make misinformed choices about their family planning options, even if it caused harm or death (Moon, 2001; Wardell, 1980). Recognizing the injustices of choice, reproductive health pioneers Emma Goldman and Margaret Sanger launched a social movement to transform the Comstock Law to allow for the freedom of speech to talk openly about inequities created by regulated rules (Moon, 2001; Mundt, 2017). The movement acknowledged the unspoken voice of women and the need to allow them to receive health education and resources to stop illegal abortions and have full ownership over their reproductive health rights.

As the reproductive health social movement continued in the 1900s, activist and reformist pioneers continued to advocate on behalf of U.S. mothers and children. Margaret Sanger’s continued advocacy and actions for change led to federal authorization of promogulated rules to provide reputable health educational messages on contraceptive use and well-mothers care to eradicate health issues such as sexually transmitted diseases (Wardell, 1980). In addition to Sanger's efforts, social work pioneers Julia Lathrop and Congresswoman Jennette Rankins also joined the reproductive health movement to advocate for equitable access to services to prevent infant and maternal mortality (Lesser, 1985). The work of the social work pioneers led to the passage of the Sheppard-Towne Maternity and Infancy Act of 1921 under the Harding administration (Rodems, Shaefer, & Ybarra, 2011). This act was one of the first progressive federal health policies that created a pathway for women and children to receive clinical access to social welfare services in both a health center-based setting as well as in the home during pregnancy, postpartum, and well-baby care phases of the lifespan (Daro, 2019).

As health policy continued evolved to determine how to support women with children and provide financial support to reproductive health mothers caring for dependent children under the age of 16 (Bortz, 2019). Under Theodore Roosevelt's admiration, the establishment of the Mothers Aid or Mothers Pension, federally mandated a pool of appropriated funds to support "abandoned" mothers caring for specialized populations, including persons with disabilities or children of absent fathers (Allard, 2004). This move to create a stable income for women to support themselves and dependents, there was a missed opportunity to create a provision that focused on the reproductive access and utilization of health systems to prevent future unwanted and unplanned pregnancies.

The 20th century was a time in history when policies were created and reframed to meet the needs of an everchanging population. Under the Franklin D. Roosevelt administration passage of the Social Security Act of 1935 formalized federal health policy to place regulatory mandates, derived from tax incentives, to support the essential benefits surrounding health care for all persons with disabilities, children, and mothers with dependents, geriatrics individuals, and those receiving unemployment insurance (Davies & Derthick, 1997). What was once known as the Mothers Aid Pension, evolved into Aid for Families with Dependent Children (AFDC) or "welfare," and established mandated services, including medical insurance, or Medicaid, to single parents carrying for dependent children or persons and the inclusion of engaging practices related to health and well-being (Rosenbaum, 2002). AFDC was designed to ensure that dependent children were healthy and create a pipeline to equitable health care. By providing single mothers access to reproductive health services created a social safety net to start looking at birth control options as a means of setting life goals and becoming less dependent on social supports. In theory, this was a great concept, but in practice, it adversely impacts how mothers became co-dependent on the federal government. With less attention focused on empowering mothers to obtain tangible skills, such as educational and vocational training to secure sustainable employment, single mothers saw AFDC as a form of receiving cash benefits to not only sustain life but care for themselves and dependent family members.  AFDC primarily focused on providing medical and dependent care supports; regulated laws lacked a strong emphasis on the development of effective reproductive plans, which are designed to assist reproductive health mothers in selecting life goals that promoted self-sufficiency, and less dependency on system supports (Friede et al., 1986).

Towards the end of the 20th century, and under the Clinton administration, enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or "welfare reform" transformed how society looked at reproductive health mothers.

This piece of legislation, AFDC was reformatted to only provide 60 months of lifetime support and was renamed as Temporary Assistance for Needy Families (TANF) government assistance of cash benefits for households caring for dependent children (Lens, 2002; Yoo, 2002). While TANF placed limits on monetary allowances, reproductive health mothers continued to have access to food stamps and Medicaid coverage, if eligibility requirements were met. TANF further mandated emerging adult reproductive health mothers to engage in educational programs, either a certificate-based or degreed, to end the perpetual dependence on governmental assistance, for example cash benefits (Pearson, 2007). Burtless' (1997) research suggests that the mothers eligible to participate in the welfare to work program often lacked a high school diploma and had low literacy levels. The lack of educational attainment or comprehension placed many of the women into a position of finding low skilled paying jobs. The overall goal of TANF was to promote self-sufficiency and self-efficacy; the pay differential between government assistance and making an adequate living wage was nominal (Burtless, 1997). Mothers depending on welfare would gross an estimated living wage of $12,000, and those working full time would only make as much as $13,000 (Burtless, 1997). TANF intended to purport reproductive health mothers in economically stable circumstances and overcome the SDOH that had created lifelong barriers and dependence on governmental supports. Instead, the new welfare to work movement created a sense of vulnerability and instilled a level of incompetence in reproductive health mothers lacking the needed literacy skills to advance in society, due to the lack of planned health and life goals.

Every presidential administration and its congress have attempted to improve the lives of all populations, by focusing on education, employment, and the health of the mothers and her dependents. The Obama administration used an integrated health approach to health policy regulations and created equitable revisions to existing health policies on focus on the reproductive health rights of women, among other legislation. The passage of the ACA in 2010 included unique designed provisions for reproductive preventative health services and specifically outlined how women, regardless of race, can access healthcare systems and services (Cantor et al., 2012; Shaw, Asomugha, Conway, & Rein, 2014). This legislation standardize care among women in the reproductive health phase of the lifespan was an attempt to reframe health policies, to address reproductive health care gaps based on life course principles. Implementation of equitable health insurance coverage was recognized as a catalyst to healthcare engagement, but populations the have lived experience of low literacy were negatively impacted by this change, as they were challenged with interpret their health benefits (Monk, 2015). Individuals with lived experiences of low literacy were placed in the situation where they were required to understand and apply the new health policy law to access and utilized health care systems. When individuals lack the necessary skills to comprehend written, visual, or verbal communication disparities are created. Among all the populations affected by the new health policy was African Americans residing in urban communities. With limited resources, and mistrust of the healthcare system, and its providers of services, posed challenges in how public health social workers and other health professionals engaged reproductive health mothers into newly designed services that provide expanded services without placing monetary constraints on an individual such as copayments (Boulware, Cooper, Ratner, LaVeust, & Powe, 2003). Through this legislation public health social workers received additional training on how to engage hard to reach populations. Working especially with African Americans reproductive health mothers that have lived experiences with low literacy and engage into care in a FQHC setting, has allowed public health social workers and other health professionals to help inform this population to grasp the key concepts to health insurance (Boulware et al., 2003; Wright, Bird, & Frost, 2015). Some of the services provided through the ACA include the following:

Well-mothers' visits
Screening for gestational
Human papillomavirus testing
Counseling for sexually transmitted infections
Counseling and screening for human immune-deficiency virus
Contraceptive methods and counseling
Breastfeeding support, supplies, and counseling
Screening and counseling for interpersonal and domestic violence (Health Resources and Services Administration, 2017)

Again, exposure to these essential reproductive health services is based on one's familiarity, cultural, and generational acceptance of health care system supports (i.e. public health social worker), which may or may not have had a positive or negative influence throughout one's life course (Richardson & Norris, 2010).

While, the ACA stabilized reproductive health services, the Trump administration and Republican allies have represented substantial legislative constraint. Passing, such decisive restriction significantly redefined how reproductive health mothers engage in healthcare. For example, FQHC's could lose funding to support the Medicaid expansion, insurance coverage that creates access to reproductive marginalized populations (Pourat, Bonilla, Young, Rodriguez, & Wallace, 2018). Other beneficial provisions that could disappear or limits how FQHCs and medical providers offer reproductive and sexual health services for mothers (i.e. no cost birth control) and limit their ability to provide quality-based health education, screening, and the development of reproductive life planning (Roye et al,, 2018). This is surely not the way Americans should treat those suffering from the misfortunes in life created by the SDOH and who are systematically placed in crushing poverty circumstances and violates their basic human rights.

## Reproductive Health

When reviewing the reproductive health literature, there are varying accounts of the challenge's mothers have experienced when determining which decision meets their overall health goal, particularly in the area of reproductive health planning. The literature provides several accounts of healthcare access among mothers which focuses on general health services and less on the reproductive phase of the lifespan. Bird, Wright, and Frost (2016) present historical health system challenges that have prevented mothers from accessing reproductive health services that offer equitable counseling concerning family planning options. The notion that reproductive health service in this nation are reactionary and not preventative poses a challenge for marginalized mothers to make informed decisions regarding their health. For example, mothers residing in marginalized communities are often influenced by environmental factors (i.e. legislation) that determine how and when reproductive health services can be accessed (Bird et al., 2016). Globally, mothers in South Africa and India experience similar challenges within health systems concerning reproductive health. In South Africa, mothers have full access to reproductive health services and information, however, governmental policies prevent individuals from comprehending family planning option, which minimizes one's ability to develop achievable reproductive goals (Waldman & Stevens, 2015). In India, mothers in the reproductive health phase are limited to their exposure of family planning options (Banerjee et al., 2015). This is largely due to spousal influence, which further minimizes a woman's ability to make an informed decision about their personal reproductive health goals. Moreover, multigenerational beliefs and perceptions of reproductive health services often pose challenges to engaging in care (Lewis et al., 2016). Furthermore, the issues of racism, perceived stereotypes, race, and melanin type also purport unspoken challenges to minority mothers engaging in reproductive health care (Lewis et al., 2016).

While stated challenges continue to exist, health policy and developed legislation are the ultimate drivers of what constitutes equitable reproductive health care throughout the life course. Under Reagan's administration, reproductive health decision making options were limited to those of reproductive age, and mothers less than 18 required parental consent to access, receive, and make informed decision concerning family planning options (Bird et al., 2016).  This process of decision making is truly a breach in confidential, but perhaps one could suggest that involving an adult or someone over the age of 18 help eradicates issues surrounding low literacy and comprehension. According to Shaw, Asomugha, Conway, and Rein (2014), the ACA of 2010 has standardized how public health entities design and provide reproductive and sexual health services to all populations regardless of social or economic class. This new approach to care transformed the view of how the patient receives care and now empowers them to have a voice in the decision-making experience when it comes to their healthcare. Averitt Taylor (2014) provides a historical context on how reproductive health policy has served as the cornerstone of a woman's existence. However, there has not been a definitive definition of what "reproductive health" means. Averitt Taylor (2014) further speaks to the global disparity as to how health policies continue to create a disparity among minority populations and categorizes care based on economic status, which further perpetuates inequitable standardizations to services when accessing reproductive health care.

