5-8-2024

Lived Experiences of Congolese Women with Postpartum Family Planning Counseling in the United States

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Walden University
2024

Abstract

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MPH, Case Western Reserve University, 2012

BS, Gardner-Webb University, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Sciences

Walden University

May 2024

Abstract

Postpartum family planning counseling experience among immigrant women in the United States has primarily involved Latina immigrant women, with little focus on African immigrant women. To address this gap, a phenomenological study was conducted to examine lived experiences of Congolese immigrant women living in the United States (U.S.) with postpartum counseling and how this type of counseling influences their decision-making processes. Additionally, the study involved understanding Congolese immigrant women's interactions with healthcare services for family planning procurement. Data were collected from 10 Congolese immigrant women who had given birth in the U.S. and attended a postpartum family planning counseling session. Analysis of data was guided by the social cognitive theory, focusing on self-efficacy and outcome expectancy. These constructs helped to understand how experiences involving postpartum family planning counseling informed women's decision-making regarding contraceptive choices. Thematic analysis of data revealed five key themes: complexity of the U.S. healthcare system, familiarity with healthcare providers, immigrant status, perceived understanding of family planning, and factors associated with procurement. Findings of this study involve the importance of the environment in which postpartum family planning counseling takes place. Counseling experiences revealed factors that can either strengthen or undermine women's self-efficacy and outcome expectancy motivators that influence decision-making processes. This study can promote social change by empowering African immigrant women in making informed choices during family planning counseling.

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Dedication

This dissertation is dedicated to my daughters. This work is a step towards leaving my mark on the community. Knowing the purpose of my calling, however small it may be, will always be my driving force. For this reason, I urge you to trust the One who has called you, for He will equip you.

To my other half, Bob, I thank you for your dedication. You have been and will always be my rock.

To my parents, family, and in-laws, being surrounded by your support is a blessing. You have always believed in me from the moment I was born. To my dear friends, thank you for the emotional support!

To my chair, Dr. Jeanne Connors, you have given exceptional guidance throughout this journey. Thank you for your patience, expertise, and contribution in making this work one of my best.

To my grandmothers, Ana and Ana, I extend my heartfelt thanks for their prayers. They have been a gentle bear and a fierce lion in my life.

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Chapter 1: Introduction to the Study

Family planning is an essential part of maternal and reproductive health (Boydell et al., 2018; Dehlendorf et al., 2018; Ewerling et al., 2018). In low-income countries, reproductive health services delivering family planning methods have served to address much more than just improving maternal health. Benefits include decreasing fertility rates to achieve population growth stability, reducing poverty through economic stability, and improving maternal education (Kadarisman, 2019; Kantorova, 2020; Tran, Yameogo et al., 2018). For this purpose, the delivery of family planning counseling ensures women receive adequate knowledge about contraceptive methods and increase their uptake. In high-income countries, delivery of family planning counseling improves maternal health by reducing unintended and short-spaced pregnancy rates (Bearak et al., 2018; Hanley et al., 2017; Ray & King, 2018).

Healthy spacing between pregnancies is associated with better maternal outcomes and quality of life. In the United States (U.S.), 40% of all pregnancies are unplanned (Ahrens et al., 2018). Unintended pregnancies are associated with poorer outcomes for mothers and children, including low birth rates (Omani-Samani et al., 2019; Pakseresht et al., 2018; Sawhill & Guyot, 2019). Unintended pregnancies also impact life in a separate way. There can be a reduced quality of life in some contexts, such as negative effects on socioeconomic status, career, and education attainment. Women have reported being willing to abort to avoid unintended pregnancy (Spierling & Shreffler, 2018). Furthermore, due to financial or career plans, women have a desire to avoid pregnancy (Jones, 2017; Spierling & Shreffler, 2018).

Besides the impact of unintended pregnancies on life, rates of unintended pregnancy vary significantly by racial and ethnic minorities due to factors such as marital status, education, insurance, type, socioeconomic status, age at first pregnancy, and U.S.-born status (Aztlan-James et al., 2017; Hernandez et al., 2020; Jackson et al., 2017; Troutman et al., 2020). Postpartum family planning becomes a context where factors affecting the rate of unintended pregnancies among different racial and ethnic groups can be addressed, and reproductive desires can be discussed (Agbemenu et al., 2019; Agbemenu, Volpe, et al., 2018; Coleman-Minahan & Potter, 2019).

African immigrant women are among increasing ethnic or minority groups in the United States. They come from various countries, including the Democratic Republic of Congo (DRC) (United Nations High Commissioner Refugees [UNHCR], 2018; U.S. Department of State & Bureau of Population, Refugees, and Migration, 2019). Many Congolese immigrant women are of reproductive age (i.e., 15-44 years), necessitating a particular need and approach to primary care and reproductive health services (Pazol et al., 2017; Royer et al., 2020). For example, culture and tradition play a significant role in how Congolese immigrant women view health, influencing healthcare behaviors and experiences (Omenka et al., 2020). Hence, cultural competence among healthcare providers is crucial in delivering targeted approaches to reproductive health services. Previously published data showed that Congolese immigrant women's access and low utilization of reproductive health services are affected by factors such as language barriers, low health literacy, lack of understanding of healthcare systems, and lack of

health insurance coverage (Evans et al., 2022; Im & Swan, 2019; McMorrow & Saksena, 2017; Tapales et al., 2018).

Although the literature mentioned above provides some aspects of health behaviors and barriers faced by Congolese immigrant women, not enough is documented about Congolese immigrant women's experiences with reproductive health services, especially postpartum family planning counseling (Coleman-Minahan & Potter, 2019; Manzer & Bell, 2022; Pazol et al., 2017; Royer et al., 2020). The current study provided further information on postpartum family planning counseling and its experience among Congolese immigrant women living in the U.S. Chapter 1 includes the background of the study, problem statement, purpose of the study, and research questions. I also addressed the theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study, followed by a summary.