Health policy has designated reproductive health as preventative health, it does not account for the learning styles or environmental challenges of women. SDOH, for example low literacy, can create challenges for mothers attempting to engage in services designed to develop life goals and reduce the occurrence of subsequent, or unwanted pregnancies (Stringer, Averbuch, Brooks, & Jemmott, 2012; Yee & Simon, 2014). While the determinants of health create challenges, Miller et al., (2014) also adds that reproductive coercion or the strong suggestion of certain family options is a challenge that is not covered by health policy and should be considered when engaging mothers into reproductive health care. According to Bello, Adkins, Stulberg, and Rao (2013) to assist mothers in developing a reproductive health plan, there must be some acknowledgment of personal behaviors as it relates to developing a meaningful goal that consist of appropriate family planning and completing educational, career, and health goals set by woman and not the public health social worker or other health professional.

## Literacy

Conceptualizing generational heritages and foundational beliefs relating to the history of linguistically formulated experiences among African American reproductive mothers purports us to understand differing perspectives inside and outside of what is considered literacy. Throughout history, African American reproductive mothers have been recognized as the backbone to the fundamental learning experiences of their children and have defined what parental involvement represents (Jackson & Remillard, 2005; Keim-Malpass et al., 2015). Looking through a societal lens suggest that parents are responsible party and should be held accountable to provide formative learning opportunities (i.e., reading, writing, comprehension), which promotes how children can communicate effectively throughout the lifespan to prevent issues of low literacy (Dale, Tosto, Hayiou-Thomas, & Plomin, 2015; Schenker & Petrill, 2015). Harris, Khami, Pollock (2001) research suggest that parental inclusion at the emergent literacy phase of the life course (i.e., 0-5 years of age), particularly those among populations of African American descent, is perhaps a method to improving necessary comprehension skills in reading and writing (p.127). However, according to Jarrett, Hamilton, & Coba-Rodriguez (2015), African American families foresee the literacy experiences as the positive relationship among multigenerational familial supports and beliefs to strengthen these skills should best be offered through the verbal articulation of ancestral folksongs and storytelling life lessons (Heath, 1989). Harris et al. (2001) notes that parents or households with low-literacy challenges, fail to recognize the importance of written comprehension and how learning happens when there is access to or the promotion of reading materials (i.e., books, newspapers) or activities that promote literacy enrichment in the home environment (pp. 136-142).

While it is challenging to normalize literacy standards in one's home environment or based on race, the role of multigenerational icons in the African American is cultural unique, whereas the mother is held responsible for the essential growth and academic development of a child (Monk, 2015; Willis, 2015). As mothers prepare their adolescents to transition into the emergent adult phase, Mahiri and Sablo (1996) and Gupta et al. (2016) discuss the prevalence of health literacy challenges among African American adolescents as being misunderstood linguistically due to presumed cultural identity and task that are not reflective of their environment. Transitioning into an emergent adult is complex and can represent difficulty when required to make decisions about one's health and well-being, mainly when the issue of low literacy is present (Marshall, Sahm, & McCarthy, 2012). However, societal norms require emerging adults to access and process information in the most efficient manner, particularly as it relates to decision making process. It is critically imperative that this transition in the life course take place as emerging adults begin to shape the health of the future (Huang et al., 2014). Hart, Blacker, Panjwani, Torbit, and Evans (2015) and Gupta et al. (2016) also suggest that those in the emergent adult phase, with experiences of low literacy, be exposed to communication tools including informational videos, feedback tools including booklets and presentations, and health information to simplify and strengthen informative communication with providers in the healthcare environment.

Moreover, as the trajectory of life begins at the onset of life, McCormack, Thomas, Lewis, and Rudd (2017) recommend healthcare systems (i.e., FQHCs) and staff (i.e., public health social workers) utilize a patient-centered perspective to meeting the comprehensive needs of patient and tailor services and care based on appropriate literacy level. McCormack et al. (2017), implies that by utilizing a system level approach to addressing the issues of health literacy among all populations, their creating the patient-centered environment to allow knowledgeable decisions regarding personal health choices. Browne, Darnell, Savage, and Brown (2015) research suggest that public health social workers working in the healthcare environments are to also consider low literacy experiences as a social determinant of health, as it plays a pivotal role in how one engages into services, for example, reproductive health planning. For instance, Roter et al. (2015) research presents the Healthy Babies Healthy Moms as a model for eliminating issues of literacy among emerging adult African American reproductive mothers in the reproductive health phase. The Healthy Babies Healthy Moms model utilizes an electronic platform to visually prepare mothers to gain confidence in talking and asking questions of medical providers to help simplify complex medical terminology into plain language that is understandable regardless of literacy level. What this model does could mode well in assisting public health social workers to facilitate the meaningful engagement to developing a robust reproductive health and life plan.

## Summary and Conclusions

While various health care systems have attempted to bridge the gap between academic learning and health policy rhetoric, there is a need to understand how designed services could assist emerging adult African American reproductive mothers with overcoming barriers formed by lived experiences of low literacy that empowered them to become leaders of the personal health, but also help in the development of achievable reproductive health goals. However, before the development of a comprehensive reproductive health plan, healthcare organizations must acquire what constitutes basic literacy and how to convey health information on topics such as family planning, career, education, and health and wellness goals (Brinkley-Rubinstein, Bethune, & Doykos, 2015). Thus, the need to attentively focus on the current version of the ACA, as it defines reproductive health service standards for women, which purports quality-based care that is inclusive of health literacy standardization (Keim-Malpass et al., 2015).

# Chapter 3: Research Method

## Introduction

The purpose of this qualitative phenomenological study was to explore the lived experiences of emerging adult African American mothers with low literacy regarding their engagement in the development of a reproductive health and life plan. The perceptions of participants highlight the challenges created by decades of reproductive health policies, multigenerational cultural experiences and belief systems, and differing health engagement approaches designed for public health practice. I individually interviewed 10 study participants; I analyzed the collected data using a template approach and thematic analysis. This chapter contains a comprehensive overview of the research method and design and rationale, the role of the researcher, and issues of trustworthiness, including ethical considerations.

## Research Design and Rationale

I used phenomenological inquiry to explore the lived experiences of low literacy among emerging adult African American mothers who have faced challenges when developing reproductive health and life goals. This approach allowed me to understand a phenomenon that has not yet been fully examined in the social work literature (Groenewald, 2004). I collected data using the following research questions:

1 How do lived experiences of low literacy affect emerging adult African American reproductive mothers engaged in reproductive health care services within an FQHC setting?

2. How do lived experiences throughout the life course of emerging adult African American reproductive mothers create challenges during the development of a personalized reproductive health plan?

## Role of the Researcher

Managing personal bias is a necessity when conducting a qualitative study (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). As the primary data collection tool, I recognized the connection between reproductive health mothers residing in urban communities and public health social workers providing services in an FQHC environment. I have worked in maternal and child health practices that are embedded in an FQHC for over 17 years and having served in multiple roles as a case manager, manager of both case management and outreach services, and the project director of an infant mortally reduction program. In these roles, I have observed numerous emerging adult mothers engaged in reproductive health care and struggling with defining reproductive health and life goals. Considered an expert in the field of public health, I have found the opportunity to research ways to reframe the narrative of reproductive health policies to meet medical and social needs of marginalized women to be eye opening. The lived experiences of participants may serve as a catalyst of social change to advocate for equitable reproductive rights among all races.

To reduce bias, I upheld the ethical standards of the social work code of ethics (National Association of Social Workers, 2017) and used integrity and responsibility to interview participants with low literacy who are engaged in reproductive health care at an FQHC but currently receive case management services at the partner agency, an urban-based community organization. Working in tandem with the partner agency eliminated the imbalance of power possible because of my role as an administrative public health social worker. My role could have intimidated and persuaded study participants to not reveal their lived experience during the interview process. Study participants were not compensated; they served as volunteers to share their story, which minimized harm (see Polacsek, Boardman, & McCann, 2016; Zutlevics, 2016).

## Methodology

### Participation Selection Logic

I explored the phenomenon of low literacy among emerging adult African American mothers residing in marginalized communities. I gained Walden University Institutional Review Board approval before the recruiting process began; the approval number is 07-24-19-0536437. Study participants were recruited from the partner agency, which is situated in an urban setting, and were currently enrolled in and receiving case management supportive services. The partner agency has a long history of working with marginalized reproductive health mothers to develop tangible goals and soft skills to address their SDOH resource gaps (e.g., literacy deficits). I sent a formal letter to the partner agency to confirm its support (see Appendix A). Before moving forward with the recruitment process, the partner agency signed a letter of corporation. The partner agency also works in tandem with several urban FQHCs and has confirmed participants' health literacy level in advance by working with the public health social worker to determine participants' Rapid Estimate of Adult Literacy Health Literacy scores. I developed a flyer, which utilized literacy standards and was designed at a sixth-grade reading level and distributed it at partner agency activities.

I verbally articulated the letter for participants concerning the purpose of the study (see Appendix B). Individuals agreeing to move forward with the study were provided with an informed consent form, which was read to them with time allowed to ask questions concerning their rights and responsibilities to share personal information (Creswell, 2014; Jimison, Sher, Appleyard, & LeVernois, 1998). I used a purposeful sampling approach to select study participants. I selected 10 emerging adult African American mothers to ensure that saturation was reached and to also account for attrition (Palinkas et al., 2015). A sufficient sample size may assist in noting powerful themes to inform future public health social work research on how to effectively advocate for equitable reproductive health policies that consider the lived experiences of low literacy of a population when developing laws (see Malterud, Siersma, & Guassora, 2016). The use of a structured interview approach was helpful in capturing the unique perceptions of low literacy among emerging adult African American mothers. By using this interview approach, I was able to highlight rich contextual information related to the barriers encountered when using a reproductive life plan to develop health and life goals (Fusch & Ness, 2015).

## Instrumentation

I used a structured interview protocol (see Appendix C) that included probing questions to fill in the gaps of the interviews when responses were not clear (see Turner, 2010). The interview guide questions were developed based on the literature (Braken, &

Fischel, 2008; Emery, Reid, Prevost, Ravine, & Walter, 2014; Eram, 2017; Guzzo & Hayford, 2018; Landry & Frost, 2008; LeCuyer-Maus, 2003; Lynn, 2006; Malacane & Beckmeyer, 2016; McKenna, Dennis, & Randolph, 1995; Reamer, 2018; Span & Anderson, 2005; Stones et al., 2017). There were six open-ended questions on the participants' perceptions of their family's place of origin, how they learned how to read, how they engaged in reproductive health services at a FQHC, familial beliefs on family planning services and selected method, and the type of relationship developed with the public health social worker or other health professional. I administered the same interview protocol and asked the same questions to all 10 participants. However, when a study participant displayed any level of discomfort when asked any question during the interview, I moved on to the next question; oftentimes, I captured the needed response to a previous question through ongoing conversation. Additional use of observational notes, recorded interviews, transcripts, and member checking with study participants improved data collection and ensured that researcher bias was minimized (Singh, 2014).

## Procedures for Recruitment, Participation, and Data Collection

The following procedures helped contact, consent, complete interviews, and analyze collected data. Once the Internal Review Board approved the study, the interview protocol was piloted with three participants to establish research integrity and displayed the care replicating questions among other study participants (Ravitch & Mittenfelner-Carl, 2016). Working in in tandem with the partner agency, I received permission to come on site to distribute the study flyer.  Flyers were passed out at the end of program activities. Participants expressing interest shared their phone numbers for future contact, and there were some that agreed to participate upon receiving the flyer. Participants that met the studies eligibility criterion and expressing interest received a letter describing the purpose of the study. I used purposeful sampling to recruit interested participants to participate in the study. Those agreeing to serve as a participant in the study were briefed on the study and received an informed consent form detailing the purpose of sharing their personal lived experiences with low literacy and engagement with reproductive health care services (Groenewald, 2004). Interview appointment times were confirmed, structured interviews, with additional probing questions, were completed at the Chicago Public Library in a meeting room. All interviews were recorded to ensure all information was captured to its entirety. There was a total of 10 interviews completed and lasted no longer than 45 minutes and it took 60 days to complete all interviews. I transcribed all the interviews manually and followed up with study participants to ask additional questions that arose in other interviews.

I followed-up with study participants within to two weeks of the interview to debrief and ask clarifying questions needed to complete the interview process. This process included informing participants on what was captured, what was said, for them to add additional comments, and I also asked additional questions, when applicable (Creswell, 2014).

## Data Collection

The goal was to complete all interviews in 120 days, with each interview lasting no longer than 90 minutes at a time. The interviews started in August 2019 and ended September 2019. The first part of the interview is to develop a fiduciary relationship and sign the informed consent form to establish the roles and responsibilities between me and the participant. To de-identify names, and to ensure confidentiality, each interviewee received a designated interview number (i.e., 001, 002). All study participants had the right to withdraw from the study at any point and time during the interview or post interview process. Should a participant withdraw from the study, data would have been shredded and discarded. Once researcher-study participant relationship was created, the interview guide questions established the origin of the participant's family generational connection. The next question established the participants learning style, and the level of literacy was provided by the partner agency. The next question determined how participants engaged in reproductive health care services. The next question gained insight on familial and personal beliefs regarding family planning options and usage. The last question gained insight into how the public health social worker is instrumental in providing explanation or assistance in developing a reproductive health plan. I used observational notes to compare with transcribed recordings to ensure there was no missing data. Reviewing the interviews at their completion, along with review of observation notes, and then going back over the audio, there were consistent patterns that presented from the text, hence the acknowledgment of reaching saturation with the 10 completed interviews.

## Data Analysis Plan

To assist with grounding I started the study, Epoche was employed to ensure that personal and professional bias where in order. Use of bracketing to ensure that when participants spoke of their lived experiences that were not influenced based on my perceptions (Bednell, 2006). While I served as the primary data collection tool, use of a semi-structured interview protocol, audio recordings, transcribed interviews, and observational notes captured all the participants' data. I used a template analysis to help develop a codebook to capture the initial codes of the study, which were derived from the principles of the life course theory. Use of a data book also helped to define terms and organize data to display categories, emerging themes, and patterns in the collected (LaPelle, 2004). Use of a template analysis provided six phases to analyzing the collected data: (1) Developing the coding manual, (2) Testing the reliability of codes, (3) Summarizing data and identifying initial themes, (4) Applying template of codes and additional coding, (5) Connecting the codes and identifying themes, and (6) Corroborating and legitimizing coded themes (Braun & Clarke, 2006; Crabtree & Miller, 1992). Use of a thematic analysis helped perform a data analysis of collected data in a manual process, which was supported by NVivo 12 data management software (Fereday & Muir-Cochrane, 2006; Vaismoradi, Turunen, & Bondas, 2013). Application of these additional six phases helped to simplify and yield results of the study: (1) Familiarize yourself with the data, (2) Generating initial codes, (3) Searching for themes, (4) Reviewing the themes, (5) Defining and naming themes, and (6) Producing the report.

Sotiriadou, Brouwers and, Le (2014) suggest that NVivo software is a data management tool used in qualitative research. All transcribed data was entered in the NVivo 12 to helped code collected data in one location, assisted in transferring transcribed interviews into file folders, which simplified the coding process, and to highlighted associated themes discovered in the study. Use of this type of data management software provided a platform to store transcribed interviews, create nodes, cases, and display the relationship of collected data. NVivo 12 has diverse functionality and provided various visual options, for example graphs, to highlight key data points, that allowed for comparison of participant responses regarding a theme.

Use of these two forms of data analysis helped to provide structure to large amounts of data, in which was coded four different times, and by looking at theme clusters, I was able to utilize both approaches to finalize emerging themes of the collected data. Both forms of analysis provided an in-depth critical thinking process to understand the lived experiences of low literacy among emerging adult reproductive health mothers but provided a great deal of detail to understand the myriad of challenges participants faced with making decisions about their reproductive health and life plan.

## Issue of Trustworthiness

Shenton (2004) discusses multiple approaches to achieving trustworthiness when employing phenomenological research. As the primary instrument collecting data, it was important to manage personal bias (Ravitch & Mittenfelner-Carl, 2016). Working closely with the selected partner agency, I established credibility among possible study participants during the recruiting phase of the study by being located onsite for participants to ask questions and receive feedback on the nature of research. The use of purposeful sampling helped to identify recruited participants that would provide rich data related to the phenomenon. The establishment of transferability will allow for the replication of the study's findings among emerging adult African American reproductive health mothers who have literacy deficits and engaged in reproductive health planning at

FQHC's located in similar communities (Shenton, 2004). Establishing confirmability at the onset of the study allowed I explored the real understanding of the actual barriers formed based on the lived experiences of low literacy among emerging adult African American reproductive mothers. Completing multiple interviews based on the developed interview guide helped provide insight into the posed research questions (Shenton, 2004). The use of a template approach, thematic analysis, and entering data into NVivo 12 helped define recurring themes and patterns of behavior shared similarly by the participants. Dependability was established by creating observational notes, jotting down reflections of the interview process and communication shared by participants, and data collected from interviews.  Lastly, connecting with study participants to perform member checking helped establish a feedback loop during and after the interview phase of the study for the reaffirmation and clarification of shared information (Birt, Scott, Cavers, Campbell, & Walter, 2016).

## Ethical Procedures

I gained Institutional Review Board approval to ensure that the study did not pose harm to emerging adult African American reproductive health mothers with lived experiences of low literacy. The site selected for this study helped to establish professional boundaries. Instead of recruiting mothers from their designated FQHC, upheld a participant’s desire to keep issues of low literacy confidential and not jeopardize the primary medical care at a FQHC for expressing their honesty about care. The study proposed minimal to no harm, as the environment in which they receive reproductive care was informed of information shared during the interview. Participants signed an informed consent form that explained their ability to participate or withdraw from the study at any point if they wish not to continue with the interview. Information collected was transposed into themes and used to inform public health social workers to advocate for health policy laws that no longer create barriers to care. Study participants have full anonymity in how they confidentially share their lived experience of low literacy challenges and the barriers experienced when engaged in reproductive health services in a safe environment. Should a participant had expressed any emotional challenges that goes beyond the researcher's professional capacity, were referred to their public health social worker located in the FQHC where the participant received reproductive health services. All informed consent forms, identified data, transcripts, and observational notes remained confidential, were encrypted and password protected, and paper copies were stored in a locked file cabinet. Data was be de-identified with a numerical value when transcripts were completed. There was no excluded data from the study. Analyzed data will be disseminated within the Walden University community and if published, de-identified data will be shared with the public health and social work community.

## Summary

FQHC's continue to depend on regulated laws to guide their service delivery across the health system. However, existing legislation does not account for the implementation of designed rules that are concerned about race and learning styles. Use of a phenomenological qualitative approach helped to inform policy representatives on how to best tailor health policy rhetoric that is aimed to improve the SDOH, such as low literacy, of African American reproductive health mothers engaged in care at urban

FQHC’s in marginalized communities. The findings from this study are discussed in Chapter 4.

# Chapter 4: Results

## Introduction

There is a need to understand how health policy influences how emerging adult African American mothers engage and utilize reproductive health care services in FQHCs. In this qualitative phenomenological study, I explored the lived experiences of low literacy of African American reproductive health mothers who have transitioned from the adolescence phase of the lifespan and are now emerging adults responsible for making choices related to their overall health and life course (Borelli et al., 2018; Lewin et al., 2019). U.S. educational institutions have developed systematic constructs to ensure that no child is left behind, so matter what the learning disability may be, children were pushed forward to next level of education, even if they were not prepared. However, African American children remain at a disadvantage in receiving equitable learning experiences tailored to their learning style (National Association for the Education of Young Children, 2018). There are systematic regulations created through the ACA and instructions outlined in the Plain Writing Act of 2010 that require all health systems engaged in patient care to develop systematic protocols to address and create appropriate literacy material for all populations entering care, regardless of race (Marquez & Ladd, 2019).

Many health care organizations have made the necessary strides to implement screening tools to identify literacy levels, for example, the Rapid Estimate of Adult Literacy in Medicine scale (Dumenci, Matsuyama, Kuhn, Perera, & Siminoff, 2013). However, there continues to be a disconnection in how urban African Americans populations engage with public health social workers and other health professionals located in FQHCs to develop essential reproductive health and life plans (Cheng et al., 2020; Seibert et al., 2019). The historical underpinnings of an FQHC are to ensure that all patients, regardless of race, receive equitable health care services throughout the entire lifespan (National Association of Community Health Centers, 2018), but the lived experience of low literacy can create unknown challenges.