Background of the Study

Few studies have examined the relationship between postpartum family planning and African immigrant women. Millar et al. (2017) provided information on the pattern of family planning methods and prevalence use among Somali women following their postpartum visits. Results indicated postpartum family planning counseling among Somali women was a key factor in terms of informing them about family planning methods and health service use. Another study assessed factors influencing reproductive health decision-making associated with resettlement in the United States among Somali refugee women. The study observed that Somali refugee women emphasized birth spacing rather than birth limiting methods when discussing postpartum family planning

options with healthcare providers (Agbemenu, Volpe et al., 2018). However, women had not consistently reported amicable relationships with healthcare providers during counseling sessions. Gele et al. (2020) explored factors associated with low modern contraceptive use among Somali immigrant women of reproductive age (> 18 years old) living in Oslo, Norway. The authors were interested in finding barriers to low contraceptive use because a previous investigation found that the rate of unintended pregnancies among this population was about 50% (Gele et al., 2019). The one-on-one interview revealed that women understood the importance of contraceptive use and its role in healthy pregnancy outcomes. They also reported overall satisfaction with the healthcare system. However, they felt healthcare providers had unfriendly attitudes towards understanding the Somali culture (Gele et al., 2020). Another study in the United States explored the perception of Latina immigrants during postpartum counseling and the role of physicians during counseling sessions. Participants perceived a sense of bias and stereotyping among healthcare providers when helping them decide on contraceptive methods (Carvajal et al., 2017).

Studies also highlighted that African immigrant women did not fully understand the healthcare system to make the best use. For example, 16 Congolese refugee women aged between 18 and 44 who resettled in the U.S. participated in a focus group interview to explore their experience with the U.S. healthcare system. Women noted the U.S. system was particularly confusing and faced difficulties securing appointments (McMorrow & Saksena, 2017). Another study noted a significant difference in the use of reproductive health services. Immigrant women had lower use rates at 69.0% compared

to U.S.-born women at 73.0% (Tapales et al., 2018). Potter et al. (2017) explored differences in postpartum family planning policies in the U.S. and Mexico's healthcare systems. The authors observed that U.S. healthcare policies involving family planning methods a significant barrier for immigrant women to meet their contraceptive needs.

Problem Statement

The postpartum period is crucial for initiating family planning, also referred to as contraception, among women of reproductive age. Counseling that is offered during the postpartum period allows women to make informed decisions about family planning methods (Brunson et al., 2017; Cooper & Cameron, 2018). Contraception reduces the number of unintended pregnancies, which results in short pregnancy intervals and low pregnancy risks (Sawhill & Guyot, 2019). In the U.S., unintended pregnancies account for 40% of all pregnancies, and 36% of those pregnancies have interpregnancy intervals that are less than 18 months in 2014 among women between 15 and 44 (Ahrens et al., 2018; Kavanaugh & Jerman, 2018). Among unintended pregnancies, disparities exist between immigrant and U.S.-born women. Non-U.S.-born women account for 73% of unintended pregnancies compared to U.S.-born women (Kim et al., 2016). Agbemenu et al. (2022) and Omenka et al. (2020) argued that studies on postpartum family planning have often classified immigrant women into one single group of foreign-born to compare use with U.S.-born women. Therefore, strategic family planning counseling recommendations are not always tailored to different immigrant populations (Dehlendorf et al., 2017; Ngendahimana et al., 2021). The U.S. is home to immigrants from various countries, including the DRC. Data from the DRC showed that the total fertility rate in

the DRC was 6.5 children, with contraceptive use of 11.2% in 2019 (Nyoni et al., 2021). In recent years, heightened involvement from the Congolese government has led to family planning initiatives to assess attitudes and beliefs, increase counseling, and address barriers to contraception use (Ho & Wheeler, 2018; Tran, Gaffield, et al., 2018; Tran et al., 2020; Zivich et al., 2019). However, with resettlement in the U.S., it is not known to what extent Congolese women's attitudes and beliefs affect their experience with postpartum family planning counseling offered in a new country.

Studies have begun to evaluate contraceptive behaviors and experiences of different immigrant groups such as Latinas or Somali women (Agbemenu, Volpe, et al., 2018; Carvajal et al., 2017). While attitudes and experiences of postpartum family planning counseling in the literature have changed among Latinas, more studies remain to be evaluated to explore the postpartum family planning counseling experiences among different African immigrant populations. Agbemenu, Volpe, et al. (2018) and Millar et al. (2017) evaluated patterns of postpartum contraceptive use and the decision-making process of reproductive health care among Somali women and found that of the 88.3% of women who received counseling, 80% chose a form of contraception. These studies have begun to shed light on understanding contraceptive behaviors among African women immigrants. Still, they only focused on reporting the prevalence of use among Somali women and their overall experience with reproductive health services. In 2017, the U.S. Department of Homeland Security (2018) reported 8,709 Congolese received the status of lawful permanent residents, a number that increased from 5,345 in 2015. Also, in 2017, an additional 8,343 Congolese were admitted under non-immigration status (U.S.

Department of Homeland Security, 2018). As Congolese women of reproductive age resettling in different states are increasing and given a high fertility rate from the native country, it is essential to understand how to provide tailored family planning counseling. Therefore, it is vital to learn how different African immigrant women communities perceive the importance of postpartum family planning and their lived experiences of postpartum family planning counseling in the U.S.

Purpose of the Study

The purpose of the study was to examine lived experiences of Congolese immigrant women living in the U.S. with postpartum counseling and explore how counseling informs their decision-making processes. This study also involved understanding their interactions with healthcare services for family planning procurement. Qualitative literature on attitudes of African immigrant women living in the United States on counseling and modern contraceptive behavior following the postpartum period is limited. Showers (2018) claimed studies on Black immigrants had been limited to shield them from discrimination or marginalization. However, as part of increasing diversity in immigrant populations, research should evaluate how Congolese women deal with various health behaviors and assess how public health initiatives improve health outcomes.

Research Questions

RQ1: How do Congolese immigrants perceive their experiences with postpartum family planning counseling?

RQ2: How do postpartum family planning counseling experiences inform their decision-making processes?

RQ3: How do Congolese immigrants interact with healthcare systems for the procurement of modern family planning methods?

Theoretical Foundation

The theoretical framework for this study was the social cognitive theory (SCT). The SCT is used to explain interplays between environmental and personal factors that fundamentally affect human behaviors through reciprocal determinism. The theory is used to understand how individual experiences, actions and behaviors, and environmental factors influence health behaviors (Bandura, 1986; Fertman & Allensworth, 2016, p. 65; Glanz et al., 2015, p. 171). Bandura (1986) claimed constructs of the SCT include environment, situations, behavioral capacity, outcome expectations, outcome expectancies, self-control, observational learning, self-efficacy, and emotional coping. By delving into the shared experiences of Congolese women, I used the SCT to identify factors that could either strengthen or undermine women's self-efficacy and outcome expectancy motivators. These factors play a crucial role in influencing decision-making processes during family planning counseling. The SCT was also used to provide a framework for interview questions, data collection, and explanation of a phenomenon or lived experience (Creswell, 2014, p.64).