In this qualitative phenomenological study, I explored the lived experiences of low literacy among African American reproductive health mothers engaged in reproductive health services in FQHCs located in urban communities. My goal was to understand the reasons why low literacy challenges have continued to create barriers for emerging adult African American mothers when engaging with public health workers to develop meaningful reproductive health and life plan goals. The research questions were as follows:

1. How do lived experiences of low literacy affect emerging adult African American reproductive mothers engaged in reproductive health care services within an FQHC setting?
2. How do lived experiences, throughout the life course of emerging adult African American mothers, create challenges during the development of a personalized reproductive health plan?

In this chapter, I present the findings of this study. I describe the approach employed in recruiting study participants, the selection criteria, how interviews were conducted, and analysis of themes and patterns from the data collection process. I begin the chapter by describing the study setting. This section helps to conceptualize the results.

## Setting

I used the Chicago Public Library meeting rooms to ensure that study participants felt safe and that information shared remained confidential. There was a total of 10 interviews completed. I believe that the collected data captured the participants' perceptions and lived experiences of low literacy when engaging with reproductive health services. Participants sharing their stories were influenced by the need to be heard concerning their reproductive health choices.

## Demographics

Ten emerging adult African American mothers responded to the flyer that I distributed at the partner agency workshops. All women reaching agreeing to participate in the study met the eligibility requirements. The inclusion criteria were as follows:

- be an African American mother,
- be 18-25 years of age,
- been pregnant in the last two years,
- receive care at a FQHC, and
- be enrolled in the partner agency.

A study participant who acknowledged currently being pregnant and/or are under the age of 18 or over the age 26 was not considered for the study. The interview process ended, and the participant was thanked for volunteering their time to participate in the study. It is important to note that I did not include a formal screening or assessment to determine pregnancy status.

Of the 10 African American reproductive health mothers meeting the set criteria, all were classified as emerging adults and verbally acknowledged they were between the ages of 18 to 25 and were receiving their health care at a local FQHC, the partner agency. They then completed the informed consent forms. The partner agency's designated staff confirmed the study participant's health literacy level using the REALM Literacy Scale, which measures a person's ability to read at least at a high school level to as low as a third-grade level (Dumenci et al., 2013).

## Data Collection

I recruited study participants for this study by collaborating with the identified partner agency. I distributed flyers over a three-week period. Using purposeful sampling I identified 10 African American reproductive health mothers in the reproductive health phase, all consented to participate in the study. I utilized the developed interview protocol with semi-structured question to support the developed research questions. I completed in-person interviews and each one lasted up to 30 minutes. Due to the nature of the open-ended questions posed and the targeted population, responses were short, hence the need to ask probing questions. Recruitment of study participants started August 2019, and the data collection process began August 23, 2019 and concluded September 19, 2019.

All interviews took place at local public libraries near public transportation. The selected location was deemed safe as participants and I had to check-in with librarian to gain access to a secure meeting room that allowed for confidentiality to be met. All study participants displayed a willingness to answer all posed questions. All participants remained committed to the study and participated in the member-checking process at the completion on the initial interviews. When response or questions were outside of the researcher's expertise, participants were referred to the partner agency or their designated FQHC. To ensure that all participants remain confidential the names were coded in a numerical value. The purpose of conducting the study is to understand how low literacy contribute to making reproductive and life goal plans with public health social workers. There was a total of six questions asked and answered, then group with the posed research question.

Interviews were recorded, and observational notes were created to assist in capturing non-verbal response and follow up questions at the conclusion of the 10 interviews. At the conclusion of each interview, I manually transcribed all interviews verbatim in Microsoft Word, which took at least 1 ½ to 2 hours to transcribe. There was a total of 34 pages transcribed and uploaded to NVivo 12 software to initiate the coding process. All coding was completed in NVivo and by hand to capture codes and patterns of collected data. Upon rereading the transcribed interviews and to validate the selected codes, emerging themes were identified. All interviews and consent forms were stored in a locked file cabinet when not in use. All electronic data was saved as an encrypted file on a storage drive that was password protected.

## Data Analysis

Before initiating the data collection and analysis process, I used a feeling audit or epoche (Bednell, 2006), to set aside past personal and professional bias, but also check preconceived perceptions of the selected population, and health policies the determine how reproductive health services are prescribed. Bracketing was used to openly allow the lived experiences of low literacy among emerging adult African American mother participants to emerge as the result of the study, and not those of the researcher. A total of six questions that aligned with the two research questions, along with probing questions to eliminate coercion of responses from participants. When asking for a point of clarification of participant responses, there was an acknowledgment of the statement previously provided, and on some occasions, more information was provided.

Used as the primary mode for the data collection process, interviews, and observational notes were manually transcribed then entered NVivo 12, a data management software, to create graphs explaining the data. Excel was used to create a codebook to organize collect text based on the life course theoretical approach for initial coding (Crabtree & Miller, 1992). Several rounds of coding were completed, in which the results displayed several themes to understand the phenomenon.

There was a large amount of data collected from the completed interviews. To perform a rigorous data analysis that yielded unbiased results, I used a template approach and thematic analysis as a mode to set a structural framework which reveal vital emerging themes (Braun & Clarke, 2006; Crabtree & Miller, 1992; Fereday & Muir-Cochrane, 2006). I used a template approach and thematic analysis (see Figure 1) and the following stages of coding data were followed:

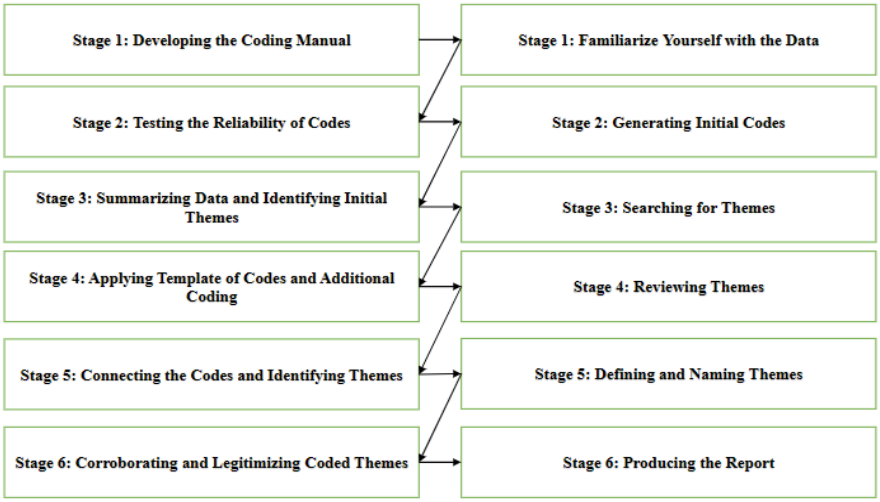

*Figure 1.* Template approach and thematic analysis.

## Stage 1: Developing the Code Manual and Familiarizes Yourself with the Data

As indicated by Miller and Crabtree (1992), the use of a template approach or “codebook” in qualitative research to help the novice researcher to become familiar with large amounts of text. A codebook was developed in Microsoft Excel after all interviews were completed. Becoming familiar with the recorded interviews was the next to help with jotting down more information not previously heard.  Collected text (i.e., interviews, observational notes) was then manually transcribed verbatim into individual transcripts. After completing all the beforementioned steps, rechecking transcribed transcripts, matching against the audio, and collected notes, helped to begin connecting initial codes with the research questions and life course theoretical framework (Braun & Clarke, 2006).

### Stage 2: Testing the Reliability of the Code and Generating Initial Code

In this second phase of data analysis, the codebook reliability was tested to affirm if initial coding was accurate. Upon review, the codebook remained the same, and the descriptions are also relevant. I jotted down initial patterns based on the repeated occurrence of particular words expressed by study participants articulated perception related to the phenomenon in Excel.

### Stage 3: Summarizing Data and Identifying Initial Themes, Searching for Themes

In the third phase, I reorganized interview questions to align with the research question, to set the framework of understanding the relationship between captured patterns. In tandem with this process, thematic mapping was used to come up with initial patterns (see Figure 2). This information was entered the codebook for tracking purposes.

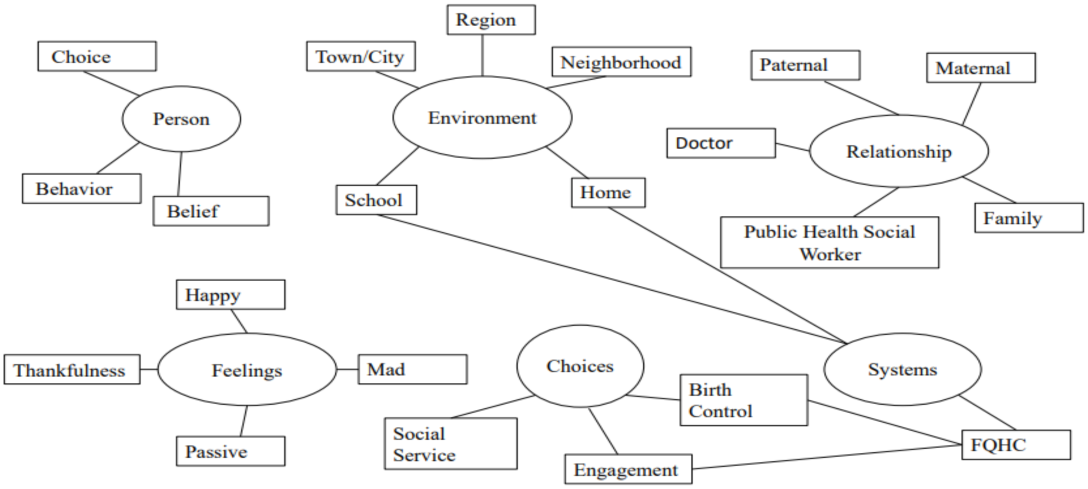

*Figure 2*. Initial thematic mind mapping.

### Stage 4: Applying Template of Codes and Additional Coding, Reviewing Themes

During the third phase, all transcribed documents were entered NVivo 12. Developed patterns where defined by nodes in the data management software. Data was then pulled from each transcript and entered under initially developed nodes in NVivo. When appropriate, new nodes were created separately and merged with other nodes when applicable. Further use of a two-level approach of reviewing preliminary themes and the connection with developed patterns were re-coded and assigned to similar nodes and to encompass more of the participant's responses upon reviewing the data over and over.