Nature of the Study

The purpose was to conduct a qualitative study using a phenomenological approach to examine perceptions of Congolese immigrant women receiving postpartum

family planning counseling and their experiences with health services. Phenomenology is a way to investigate and obtain information pertaining to behavior based on personal values, environmental contexts, and cultural factors that inform decisions about contraceptive use (Downey et al., 2017). I used one-on-one semi-structured interviews. Participants were asked to describe their lived experiences when receiving family planning counseling during the postpartum period and explain how information they received informed their decisions about choosing a method. The phenomenological approach was used to understand experiences of going through postpartum family planning counseling, factors influencing their decision-making process, and barriers and enablers to postpartum contraceptive access.

Definitions

In this section, I define and elaborate on key terms and phrases.

African Immigrant Women: Women who were born in any African country and migrated to the U.S.

Congolese Woman: Woman who was born in the DRC.

Family Planning methods: Family planning and contraceptive methods are used interchangeably. It consists of methods to avoid unintended pregnancies, space births, or limit births. Methods include pills, implants, injectables, the patch, vaginal rings, intrauterine devices (IUDs), condoms, sterilization, Lactational Amenorrhea, fertility awareness, and withdrawal (Cooper & Cameron, 2018; World Health Organization [WHO], 2018).

Postpartum Counseling: Sessions which consist of educating women about postpartum family planning methods (e.g., how each method works, advantages and disadvantages of each method, and costs) and understanding their needs regarding future pregnancies. While family planning counseling can also be done during prenatal visits, it is standard care during the postpartum period (Schivone & Glish, 2017).

Postpartum Period: This is separated into three different periods. The first is the acute period, which is the first 12 hours post-delivery. The second stage, the subacute period, is between 2 and 6 weeks. The final stage is the delayed postpartum period and lasts up to 6 months (Romano et al., 2010) .

Reproductive Health: The WHO (2010) defined it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 10). Reproductive health involves all matters of the reproductive system and includes education and information about sexual health and family planning as well as sexual desire (Metusela et al., 2017; WHO, 2010, 2017).

Limitations and Assumptions

One potential limitation was social desirability bias, where participants tend to answer questions based on what they felt was socially acceptable. One-on-one interviews were meant to address this limitation by allowing participants to answer truthfully without being influenced by someone else's responses (Bergen & Labonté, 2020). The assumption was that participants shared their experiences voluntarily and provided honest answers to interview questions.

Scope and Delimitations

The study involved the postpartum period and family planning counseling that women received to decide on choice of contraceptives. The study was delimited to Congolese women who immigrated from the DRC and lived in the U.S. Participants resided in North Carolina. Since this study was specific to Congolese women, it added to the body of research concerning African women immigrants and their reproductive health decisions while living in America. However, results of this study cannot be transferred to other African immigrant women groups.

Significance of the Study

Implications for social change include valuable knowledge for program developers, reproductive health counselors, healthcare providers, and researchers involving improving reproductive health needs among Congolese immigrant women. Long-term results of programs tailored to different African immigrant populations would hopefully increase knowledge, increase rates of family planning use, decrease unplanned pregnancies, and improve healthcare service delivery. Study results will contribute to the community and institutions by understanding how Congolese immigrant women perceive family planning counseling and navigate the healthcare system for procurement. Understanding factors that influence their decision-making processes is essential for interventions and interaction between healthcare providers and patients. Furthermore, when providers are informed about different immigrant populations and barriers they face, services offered can be less subject to assumptions and biases (Agbemenu, Hannan et al., 2018; Okeke-Ihejirika et al., 2018).

Summary

Reproductive health services are underused among immigrant women. Several challenges, such as limited knowledge of the healthcare system, resettlement challenges, and language barriers in the host country, are reasons why foreign women place low prioritization on reproductive health services (Åkerman et al., 2019; Mehta et al., 2018; Metusela et al., 2017). I focused on the postpartum period and experiences with postpartum family planning counseling among Congolese immigrant women. Chapter 1 included an overview of the problem, research methods and theoretical foundation, and social change implications.

Chapter 2 includes in-depth research of evidence, and Chapter 3 contains a review of the methodology. Chapter 4 includes study results, and Chapter 5 includes findings from results as well as implications for social change.

Chapter 2: Literature Review

The purpose of the study was to examine lived experiences of Congolese immigrant women living in the U.S. with postpartum counseling and explore how counseling informs their decision-making processes. This study also involved understanding this population's interactions with healthcare services for family planning procurement. Immigrant populations and minorities are disproportionally affected by reproductive healthcare services and outcomes. Specific services such as postpartum contraceptive counseling among immigrant women have not been widely used due to barriers such as language, lack of proper insurance coverage, not understanding the healthcare system, and lack of trust in healthcare providers (Mehta et al., 2018; Ngendahimana et al., 2021; Oakley et al., 2018).

Studies among foreign-born women living in the United States have been increasingly focused on Latinas (Carvajal et al., 2017; Hernandez et al., 2020; Oakley et al., 2018; Tapales et al., 2018). As a result, policy interventions to educate immigrant women have essentially been based on experiences of a specific population (Omenka et al., 2020). In contrast, subpopulations such as women from sub-Saharan Africa have been scarcely studied. For example, satisfaction with postpartum contraceptive counseling among African-born immigrant mothers and how they inform contraceptive use has not been extensively studied. Despite the increase of African women immigrating to America, scarcity of research among African immigrants and postpartum counseling is evident, so addressing the gap in the literature was significant (Agbemenu et al., 2022; Omenka et al., 2020). Congolese immigrant women were chosen for this study to

examine their attitudes and experience with postpartum counseling and understand how they have impacted their decision-making processes.

The literature review drew on studies that explored experiences, attitudes, and knowledge about postpartum contraceptive counseling among immigrant women. Immigrant populations such as Latinas, Ethiopian and Somali women have gained more attention in research to understand how policy interventions impacted them differently (Hernandez et al., 2020; Oakley et al., 2018; Oliphant, 2019). Early literature on African immigrant women, including Congolese-born women, has primarily focused on refugees and asylum seekers (Im & Swan, 2019; McMorrow & Saksena, 2017; Mehta et al., 2018; Royer et al., 2020; Saksena & McMorrow, 2017). Because of their different immigration status and experiences involving displacement and resettlement, these minority groups are more likely to report different experiences in the U.S. (Mehta et al., 2018; Royer et al., 2020).

Literature Search Strategy

I used a variety of databases to acquire articles for the literature review. The following search engines and databases were used: EBSCOHost, PubMed, Medline Plus, Google Scholar, and Walden Library. The first step was to find relevant literature on immigrant women and postpartum contraception. I then narrowed my search to include African immigrant women to identify current findings and the gap in literature. I used the following terms: *immigrant women*, *African immigrant women*, *postpartum family planning counseling*, *postpartum contraceptive counseling*, *family planning knowledge*, *postpartum education*, *reproductive health services*, *gynecologic care*, *social cognitive*

theory, *affordable care act*, and *preventive services*. Since there was little information about Congolese-born women settled in the U.S, I mostly referred to studies that used immigrant women from other African countries and other subgroup populations that shared similar characteristics.

Due to the nature of the topic, I chose articles that were published between 2017 and 2022. Sources involving the theoretical framework and historical information were not limited to the five-year review.

Theoretical Foundation

I examined experiences of Congolese immigrant women using the SCT. Behaviors are learned within a social context through observational learning and the presence of reciprocal interactions between personal and environmental behaviors (Chess et al., 1978; Wood & Bandura, 1989). The SCT is used to understand how thoughts and emotions affect individual decisions involving new health behaviors. The SCT is also used to address the importance of experience as a determinant of individual behaviors, as well as environment and social support. In making decisions about new health behaviors, the SCT highlights the importance of the individual having beliefs and capabilities as well as the knowledge about desired outcomes before engaging (Chess et al., 1978; Lopez et al., 2016). Thus, for this study, I focused on self-efficacy and outcome expectancy constructs.

Self-efficacy refers to an individual's belief in their capacity to exert control over their goals and expectations, as well as their ability to carry out the necessary actions to achieve the desired outcomes. This construct, as highlighted by Bandura (2004) and

Chess et al. (1978), plays a crucial role in predicting not only the adoption but also sustainability of new health behaviors. Expectancy outcome construct, on the other hand, pertains to the individual's confidence in their ability to engage in new health behaviors based on the anticipated outcomes. Subsequently, the purposefulness and meaningfulness of the new task serve as powerful motivators for the individual (Chess et al., 1978; Lopez et al., 2016).

The adoption of new health behaviors, such as contraception and uptake, requires individuals to possess adequate knowledge to make informed decisions. Therefore, postpartum family planning counseling acts as a medium for women to gain insights into different family planning methods. These counseling sessions are pivotal in enabling women to make decisions that resonate with their reproductive health desires. Consequently, the experiences encountered during these counseling sessions form part of the cognitive process that will shape women's decisions, as elucidated by the SCT. By delving into the shared experiences of Congolese women, I examined factors that could either strengthen or undermine women's self-efficacy and outcome expectancy motivators during family planning counseling. By identifying these factors, efforts can be directed towards establishing a supportive and empowering environment for Congolese women.

African Immigrants in the U.S.

In the last decades, the U.S. has seen increased immigrants from African countries (López & Bialik, 2017). In the early 1990s, most African immigrants came from Anglophone-speaking countries such as Ghana, Nigeria, Sierra Leone, and Liberia (Tamir, 2022). In contrast, most asylum seekers and refugees came from non-English

speaking places such as Sudan, Ethiopia, and the DRC (Anderson, 2017). Over the years, African-born immigrants have come for reasons such as diversity visas, family resettlement programs, educational purposes, international schooling, and refugee and asylum programs (Anderson, 2017; Refugee Processing Center, 2022). In the U.S., African immigrants have increased by more than 41% from 2000 to 2013 (Anderson, 2017).

States such as New York, Maryland, and Minnesota have been the primary destination for immigrants and hold about 12% of all African immigrants (Opoku-Dapaah, 2017; Tamir, 2022). Increasingly, states like Texas, Georgia, Illinois, and North Carolina have become primary locations (Opoku-Dapaah, 2017). According to the Refugee Processing Center (2017), North Carolina became the third largest resettlement location in 2017, while Congolese immigrants have become the largest immigrant group coming to North Carolina.

Reasons for immigration among sub-Saharan populations have been well documented (Chand, 2019; Covington-Ward et al., 2018; Echeverria-Estrada & Batalova, 2019). For many Congolese immigrants, one of the ultimate goals has been to achieve economic advancement to offer a better future and stability for their families, just as documented in the literature for many of their African counterparts (Anderson, 2017; Chand, 2019; Covington-Ward et al., 2018). Although early literature had focused on African men's immigration and their experience in the United States, growing data showed a surge in women's immigration (Muruthi et al., 2017; Showers, 2018). The

number of female African immigrants has been rising in the last decades compared to male African Immigrants (Nawyn & Park, 2019a; Semu, 2020)..

Characteristics of Female African Immigrants in the U.S.

Immigrant women have unique needs and play an essential role in their host country (Nawyn & Park, 2019; Okeke-Ihejirika et al., 2018). Muruthi et al. (2017) documented that one of the roles played by African women immigrants was their increased financial contribution to their families in their native countries. In their study, women participants were from Rwanda and Kenya, were between 22-30 years old, and had lived in the United States for 1 to 6 years (Muruthi et al., 2017). Participants had a 60-120 min interview in English. Themes developed from the study revealed first that women felt a sense of responsibility to send money back to their families. Second, participants' families had a skewed understanding of financial expectations, and finally, participants wanted to invest in their country of origin. In parallel, another study examined the immigration experience of 14 Ethiopian women living in Washington, D.C. The major themes discussed in the findings were: (1) arrival at the airport, (2) living arrangements, (3) finding jobs, and (4) furthering education. Participants discussed the importance of saving money to send it back to their native country. Women also expressed the importance of relying on institutions like family and friends to help them navigate their new life in the United States (Oliphant, 2019). While these two studies do not address Congolese women specifically, it is essential to note the additional role African women have taken on while living in the U.S. and how it impacts their decision-making experience and process.