## Stage 5: Connecting the Codes and Identifying Themes, Defining and Naming Themes

Figure 3 illustrates the mind mapping of final themes.

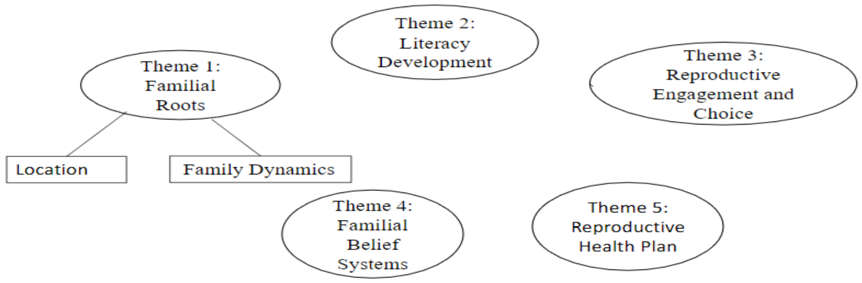

*Figure 3*. Final thematic mind mapping.

## Stage 6: Corroborating and Legitimating Coded Themes, Producing the Report

During this last phase, I reviewed all previous steps with a critical eye to ensure all data was included to begin writing up the thematic analysis to display the story of African American reproductive health mothers with underdeveloped reproductive health plans and making reproductive health choices that are not based on individual goals. As a phenomenological study, I explored the lived experiences of low literacy among emerging adult African American reproductive health mothers engaged in the development of a reproductive health plan. Study participants all reside in urban communities and engage in care at urban FQHCs. Participants articulated their perceptions of their life experiences that contributed to making the “best” decision as it is related to birth control options.  Use of a semi-structured interview protocol served as a roadmap to explore a meaningful experience through conversation, sharing of personal information that helped to inform how public health social workers can advocate for health policies that incorporate an individual’s learning style and history of life development in order to make an informed decision about their overall health.

## Evidence of Trustworthiness

Use of a phenomenological approach helped to examine the study results. Establishing creditability helped to understand collected data to display the connection between expressed perception of the lived experiences of low literacy and how their respective environmental experiences have contributed to establishing barrier when engaged into reproductive health services (Shenton, 2004). All interviews were recorded, and observational notes were jotted down to capture nonverbal and verbal expressions of the study participant. Used of a template approach helped develop initial codes for each interview, which captured the continuous patterns of the expressed perceptions of study participants. Additional use of a thematic analysis helped to perform an analysis of derived patterns from the developed codes to define emerging themes.

Establishing transferability for future studies is limited to the selected populations gained from this study. The results have added value to public health social workers, and other health professionals, seeking to develop equitable organizational workflows to align with how people learn, which is currently not based on regulated health laws. While captured themes highlight the lived experiences of low literacy among emerging adult African American reproductive health mothers in urban communities, one should consider the familial background of the selected population before applying the findings from this study.

Rechecking the data after each interview always ensured that I remained unbiased. Following up with the study participants after all data were transcribed and coded; I was able to ask follow-up questions that arose in various interviews. Lastly, jotting down what was observed, also helped to ask questions in multiple manners to ensure that study participant understood the question. For example, when requesting the participant to discuss their reproductive family planning choices, I had to use the language “birth control method” to simplify the asked questions.

## Results

The first research question was, How does the lived experiences of low literacy affect emerging adult African American reproductive mothers engaged in reproductive health care services within an FQHC setting?

### Theme 1: Familial Roots

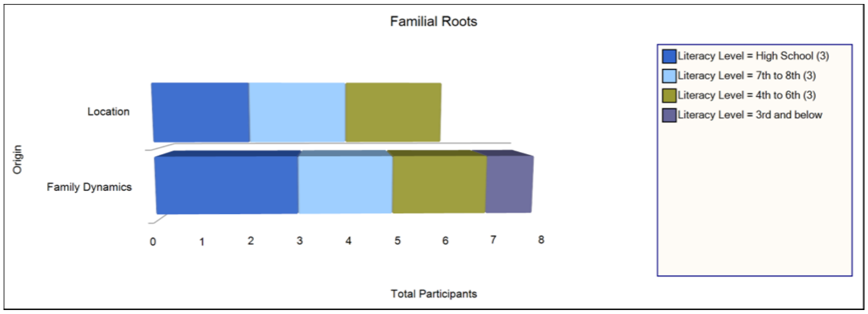

*Figure 4.* Familial roots.

**Location.** The use of the life course theory suggest that familial connections establishes a person life trajectory. To understand how study participants, connect with their respective families, I asked them to tell me how they would explain their family's origin (i.e. family history). This question served as an ice breaker, to relax and provide insight on their family history. All responses were different, whereas only six participants could speak to their connection to a location in the country or even locally. For example, three participants identified their family roots as being connected to "down south." However, only one participant (Participant 004) explicitly stated the following:

> My grandma is like from Arkansas, so it like I know about the slavery and all that. So, I really …I know some of the stuff, but they kept us in the dark for a lot of the stuff. I know my mama use to have to pick cotton with my grandma and great grandma. But that's pretty much it, or that's all I really know.

The other location connected to the south region of the country was Mississippi.

The other location referenced in the interviews was closely to Chicago area ties. Chicago is known for its four sides of town, and the "Westside of Chicago" was identified by three participants. One participant (Participant 006) explained her location as from the Westside of Chicago. I just focus on my immediate family here in Chicago. I don't know about the people down south." The lack of connection to one's family roots diminishes the historical reasons as to how and why an individual function independently in the external environment.

**Family Dynamics.** When exploring the familial roots, eight participants explained their family dynamics in the form of behavior and human connection. One participant stated:

“I think our family is dysfunctional, very dysfunctional” (Participant 001). Upon following up with this participant during the member checking process, she validated her lived experiencing during childhood was filled with continuous emotional rollercoasters. At a very early age the participant was removed from her mother’s custody due to untreated mental health issues and substance abuse usage, hence the identification of dysfunction as a part of the family origin. There were two participants that recognized their family dynamics in connection with their fathers. One participant explained her connection as familiarity: “I’m more familiar with my father’s side of the family.” (Participant 003). However, the other participant, through observational notes, captured the nonverbal expression of displeasure when speaking of her father by stating: “I don’t really know my daddy side of the family.” (Participant 002). When both participants discussed their fathers’ background it was limited and lack the connection to understand a portion of their family’s origin of existence. In addition to the acknowledgement of the presence of their fathers, or the absence thereof, five participants discussed stronger connections among female guardians and family origin. The separation, death, and placement with one participant’s grandmother formed unique experiences among one participant:

> “Umm yeah, I got two brothers, then it’s me, and I got two little sisters, but well we don’t know where they are it, because we all got separated when we were little kids. My mom is deceased now my dad is on earth, but Lord knows what he is doing now. And my foster grandma, she's is deceased now. That’s about it about them.” (Participant 005)

There was an observed sadness when the participant discussed her thoughts about her family origin. Upon follow up the participant did not share more information but did say the question had her thinking about ways to investigate her family history. The next participant acknowledged familial dynamics as the inability to connect with extended family members. This loss of connection was solely due to controlled isolation and exposure to drugs among extended family members. The participant presented the dynamics of her family as the following:

> “Well I don’t know my family like that we know for a family like, it’s just me and mom and her kids. She has isolated us from the family, so I really would not know anything about them. My grandmother is on drugs, I don’t know anything I know her, but my grandfather, but my grandfather, he don't, he don't claim my father, and I know is that they families is really big.” (Participant 007)

The participant did not care to share additional information concerning family dynamics but reaffirmed that information provided was all she could recall from her familial background.

The next participant provided a limited response regarding her family dynamics and stated the following:

> “Like as far as going way back, not very much. Okay, not very much and I just know what's here, what's gone on, like right now, as they grew up my mother, father, and grandmother, that's it no back history” (Participant 008)

When attempting to gain additional insight into this statement, the participant was adamant this all she had to offer concerning her family history. The next participant provided a thoughtful insight in how her family dynamics molded her perspective of origin:

> "I know my grandma because she raised me, because my mom was locked up, and she's not really a good person now. She use to be good when I was growing up. She had me spoiled, but then when I wanted to become a woman. Everything changed with her, she became spiteful and grimy. Yeah actually my mom is now like the best person in my life right now. Well we did not have a great relationship in the beginning, because my grandma raised me to hate her, but then once figured out what really happened, she's actually, the one I go to now. Yeah, I don't really know my family and I don't be around them. I started my own family, so I don't really care about my family." (Participant 009)

The expressed toxic behavior of the participants' guardians formed a disconnection in family ties and strong need to rewrite history through the creation of her own familial roots. The next participant identified the absence of her mother during her upbringing created a strong bond with her father and grandmother, but displaced a connection with her older sibling:

> "My daddy was a very good person, always around and took care of me. I was always with my daddy or my grandmother." My older sister, my sister she was always gone. She left when I was like thirteen or fourteen years old, so I really did not know her but me and my baby sister got along real good." (Participant 010)

The participant expressed a feeling of frustration in our follow up session, in the sense that although her grandmother was present, had her mother been there, all her siblings would have stayed together.

## Theme 2: Literacy Development

Figure 5 illustrates participants' ways of becoming literate by literacy level.

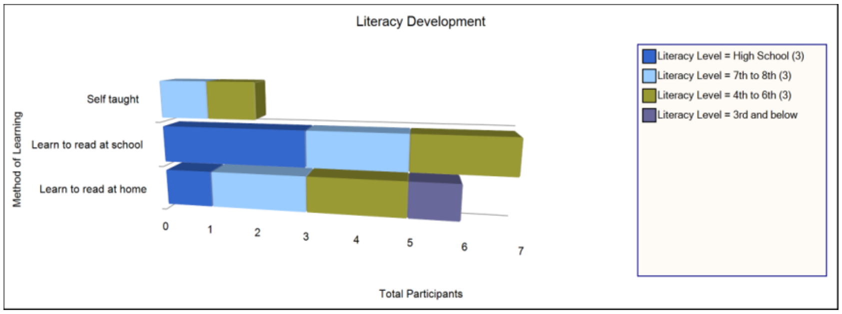

*Figure 5.* Literacy development.

Exploring the lived experiences of literacy development among study participants provided insight on how they learned how to read was influenced either by the school system or various family members. Among study participants those scoring at a high school level of literacy, learned how to read in either the home or school environment, but lacked the remembrance of maternal support. For example, the participant stated the following:

> "Thinking back, I really don't remember, when I first started to read. When I first started reading, so if I have to take a good guess, I would say probably from home or school maybe a mixture of both to make for sure." (Participant 002).

Another participant discussed the challenges of her mother being incarcerated and being raised by her grandmother. The participant solely relied on the school system to learn how to read. The participant stated the following:

> "I had my Kindergarten teacher, I stayed with her a lot. She was one of those teachers that wanted her students to do really good, improve it. She really helped me a lot, she has helped me graduate high school, I mean middle school, yeah, my kindergarten teacher. Yeah it was weird because she's, a kindergarten teacher she doesn't know like you know first, second, third, fourth grade, but she helped me all through high, I mean middle school." (Participant 009)

The third participant (001) provided a response of learning how to read through the school system but provided no further insight on her literacy development process.

Participants scoring at a seventh to eighth grade reading level learned how to read through various approaches, including the home and school environment, as well being read to by their family matriarchs. Three participants provided insight on their experiences:

> "I think more so school taught me how to read, because my mom was always at work. I had to take me and my brothers back and forth to school. So, I think school was the one that taught me how to read." (Participant 004).
>
> "So, I know that my mom read it to me a lot, my brother would also put a selection of words together, so I guess that coming up I really liked spelling bees and children books." (Participant 003).
>
> "We get a lot of books, we did read a lot, my grandma and I picked up from there. I have a lot of cousins as well. We always played school, my mom, my aunt use to read to us, and we read back to them, and then have us say as many words that we would hear them say and we picked that that's how I remember." (Participant 008)

Participants that read between a fourth and sixth grade level experienced learning similar challenges as those reading at a high school level. Two participants lacked the presence of their mother and were essentially was taught how to read either at home or school, or learned on their own, through the teacher, or activities were created by a female figure. Participants shared the following:

> "Our grandma made us read dictionaries on weekends, we could not go outside because we had to read books" (Participant 005)
>
> "I was by myself, I isolated myself from everybody, yeah just would be bored in the room and picking up books, trying to read, wasn't close to my mother when I was younger" (Participant 007)

The last participant scoring at this level of literacy had a team of supports to learn how to read. Through observation, the participant great deal of happiness when affirming her method of learning by stating the following:

> "Godmother, my godmother, and my first-grade teacher she would have me read the same paragraph over and over and over again until I got it. Instead of actually knowing I started remembering that paragraph and then I would just say I would not have to look at the paragraph." (Participant 006)

The participant presented with a reading level that was below a third-grade level. The participants began showing a great deal of emotion when discussing how her grandmother helped her learn how to read. By her own admission, the participant stated her mother was not involved, and stated the following:

> "My grandma see basically my mom was not always around, so really I say my grandma and my aunt. But my grandma stayed on me more about school period than my aunt, like my reading and math, she wanted to make sure I graduated out of eighth grade. Like once I graduated out of eighth grade, she started getting real sick." (Participant 010).

## Theme 3: Reproductive Engagement and Choice

Figure 6 illustrates the participants purpose of engaging into reproductive health services Figure 7 illustrates the birth control methods used by participants by literacy level.

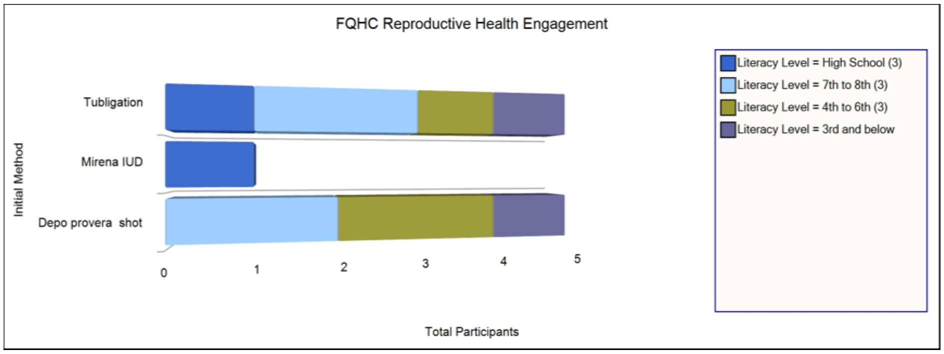

*Figure 6.* FQHC reproductive health engagement.

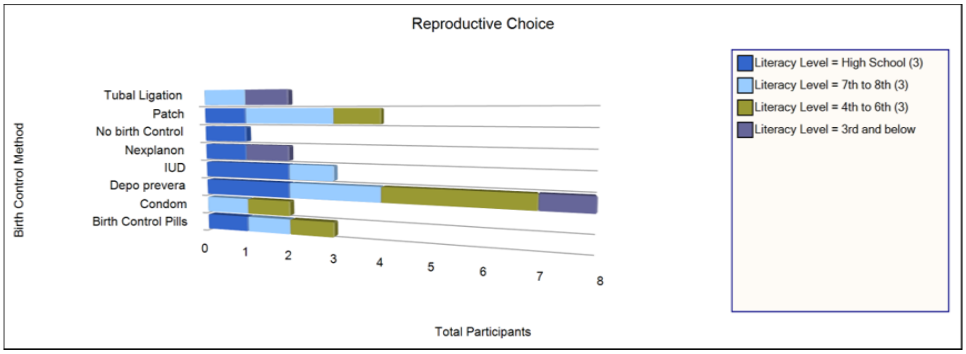

*Figure 7.* Reproductive choice.

In relationship to the literacy levels of 10 study participants, which ranged from a third grade to high school level, capacity to comprehend visually or verbally articulated material was dependent on the style of learning, which is often formed throughout the adolescence phase of the lifespan. The explanation of birth control method choice is complex, whereas an individual must select an option that either meet their needs or alter various aspects of the human body. To recognize the relationship between birth control choice and learning style among participants attending a FQHC are inconsistent based on literacy level.

There were five participants that acknowledged the need to receive content on the different type of birth control methods in visual format before processing their choice. While first participant shared the disbelief of using any form of birth control but did use Depo Provera in previous years. However, when ask how education concerning methods was provided the participant stated the following:

> "I think when I went in, I knew what I wanted. I did not go in looking for because I went in asking what I directly wanted. So, when I asked about the depo shot, they gave me a pamphlet so I could read up on it. I did not ask for options."
>
> (Participant 002)

The second participant expressed a desire to use multiple methods, but due to her "high-risk" lifestyle, the medical provider educated the participant on Depo Provera and stated the following:

> "I was provided a ahh, not a pamphlet, it's like a little a chart and it had a listing of all the birth control and of course I was given a little information of each one.

> So of course, which ever one I liked or wanted to choose he gave me more information. Mainly the ones I inquired about is how the doctor educated me" (Participant 003)

The third participant expressed the desire to receive information and then investigate her choice later. During her engagement in birth control services, she initially used Depo Provera and finally had a Tubal Ligation procedure. The participants recall in receiving birth control was through visual tools:

> "Yea depo was like the only method that he recommended. It was like He really, he told me about the different birth controls, but when he ask me which one I wanted to try I told him three month shot. And it was like after that, we continued to stay on that one." (Participant 005)

The fourth participant presented with several scenarios of how and when she started birth control and the reasons to support her choice. Due to the constant back and forth of going to multiple FQHC networks, the participant used multiple methods that oftentimes overlapped. This indecisiveness in medical care utilization, caused the participant to be in the current position of using the Depo Provera and the Patch. Based on the participants response, the birth control instruction was stated in the following context:

> "They just gave me a handout and it would say or show what it looked like. Like it's 99 percent chance of getting pregnant … Yeah, it was a piece of paper." (Participant 009)

Of visual group of learners, the fifth participant had a mixed style of learning, in which she was visually, verbally, independently inclined to receive, process, and make a definitive decision on information acquired:

> "If they have more information on it, I would like to ask them, and they could tell me what they think and what they believe from it, and if I decide to go with it then that's what I do. But I don't think that I will go with it or even ask them with something that I am already comfortable with." (Participant 006)

There were three participants that expressed the needed to receive birth control information verbally. One participant discussed how the FQHC medical provider utilized shared decision-making tools to educate on the side effects and benefits to assist her in making a choice to switch from the Nexplanon (i.e. device inserted under skin) to the Mirena (i.e. IUD):

> "They pulled out a chart and they just showed me basically the side effects of the Mirena and the umm what could happen while I'm on it, and then they give me the paperwork to sign to make sure I was going to go through with it … They verbally told me." (Participant 001).

The second participant's medical provider orally articulated birth control methods based on hormone levels and what option would benefit the participant. The participant stated the following:

> "Cause he always put out there that if it's too much hormones in my body or if it's too less. So, he always made sure that He said the pills had too much hormones for my body, so he put me on the depo, the three month shot and to me

> I think the depo was good. Only thing is that I’m gaining to much weight” (Participant 004).

The third participant that required verbal education discussed how the medical provider went through a series of resources to help her make an informed decision, by stating the following:

> “He would just basically naming some of the stuff on the computer and it was like whatever, I was like none of that I’m done, I was like I just want my tubes tied.” (Participant 010).

The remaining two participants did not provide insight on how they received and processed birth control health education when engaging in reproductive health services in the health center. Both participants acknowledged the usage of birth control, but only based on their self-selection. The lack of identifying their learning style had no relationship to their literacy level or birth control option selection.

The second research question was, How do lived experiences, throughout the life course of emerging adult African American mothers, create challenges during the development of a personalized reproductive health plan?

### Theme 4: Familial Beliefs Systems

Figure 8 illustrates the birth control practices, knowledge, and perceptions of participants by literacy level.

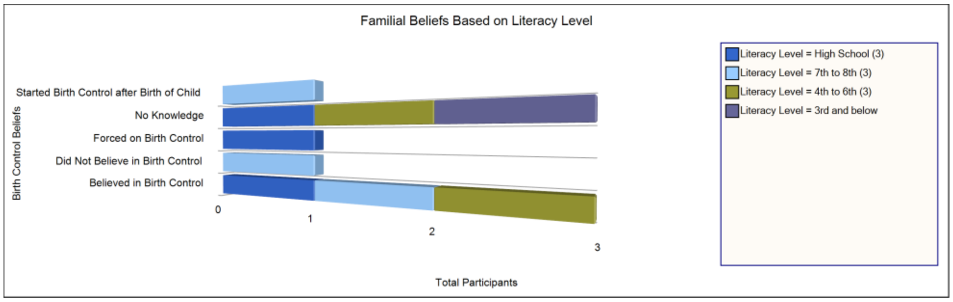

*Figure 8*. Familial beliefs based on literacy level.