Aside from their vital roles, research has also documented African women's needs in their host countries. For example, one study focused on Congolese refugee women to explore their resettlement experiences in the United States. Women described experiencing loneliness, isolation, and being overwhelmed trying to juggle professional and family life in their new country (Saksena & McMorrow, 2019). Similarly, McMorrow and Saksena (2017) conducted an earlier study to assess the health needs and look at the assets of Congolese refugee women. Women reported that the social support was tailored around their community with people from back home and to make a connection with American Society. Health needs and frustration included their lack of understanding of the healthcare system, precisely the meaning of medical appointments and understanding of the medical insurance system (McMorrow & Saksena, 2017). These studies highlighted women immigrants' position in the United States, psychosocial changes in adapting to a new country that influence their everyday living and eventually impact how they make decisions. Among African immigrant women's priorities of making a new life in their new country, little attention has been devoted to reproductive health and their experiences with navigating the system, thus prompting further attention in research and public health.

Postpartum Family Planning Counseling

Postpartum is a crucial time for education about family planning. Reasons include a woman's desire and decision about future pregnancies, cost-effectiveness, and a higher chance of continuing contraception use (Williams et al., 2019). A woman can regain fertility within six weeks if she is not fully breastfeeding during the postpartum period.

During this time, a woman runs into a higher risk of unintended pregnancy and short-spaced pregnancy interval. For women who choose to breastfeed exclusively, the literature has shown that lactational amenorrhea provide at least 6 months of protection against pregnancies (Cooper & Cameron, 2018; Glasier et al., 2019; Sridhar & Salcedo, 2017). Healthcare providers play a critical role in interacting with women and discussing further intentions on pregnancies (Manzer & Bell, 2022; Thiel de Bocanegra et al., 2020). Due to different contraceptive methods, postpartum family planning counseling is crucial in determining the decision to use contraceptives and the best timing for each method (Cooper & Cameron, 2018). Postpartum counseling remains an underused option among providers and patients (Moniz et al., 2017; Ray & King, 2018).

Before exploring the topic of postpartum family planning, I looked at differences in unintended pregnancy, preterm births, and birth spacing among women across races and ethnicities. Some studies have shown that race and ethnicity were associated with unintended pregnancies. Quinn et al. (2020) did a cross-sectional study from a national sample of 2302 women to examine patterns of unintended pregnancies and contraceptive use among different racial and ethnic minority groups of women veterans. In the sample, 57.2% of pregnancies were unintended. Non-Hispanic Black women showed the highest percentage (66.8%) of unintended pregnancies, followed by Hispanic and non-Hispanic women, respectively (60% and 50.8%). The authors found that factors associated with unintended pregnancy were low contraception knowledge and reproductive health service use among minorities. The study's limitation is that race and ethnicity categories were limited to White, non-Black, and Hispanic women. Moreover, participants were veteran

women and VA primary care users, which meant that most women were from racial and ethnic minority groups and had poorer overall health (Quinn et al., 2020).

Studies in the United States have shown that women of racial and ethnic groups compared to white non-Hispanics had a higher rate of preterm births (Tucker et al., 2020). Oliver et al. (2018) conducted a study of four different groups of women to compare preterm birth rates and gestational age. First, race and ethnic group were categorized into four sections: U.S.- born non-Hispanic white, U.S.- born non-Hispanic black, African-born black (women from west African countries), and Somali-born. Preterm was classified as gestational age less than 36 weeks, full-term was between 37-40 weeks, and later-term was 41 weeks. Interestingly, the authors found that Somali-born women had a lower rate of preterm birth (5.9%) compared to U.S.-born non-Hispanic black (13.0%), African-born black (8.4%), and U.S.-born non-Hispanic whites (7.9%). However, Somali-born tended to have longer gestational age (41 weeks) (Oliver et al., 2018). One of the study's strengths was that participants were drawn from the same registry, indicating that obstetric practice guidelines were uniform which allowed the assessment of different ethnic groups. Another study found that U.S.-born black women had a higher preterm birth rate than foreign-born black women and U.S.-born white women (11.1% vs. 7.9% vs. 6.8%, respectively). One of the primary explanations for this persistent disparity between African-born women and U.S.-born blacks is the health profile. African Americans tended to have comorbidity factors such as hypertension and smoking and social factors such as lower educational attainment and less likely to be married (DeSisto et al., 2018).

Recent research examining further the difference between African American women and foreign-born women continued to point out that foreign women had a lower rate of preterm births but had a higher percentage of short pregnancy intervals than U.S.-born women (Agbemenu et al., 2019). Short pregnancy intervals are associated with the risk of preterm births when interpregnancy intervals are close together, not allowing a women's body to recover properly. The difference in pregnancy spacing has also been noted among women of different socioeconomic backgrounds. Cross-Barnet et al. (2018) conducted a study with Medicaid participants to explore facilitators and barriers to healthy pregnancy spacing. Type of medical insurance coverage, which is sometimes used as a proxy for socioeconomic status, indicated that women with Medicaid were less likely to go for postpartum visits. This was a barrier because women were less likely to receive optimal information regarding family planning and the importance of birth spacing (Cross-Barnet et al., 2018).

Postpartum Family Planning Among African Immigrant Women

To further understand the experience with postpartum family planning counseling, we first explored studies that discussed African immigrant women's knowledge, attitudes about family planning, and then satisfaction with family planning methods. These concepts are explained to show how they are related to the study's topic and identify gaps in the literature review. Due to limited information on Congolese immigrant women and their use of reproductive health, this section drew on studies assessing these factors among different African immigrant women groups living in the United States.

Knowledge. The level of knowledge about family planning methods among African women has been crucial to evaluating factors influencing family planning and the decision-making process. For example, 30 refugee and asylum Somali women 18 years or older were recruited for a focused group interview in a qualitative study. Some women reported high knowledge of birth control options and differences between them based on a previous experience (Agbemenu, Volpe, et al., 2018). A quantitative study by Millar et al. (2017) supported the argument of the relationship between knowledge and contraceptive uptake. In their study, 325 women were included in the analyses to evaluate contraceptive use patterns among Somali immigrant women following their postpartum period. Participants had to have had at least one delivery, and they received family planning counseling within 90 days of delivery (Millar et al., 2017). However, a high knowledge of family planning methods does not always translate to high use. A cross-sectional revealed that knowledge about family planning was relatively high. Out of 100 participants, only 3.4% reported having no knowledge of family planning methods. While 64% of the mothers reported a desire for future pregnancy, only 35% of the sample were currently using a family planning method (Agbemenu et al., 2020).