Study participants family belief system concerning birth control varied among participants regardless of literacy level. Many of the participants had took time to recall their familial practices, which was interesting as many of the participants were currently using or have used a birth control option in the past. One participant stated that she had no knowledge of the generational beliefs and relied on life experience to help her choose her birth control method and stated the following:

> "I didn't actually have anyone to talk to me, it was like everything like thinking I did, I did on my own. Like running around trying to figure it out myself … No friends, because the majority of my friends was in the streets. So, they basically they learned on their own like me." (Participant 005)

While another participant had a close relative provide guidance on getting on birth control, she had no known knowledge of what her mother and older relatives believed in. She stated the following:

> "Well cause it's not too many girls or women in my family. It's mostly men and she was closer in age. I think it was more, so my cousin put me on depo cause, we was hiding it from my momma, and It was every three months versus she was

> older and she choose the pill.  I'm not sure about my momma because we never talked about "I was on this or I used that…" (Participant 002)

For participants acknowledging that there was a generational belief the birth control was a priority shared the following perceptions:

> "Well, when my mom, when she first saw that I got my period, was is like get on birth control because our family is very fertile. Then when I got to eighteen, she told me to get off of it because she wanted grandkids." (Participant 009)

There were two participants that shared similar thoughts on the familial passage in birth control beliefs. Participants stated the following: "Yes, they believe in birth control that's why I started the pill when I was a teenager." (Participant 008)

> "um, they feel like it works, that my family believe in having your tubes tied after the first child. Birth control um, actually my auntie she took the pill since she was 17 years old and still don't have any kids." (Participant 003)

**Theme 5: Reproductive Health and Life Plan**

Figures 9 illustrates participants' engagement with different FQHC staff by participant literacy level. Figure 10 illustrates participants' development of a reproductive health plan with FQHC staff.

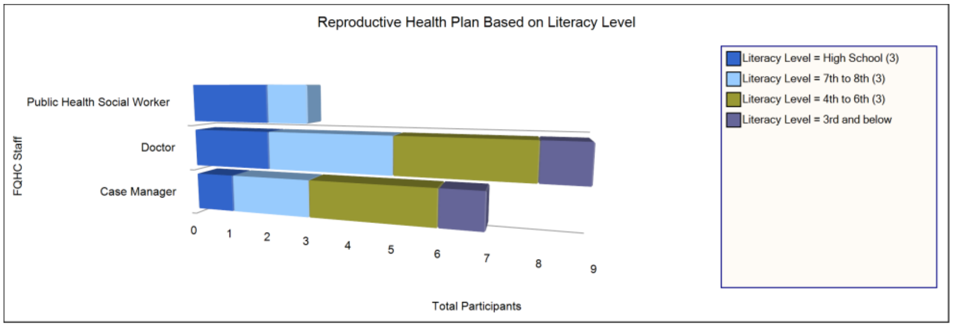

*Figure 9*. Reproductive health plan based on literacy level.

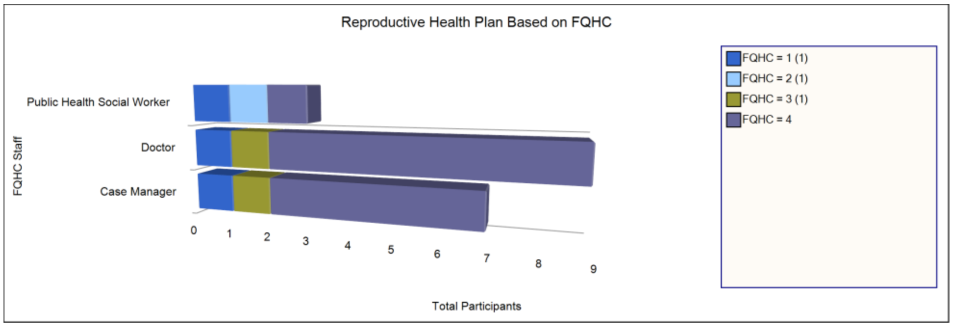

*Figure 10.* Reproductive health plan based on FQHC.

Each study participant had a different experience when engaging with a public health social worker or case manager, which both terms were used interchangeably. Participants expressed that the public health social worker was essential to the development and maintenance of their reproductive health planning pre and post pregnancy. The participants shared the following:

> "When I met my social worker in 2016 or 2017, she started to help me understand why I was using the different types of birth control… And then when I had my son my case manager, she was great and she is amazing she helped me pick out another birth control, but it's like the same one the shot. I'm losing more weight now, I don't know how my body was after I had birth so she helped me figure it out." (Participant 004)
>
> "It was good, I mean cause I was under "case manager" when I first got pregnant. Well, when I first got on my depo she became my case worker. And she's been working with me ever since then, I could reach out to her about anything, she was

> checking up on me and then, when I got pregnant it was like she was my biggest support in my corner. So, it was kind of good the case worker …When I get pregnant with my first child, she was walking me through the steps, my goals or what I wanted to do in life and she tried to help me get to those goals, but I got pregnant again. Then when I tried to start where I stop off at that then I got pregnant again." (Participant 005)
>
> "Case managers, not the doctors, but the case manager. They always been as far as helping with me, they said that's what you want to do, because you have to be comfortable with using it, so the case managers did it real good and will help me make that decision and make me stand on it. The doctors be like whatever you want, would say whatever you want, we would give it to you." (Participant 006)
>
> "My case manager was like my mom, she was in my ear like you need to do this and make sure before you leave out of this doctor or hospital make sure you get this birth control she was like on it more than I was." (Participant 007)
>
> "My case manager made sure I was on it. When it was time for me, like not every month, but every six months, yeah, every six months, yeah, she would look at my folder and stuff and make sure I was on it, and I would be like okay okay. It was like a parent or you know what I am saying, doing for me or whatever." (Participant 010)

One participant saw the medical provider as someone that helped them developed their reproductive health and life goals. The following participants stated the following:

> “I don’t have a case manager anymore and I did in the past. But now I work with the doctor and to create a birth control plan. That’s why I’m on the depo cause we talked about that option using the chart I talked about.” (Participant 003)
>
> “Oh I’m not having any more kids I talked to the doctor, but I haven’t told anyone that I’m not having any more kids.” (Participant 009)

## Summary

The results of the study provided a thorough understanding concerning the lived experiences of low literacy among emerging adult African American reproductive mothers engaged in the development of reproductive health and life goals. The collective thought of rich experiences provide data from 10 interviews, in which the literacy levels varied from third grade and below up to high school. What was interesting is that no matter the literacy level, participants needed assistance at all levels to understand the importance of engaging in reproductive health services. Various participants often relied on the medical provider to make the informed choice regarding their reproductive health. When engaged in reproductive health planning, the public health social worker represented various figures in the participants’ lives, but a mother or case manager was a consistent term used. From reviewing the collected data and the defined themes revealed that many of the participants that suffered from low literacy experiences throughout childhood, and the lack of historical connection, made frequent choices in birth control methods, which lead to multiple unplanned pregnancies during the emerging adult phase of the lifespan. Furthermore, due to the lack of strong familial connections at an early age, the value of engaging with a public health social worker is not seen as a resource for many of the participants until after the delivery of a child or the need to understand which birth control option would be best for them as a person. Chapter 5 will provide an in-depth explanation of the study’s finding, recommendations, limitations, and implications for social change.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this phenomenological study was to explore how the lived experiences of low literacy among emerging adult African American mothers create unknown challenges when engaged in reproductive health services in an FQHC setting. The role of the public health social worker is essential when working with African American reproductive health mothers engaged in care to develop a meaningful reproductive health and life goal that aligns with the participant's vision for the future. The promulgated rules of the ACA standardized how health systems create a staffing structure that recognizes the challenges that SDOH such as low literacy can create when individuals in engage into health care and assess for health literacy to remove some of those barriers to learning (Institute of Medicine, 2013). Findings from this research showed that emerging adult African American mothers with low literacy developed coping mechanisms over time that determined their level of engagement during the development of reproductive planning. Data collected indicated that participants, regardless of the urban FQHC they attended, shared similar experiences regarding familial history, ability to learn how to read, reproductive health engagement and choice, familial beliefs about birth control options, and exposure to public health social workers and other health professionals.

## Interpretation of the Findings

The collected data provide insight on how African American reproductive health mothers who have lived with issues of low literacy became chameleons within their urban environment. My original thought was that due to overall structured historical health policy regulations, that dictated how and when a woman could access reproductive health services might result in the formed perceptions of mistrust in the health care system. I was surprised that participants expressed the opposite. FQHCs and staffing supports were a catalyst in helping them make life decisions about their reproductive health. FQHCs that implemented prescribed promogulated rules provided additional educational supports that participants might not have been aware of. Many of the study participants were not prepared to transition into the emerging adult phase of the lifespan and made decisions concerning their reproductive choice based on the influences of family members. This speaks to how participants transitioned from adolescence to the emerging adult phase of the life span, which requires a level of personal agency in making reproductive choices. Often participants relied on their public health social worker and other health professionals to serve in the role of a parent. This built in support system displays the strength and role of a FQHC. Although participants could not articulate that information they received was in the form of a shared decision-making tool, which is designed to help a person select the appropriate birth control option, many were able to articulate that some form of visual or verbal articulation was provided to help gain understanding of the risk and benefits associated with using various family planning methods. I was of the belief that African Americans learned how to read based on a skills-based approach and through continuous infusion of memorization and articulation of the same words. Participants experiencing some form of low literacy was often determined due to mutigenerational family behaviors and belief systems. Many of the participants had developed coping mechanisms and became empowered to push pass the challenges associated with low literacy. What the study highlighted was that some of the participants experienced issues surrounding learning styles, and how they learned either helped or hindered them from engaging into services.

The use of a phenomenological qualitative inquiry helped me to capture the perceptions of the lived experiences of low literacy through the eyes of the participant (see Greenfield, 2010). The transcribed data discussed in Chapter 4 revealed that the perceptions of low literacy among emerging adult African American mothers were overcame by working in tandem with public health social workers and other health professionals embedded within an FQHC.  Five themes were identified in Chapter 4 and use of the life course perspective help guide me into to understanding participants' lived experiences of low literacy. All participants currently resided in different areas in the urban environment and engaged in care at four different FQHCs in an urban setting. Through the course of their lifespan, participants lived on different sides of town but continued to receive reproductive health care at the same FQHC during the emerging adult phase.