Attitudes. The concept of postpartum family planning and understanding the critical time for uptake plays a role in the way women decide to seek counseling. Hence, attitudes towards family planning methods have been a factor in assessing views and use. In a qualitative study of Somali and Congolese refugee women, the concept around the role of family planning varied according to their country of origin and resettlement in the United States. Somali women emphasized that women should not manipulate their fertility. In

some instances, women mentioned that it was acceptable to use contraception but only for birth spacing. On the other hand, Congolese women were accepting of the idea of birth spacing in addition to limiting total births (Royer et al., 2020).

The response from Somali women has been previously supported by another qualitative study by Egeh et al. (2019) with Somali religious leaders. Seventeen religious leaders, mainly from the Islamic faith, between 28-59 years, were recruited for an in-depth interview to discuss their views on birth spacing. The leaders' main view was that family planning methods were acceptable as long as the goal was to space births. Leaders stressed that the idea of limiting births is a sin. Furthermore, participants added that not all family planning methods were acceptable, even in the case of birth spacing. They encouraged couples to limit to breastfeeding or contraceptive pills as a tolerable method (Egeh et al., 2019).

Another study using a cross-sectional method was conducted among women refugees resettled in Buffalo, NY. Participants were between 18-50 and had at least one child or were currently pregnant. Most women came from the DRC and Somalia, 49% and 30%, respectively. When asked about attitudes around family planning, almost 25% of women reported that becoming pregnant was a timing decided by God, but 26 % had a time frame in mind for future pregnancies, the remaining 36% chose to either not answer or did not want a future pregnancy (Agbemenu et al., 2020).

When it came to attitudes towards postpartum family planning, family and a partner’s role occupied an essential role in women’s final decision about use. Royer et al. (2020) explored two refugee groups ‘attitudes, Somali and Congolese women between 18

to 64 years old. The authors documented the nuances between the two study groups when assessing themes around reproductive health access and barriers, family planning, and the decision-making process. As part of the decision-making process, Somali women reported not needing to discuss family planning with family or partners. On the other hand, Congolese women had mentioned that their husbands had the final say about family planning methods, and marriage could end if the wife were to go against that decision. Some Congolese pointed out that the reason for not currently using any methods was because their spouses were not in the U.S. (Royer et al., 2020).

Satisfaction. Satisfaction is an essential indicator of whether there has been previous use of family planning methods and determines how likely a woman is to decide on a method based on experience from someone in her social environment. An example of this can be found in the study by Agbemenu, Volpe, et al.(2018) of Somali immigrant women living in Minnesota. Participants revealed that they were more likely to find the benefits of family planning based on sharing personal experiences. Women had shared that their choices were sometimes based on advice from other women (Agbemenu, Volpe, et al., 2018).

Reproductive Health Service Access and Utilization

Previous studies have shown the extent of disparities between immigrants and U.S.-born women regarding reproductive health services utilization and preventive health services (Tapales et al., 2018; Troutman et al., 2020). Furthermore, data showed that postpartum visits have a low utilization rate (Millar et al., 2017). Some of the factors influencing such a low rate included a level of acculturation, lack of knowledge about the

healthcare system, cultural beliefs, and even variance in counseling practices (Dehlendorf et al., 2017; Gele et al., 2020; Ngendahimana et al., 2021; Pinter et al., 2017; Thiel de Bocanegra et al., 2020).

Acculturation

Acculturation can impact health behaviors among an immigrant population. According to Berry's (2005) definition, acculturation is the process of integrating a new culture into one's own and how individuals respond to the process. Social constructs that influence acculturation include language, religion, age at immigration, type of immigration, length of stay in the host country, and education and socioeconomic status (Berry, 2005; Fox et al., 2017). African immigrants have mentioned language as a barrier in navigating the healthcare system. A qualitative analysis of African refugees and immigrants revealed that their no or low English proficiency hindered interaction with (Lynn Woodgate et al., 2017) healthcare providers. Participants were from 15 African countries, including the DRC, Ethiopia, and Somalia. One female participant mentioned that she would just nod at the doctor but left the facility clueless. In some healthcare settings where an interpreter was present, there was a change in health behaviors and an increased use of healthcare services (Ejike et al., 2020).

The type of immigration, such as refugee or asylum and socioeconomic status, can impact reproductive health outcomes due to low healthcare utilization. Agbemenu et al. (2019) conducted a study to test if lower SES, risk factors associated with the refugee process, and low familiarity with the healthcare system were associated with poorer reproductive health outcomes among African refugee women in comparison to U.S.-born

women. African women participants were mainly from Burundi, the DRC, Eritrea, Rwanda, and Somalia. Medicaid status was used as a proxy for SES, and maternal country of birth was used as a proxy for refugee status. African refugee women represented 1%, while U.S.-born blacks and Whites represented 22.5% and 76.5%, respectively. Interestingly, the results showed a positive trend with African immigrants having overall better reproductive health outcomes, such as lower rates of preterm births. However, women reported late perinatal care and low reproductive care utilization compared to U.S.-born women (Agbemenu et al., 2019). This study was limited because the country of birth used as a proxy did not properly differentiate the type of immigration status (e.g., refugee, asylum, and students). The representation of African refugees was reasonably low compared to U.S.-born women. The concept of acculturation is an exciting topic that can be further studied in future research.

Healthcare Knowledge and Use

Health concerns, access to health, and health insurance coverage are areas of interest where public health can address the gap of inequalities by understanding the health experiences of Congolese immigrants. Saksena and McMorrow (2019) highlighted in their qualitative study that Congolese refugee women knew the importance of having health insurance but did not fully understand how to use it. For example, women mentioned having Medicaid coverage and could not comprehend why they would still get a bill from the hospital. Participants also had difficulties familiarizing themselves with billing, payments, and copay processes (Saksena & McMorrow, 2019). Until recently, the focus has been on women facing challenges in their reproductive health needs. In

Massachusetts, a study was conducted on Congolese and Somali women to understand the low reproductive health service utilization. The authors looked at gynecological seeking behavior and discussed barriers to health access. Gynecological care was sought only for pregnancy or when something wrong was causing extreme pain (Mehta et al., 2018).