Regarding the impact of familial roots and experiences on their ability to thrive in their respective environment, six participants were able to identify their family's origin based on geographical location. Some of the participants acknowledged that their grandparents worked hard either picking cotton or serving in the military. Some participants had no knowledge of family origin and were oblivious to any part of their family outside their mother and how that shaped how they function in the environment. Other participants only spoke of the side of town where they grew up, and others had no knowledge due to the lack of connection to their biological mother or father. The familial history of eight participants was linked to negative family dynamics, including dysfunctional behaviors that were related to substance abuse usage, foster care placement, or paternal involvement in the judicial system. Four participants expressed positive social ties and strong connections with their fathers or grandmothers that step up to raise them when the mother was not in the picture.

The health literacy assessment levels ranged from reading at a high school level to below a third-grade level. Although participants were screened for the level of literacy based on processing health information at their local FQHC, it was not a determining factor in how they learned how to read. All 10 participants had experiences with learning how to read during the adolescence phase of the lifespan. Literacy development took place in the home and school, and some acknowledged that they taught themselves how to read. Many educational influences were supported by maternal guardians (i.e., grandmother, aunt, other relatives) and educational systems.

Reproductive health engagement and choices were based on the learning style of the participants. Four participants said they felt that visual prompts enable them to make an informed decision about the best method of choice. Three required reproductive health choices to be presented through verbal articulation. One participant required both visual and verbal prompts to understand how to select the best reproductive method. The remaining two participants could not articulate which method of learning suited them best when making reproductive health choices, but merely suggested the selected methods based on their own choice. Regarding familial influences when starting the reproductive health journey during the adolescence phase, some participants were influenced by generational practices, but others did not know what previous family members practice.

Last, the development of a reproductive health and life plan was not easily identified by participants as something they participated with a public health social worker. Many of the participants used the term *case manager* interchangeably with *public health social worker*. Also, many of the participants relied on other health professionals such as doctor to determine their reproductive health plan. Participants looked at a reproductive health plan as something that FQHC staff managed by reminding them of upcoming appointments--for example, reminding women to return to care every 3 months to take their Depo Provera shot. None of the participants discussed how they might develop a reproductive health and life plan that extended beyond the emerging adult phase. Findings from this research show that low literacy, while a barrier, was not the reason for challenged experienced when engaging public health social workers. The barriers were to style of learning, visual or verbal, that created the challenge.

## Limitations of the Study

As discussed in Chapter 1, three limitations were acknowledged from employing this study. The 10 participants of the study were only emerging adult African American reproductive health mothers, White and Hispanic women in the same phase of the lifespan were not interviewed. Therefore, generalizability is limited to other races and other ages with the reproductive phase of the lifespan. Recruitment of study participants was limited to only the partner agency and not the FQHC in which participants received reproductive care services. Additionally, I was reliant on the partner agency to confirm the health literacy level, which was used to affirm low literacy barriers. Since I did not formally evaluate participants, low literacy levels were based on an informal assessment based on the Rapid Estimate of Adult Literacy Health Literacy Scale. This assessment only provides a snapshot of the actual barriers to literacy. Many of the words were easily recognizable on the health literacy scale, and perhaps participants were familiar with the language and not so much on the definition of the word. However, to minimize personal bias as a public health social worker, I recognized the strength of working in tandem with the partner agency to complete the data collection process. Not including the public health social worker in the interview process limited the researchers understanding of barriers experienced when participants engage in reproductive health services in a FQHC. Furthermore, not including the public health social worker, who may be familiar with the slang terms, such as “the three-month shot,” would have been easily identified due to the nature of their relationship with participants.

## Recommendations

The current study posed three recommendations for future research. The first recommendation is focused on improving services for the individual participant. Recognizing the role of public health social workers' role in the FQHC environment, health system administrations should work in tandem with staff to develop policies and procedures that develop and implement a fluid workflow that incorporates the learning styles of participants engaged in reproductive health and life planning. Second, there is an opportunity for public health social workers across the nation working within the walls of an urban FQHC to measure success when addressing SDOH, such as low literacy, from an organizational and community lens. Public health social workers should lead the efforts to complete focus groups, or key informed interviews to gain insight on how (a) services should be designed to help individuals overcome lived experiences of literacy and (b) how to effectively overcome learning barriers to help develop personal health and life goals. The final recommendation is that public health social workers should work in tandem with organizational leaders to employ a mix-methods research design to survey urban FQHC's across the nation to gain a broader understanding of how low literacy creates barriers for emerging adult African American mothers within their health systems. Public health social workers can use findings from this type of study to help inform federal officials on the need to revise enacted legislation that expands the focus on health literacy but incorporates low literacy and inclusive learning styles.

## Implications

This phenomenological study explored the lived experiences of low literacy among emerging adult African American reproductive health mothers engaged in reproductive health services for the development of health and life plans. The results of the study suggest that although participants had low literacy challenges, they adapted to health system services based on learning style. All participants recognized the importance of accessing birth control options and saw the benefit of staff in the FQHC to help them maintain their reproductive health. While a formal structure was not identified in developing a reproductive health plan with a public health social work, there was one defined by verbal communication.  To truly bring about social change, this study should be duplicated in other FQHCs across the nation to determine if similar results are achieved. While there are limitations to this research, it provides insights on how health policy regulations are implemented at the community level but lack the needed structure to display a consistent change in improving the literacy levels of individuals engaged in reproductive health services. Also, the results showcase the need for public health social workers' roles to be defined as a necessary resource to helping emerging adult African American reproductive health mothers live for the future and not make temporary choices regarding their health and life. Participants did share similar life experiences, including familial roots, the way they learned how to read, belief system regarding birth control usage, and engagement of services with FQHC and public health social workers. Findings from this study is another avenue to help public health social workers to partner with FQHC administrators and policymakers to bring about social changes at the system level to revise health policy rhetoric that is more inclusive and defined. Mandating that all health systems screen for health literacy to address low literacy for all populations is a start but developing a reproductive health and life goals based on learning style is a forward-thinking step to understanding what lived experiences individuals bring to health care, and how to genuinely improve health disparities by the person who is a part of the broader population.

## Conclusion

In conclusion, this phenomenological qualitative study acknowledges the challenges of low literacy among African American reproductive health mothers, when utilizing services tailored to their phase of the lifespan. In the field of public health there is a tendency to look at population health from a system level lens, hence the desire to improve health disparities and the SDOH based on trends in the data. However, public health social workers have been trained to see an individual as a "person in the environment" by recognizing each level of interaction (i.e., micro, mezzo, and macro) and how each level contributes to a person receiving and responding to services provided. The is a need to merge social work and public health principles to not just identify pockets of issues, but to begin to address each disparity person by person. The only way a marginalized community can heal from the lived experiences of low literacy, which have formulated a person's daily coping skills, is to gain insight on the generational challenges, then begin to rewrite negative outcomes into positive acceptance of the benefit conceptualizing and processing information from a learning style standpoint.

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# Appendix A: Letter to Partner Agency

## Letter to Partner Agency

Name, Title
City, State

Date:
Dear [Name],

My name is Timika Anderson Reeves and I am a doctoral candidate at Walden University. The focus of my dissertation is to explore the lived experiences of low literacy among emerging adult African American reproductive health mothers engaged in reproductive health and life goal planning. As health policy (i.e. the Affordable Care Act) has transformed how Federally Qualified Health Centers provide care to marginalized populations, mothers continue to not develop reproductive life goals due to obstacles experience throughout the life course. Conducting this research will help public health social workers how to work with mothers with issues of low-literacy and help revise health policy to meet the needs of those with literacy challenges.

Your organization would greatly help to understand this proposed research. If you agree to support this proposed study, I would like to work closely with you to identify participants who met the study requirements. Eligible participants must be African American reproductive mothers18-25, have low-literacy challenges, been pregnant at least once in the last two years, reside in a marginalized community area, and receive reproductive health services within a FQHC setting. Participation in this study is free and participants can end participation at any time. All information shared during the interview process will remain confidential and only information that is non-identifying will be shared. I am open to speaking with in-person to discuss in further detail. Feel free to contact me at [redacted] or timika.anderson-reeves@waldenu.edu.

Sincerely,
Timika Anderson Reeves MSW

Doctoral Candidate
Walden University

# Appendix B: Letter to Participants

Name
Address
Date

Dear (Participant)

My name is Timika Anderson Reeves and I am a doctoral candidate at Walden University. The focus of my dissertation to explore the lived experiences of low literacy among emerging adult African American reproductive health mothers engaged in reproductive health and life planning. As health policy (i.e. the Affordable Care Act) has transformed how Federally Qualified Health Centers provide care to marginalized populations, mothers continue to not develop reproductive life goals due to obstacles experience throughout the life course. Conducting this research will help public health social workers how to work with mothers with issues of low-literacy and help revise health policy to meet the needs of those with literacy challenges.

I hope that you consider participating in this study. Your life experiences will help me to understand the barriers you have encountered while developing reproductive health goals. I will need no more than 90 minutes of your time. I am open to meeting you at the local library or a location that you feel most comfortable. The study is voluntary. By sharing your lived experiences of literacy challenges will help inform public health social workers on how to meet the needs of participants like you. Participating in the study will bring about awareness on the need to formulate health policy to accommodate individual learning styles when engaging in reproductive health services. All information shared during the interview process will remain confidential and only information that is non-identifying will be shared. I am open to speaking with in-person to discuss in further detail. Feel free to contact me at [redacted] or timika.anderson-reeves@waldenu.edu.

Sincerely,
Timika Anderson Reeves MSW

Doctoral Candidate
Walden University

# Appendix C: Interview Protocol

## Interview Protocol

Date: ____________________
Location: ___________________________________
Name of Interviewer: _________________________
Name of Interviewee: _________________________
Interview Type: Initial Follow-up

1. Tell me how you would explain your family's origin (i.e. family history)?
2. How did you learn how to read as a child?
3. Describe how you engage in reproductive health services (i.e. family planning services) in a federally qualified health center?
4. Describe your family beliefs in using family planning (i.e. birth control) services.
5. Describe the type of family planning (i.e. birth control) services you have used.
6. Describe your relationship with your public health social worker when making a reproductive health plan (i.e. life and birth control) goals?

Probing Questions

1. Describe how that made you feel?
2. Tell me more about that experience?
3. Describe a few examples of that experience?
4. Say more information at that encounter?