Medical Trust

Another factor influencing health service utilization is satisfaction with health care providers. If healthcare providers are not culturally sensitive, immigrant women will be less likely to seek care or talk about family planning intentions. Some studies have shown that women valued their healthcare providers' advice when women felt like family planning counseling was individualized and tailored to their current needs and expectations. Women expressed the desire to be heard and trusted that they would make the right choice based on providers' recommendations (Sundstrom et al., 2018). In their qualitative analysis, Cross-Barnet et al. (2018) reported that women sometimes felt pressured to choose a family planning method without being explained or aware of their side effects or contraindications adequately. Participants also said that some providers did not allow them time to think and decide on a method during their postpartum visit (Cross-Barnet et al., 2018). Mistrust also includes the fact that healthcare providers can be prejudiced, assuming that certain ethnic groups would only choose one method over another. For example, Latina women have expressed a feeling of being unheard and just presented with certain family planning options during counseling. Some also mentioned

that providers were trying to rush them into deciding (Carvajal et al., 2017; Rosenthal & Lobel, 2020).

Summary and Conclusions

This chapter included current research on postpartum family planning counseling, African immigrant women, and reproductive healthcare service use and satisfaction. Postpartum family planning counseling is not well-discussed among African immigrant communities, especially Congolese women. Understanding experiences with counseling among women will empower them and make them feel open about discussing family planning desires and options. Additionally, it will give healthcare providers tools for understanding the uniqueness of immigrant groups.

Postpartum counseling increases contraceptive use and decreases pregnancy-related health risks to mothers and babies, including unintended pregnancies and preterm births (Thiel de Bocanegra et al., 2020). Female immigrants have received little family planning counseling due to acculturation factors like language barriers, lack of understanding of the healthcare system, and mistrust of healthcare providers.

Participants in this qualitative study provided valuable contributions to the body of research involving Congolese women. Literature on African Immigrant women is focused on African refugee women. For this reason, not all of experiences can be generalized to immigrant populations. Post-resettlement due to war conflicts and displacement have been shown to affect women differently. However, these studies provided baseline insights regarding some factors related to reproductive health experiences among African immigrant women. Furthermore, I identified the gap in

research. The next step was to study experiences of nonrefugee women and explore their experiences with postpartum family planning counseling.

The postpartum period is vital to help women decide about family planning during their reproductive years. My goal was to provide in-depth information from Congolese immigrant women for healthcare providers and policymakers. Chapter 3 includes an explanation of the methodology and process of finding women as well as data to understand the phenomenon.

Chapter 3: Research Method

The purpose of the study was to examine lived experiences of Congolese immigrant women living in the U.S. with postpartum counseling and explore how counseling informs their decision-making processes. This study also involved understanding Congolese immigrant women's interactions with healthcare services for family planning procurement. This chapter includes information about the methodology that I used to explore this topic. I explained the rationale for the research design. I discussed how participants were selected, ethical implications, setting, and my role as the researcher. Additionally, I explained data collection, analysis, and management.

Research Design and Rationale

Phenomenology was the most appropriate approach for a comprehensive data analysis. In-depth interviews were used with semi-structured questions. I used a set of prepared questions but let conversations flow according to participants. Questions were written to drive conversations and remain on topic.

Role of the Researcher

My role as a researcher was to provide an environment that was suitable to conduct each interview. Since interviews were semi-structured, my role was to ask questions that helped participants be comfortable telling their stories and open up about their experiences. One of my roles as the researcher was determining when data had reached saturation. The sampling methods helped reduce the researcher's bias, which can occur with purposive sampling, where the researcher is looking for information-rich

subjects. However, the snowball method helped reduce the researcher's bias (Clark & Vealé, 2018).

Research Questions

RQ1: How do Congolese immigrants perceive their experiences with postpartum family planning counseling?

RQ2: How do postpartum family planning counseling experiences inform their decision-making processes?

RQ3: How do Congolese immigrants interact with the healthcare system for procurement of modern family planning methods?

Methodology

Participant Selection Logic

The study population was Congolese immigrant women born in the DRC who relocated permanently to the U.S. and have resided for at least 5 years. Participants were between 18 and 45 and had at least one child born in the U.S. within the last 5 years. I excluded women who had refugee or asylum status. I collected information that was pertinent to the study during individual in-depth interviews. I recruited 10 participants, after which I reached saturation.

I used purposive and snowball sampling methods. Purposive sampling involves looking for information-rich participants and providing data to enrich the research topic (Bernard, 2017). One of the disadvantages of using purposive sampling is judgment bias. One way to reduce such bias is to use the snowball sampling method to access subjects using existing participants who are already enrolled in the study (Naderifar et al., 2017).

This allows access to hard-to-reach populations. This study's subjects were immigrant women who needed to talk about their healthcare providers' experiences. If they were approached by acquaintances, they were more likely to accept to become part of the research.

Participant Recruitment

I recruited participants from counties in North Carolina. The state is home to many African associations, including the Congolese Community Association. I posted flyers (see Appendix A) around African beauty salons, African churches, and international grocery stores. I contacted owners of these establishments to help spread the word to their female customers and contacted leaders of African community groups. Approaching community leaders and organizations as points of contact to recruit participants was more successful than using phone calls, email, or flyer strategies alone (Agbemenu, Hannan et al., 2018; Olukotun & Mkandawire-Valhmu, 2020). Flyers contained a summary of research, inclusion criteria for participants, and my contact information. I conducted a phone interview with interested participants and scheduled an individual interview. Participants were legal immigrants in the U.S. and at least 18 (and had a valid state-issued identification card), had lived in the U.S. for at least five years, had a child born in the U.S. within the last five years, received postpartum family counseling at a hospital following a birth or follow-up postpartum visit, sought or tried to navigate the healthcare system for contraception procurement, spoke English, and signed consent forms before interviews.

Before posting flyers, I submitted my application to the Institutional Review Board (IRB) to collect data after receiving approval to work with human subjects.

Data Collection

I collected data through one-on-one in-depth interviews while asking semi-structured questions. The process started once I received approval from the IRB (see Appendix B). Before interviews, I asked participants if they had questions about the study. Then, participants signed informed consent forms or verbally consented. Each interview lasted between 40 and 45 minutes, and participants had the option to choose where meetings took place. Options included a public library, church, and online. I used questions to begin interviews and let participants feel at ease using a conversational manner. At the start of interviews, I also asked participants for their permission to audio record. If they declined to be recorded, I informed them that I would take notes and type them shortly after interviews.

Instrumentation

Data collection instruments included an audio recorder and interview question sheets (Barrett & Twycross, 2018). Demographic information (Appendix C) was collected at the beginning of the interview. Interview questions (Appendix C) were developed according to the researcher-developed instrument using literature sources on contraceptive counseling perception, contraceptive decision making, and phenomenological inquiries (Gele et al., 2020; Metusela et al., 2017; Oakley et al., 2018; Royer et al., 2020). The next step was to test the researcher-developed instrument to assess if the interview questions would capture what they were designed to measure. One

process used in qualitative research is doing a pilot study, which helps determine the study's feasibility, participant selection plan, data collection, and data analysis method (Ismail et al., 2017). I performed a pilot study once the IRB was approved (#09-21-22-0420219).

Data Analysis Plan

Data management is essential for qualitative analysis. The amount of data produced from the interviews needed transcribing, coding, and sorting. Unlike quantitative analysis, qualitative research does not have dedicated software to perform the coding process. However, software analysis tools are available to store the data and support the researcher in managing the data and coding. I used NVivo to complete the data analysis and find emerging themes that helped form the meaning of participants' lived experiences.

Issues of Trustworthiness

Qualitative analysis requires a certain level of replicability of the process and the results. The researcher ensures validity through accuracy and reliability through consistency within the qualitative approach. Trustworthiness refers to a set of criteria that the inquirer uses to determine the quality of the study and the confidence that the reader will have in the results (Cypress, 2017; Guba & Lincoln, 1982). Traditionally, the criteria were identified as truth value, applicability, consistency, and neutrality (Guba, 1981). They have evolved to more practical terms of credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1982). In this section, I described strategies I

applied throughout the methodology to achieve criteria established by Guba and Lincoln (1982) to confirm the trustworthiness of the research.

Credibility

Analogous to internal validity, credibility seeks to ask whether the findings are believable. Among the methods discussed in the literature, I focused on member checks to ensure that participants' lived experiences were kept throughout the interpretation (Cypress, 2017; Guba & Lincoln, 1982; Johnson et al., 2020; Korstjens & Moser, 2018). I continuously checked with members from which the data had been solicited during the data analysis and in the final report to ensure that the interpretations had captured the meaning articulated in the interview (Korstjens & Moser, 2018).

Transferability

Even though qualitative studies such as the phenomenological approach tend to be unique in studying a particular phenomenon observed among a group of people, steps should be made to achieve a sense of generalizability (Guba & Lincoln, 1982). I first displayed transferability through participant selection. According to Guba and Lincoln (1982), purposive sampling is a good method to enhance the transferability of the study. With purposive sampling, the participants are chosen based on a specific purpose, providing rich and in-depth findings of the phenomenon being studied (Cypress, 2017). Additionally, a thick description of the methodology ensured transferability with an in-depth explanation of the data collection, analysis, and final report (Cypress, 2017; Korstjens & Moser, 2018). A thick description will allow other researchers to determine

what aspects of the study can be transferable in a similar context (Guba & Lincoln, 1982).

Dependability

Data produced from phenomenological studies are from emerging themes, so exact replications cannot be achieved. However, the research must take steps to create stability in the data (Guba & Lincoln, 1982). To achieve dependability, I used an audit trail. In this process, I detailed all the research decisions and document all activities involved in the data collection, interview process, and data analysis (Korstjens & Moser, 2018). Koch (1994) argued that even if readers might develop different interpretations from the researcher, they need to know the steps and the decision process taken to arrive at the final report.

Confirmability

The researcher is also considered a vital instrument in qualitative research whose decision-making should be documented. Along with the same procedure used for dependability, I maintained a reflective diary to record the research process and explain the extent of my involvement with data analysis and interpretation. The information in the diary included thoughts, ideas, thought processes I went through when developing themes (Cypress, 2017; Guba & Lincoln, 1982; Korstjens & Moser, 2018).

Ethical Procedures

I only approached participants once I received IRB approval (#09-21-22-0420219). I placed flyers around African beauty salons, African churches, and international grocery stores (Appendix A). I informed women that their participation was

voluntary, and I did not use any coercion or incentive strategies. Participants had an informed consent form that explained the study and were aware that they could withdraw from the study at any point without any penalty. As a sign of gratitude for their time and willingness to share their experience, participants received a $15 gift card.

To maintain confidentiality, I assigned a pseudonym to each participant. Only the signed consent form had the participant's signature, which I kept in a locked cabinet in my home office. Interviews were conducted in a location agreed upon with participants. All recorded materials were saved on my personal computer, protected by a password. I continued to use pseudonyms on the final report, presentations, and any following publications. All related study information, including paper and digital copies, will be kept for five years and deleted after that. Papers will be shredded, and electronic materials will be erased.

Summary

Qualitative interviews were used to provide information that was necessary to address Congolese immigrant women's satisfaction with care while receiving postpartum counseling in the U.S. Data coding required in-depth analysis and interpretation to tell participants' stories. The phenomenological approach was used to describe lived experiences. Chapter 4 includes results and explanations of the findings.

Chapter 4: Results

The purpose of the study was to examine lived experiences of Congolese immigrant women living in the U.S. with postpartum counseling and explore how counseling informs their decision-making processes. I also examined their interactions with healthcare services involving family planning procurement. To achieve this, I interviewed 10 women who described their experiences with family planning postpartum counseling, talked about their perceptions of their visits, and interactions with the healthcare system to obtain contraceptive methods. This chapter includes a discussion of the pilot study to explain how instrumentation was validated. I then present the setting, demographic characteristics of participants, data collection, and analysis. Findings are summarized at the end of the chapter. Quotations from participants were provided to support each theme.

Research Questions

RQ1: How do Congolese immigrants perceive their experiences with postpartum family planning counseling?

RQ2: How do postpartum family planning counseling experiences inform their decision-making processes?

RQ3: How do Congolese immigrants interact with healthcare systems for the procurement of modern family planning methods?

Pilot

The purpose of the pilot was to test the researcher-developed instrument to assess if interview questions would capture what they were designed to measure. After receiving

IRB approval (#09-21-22-0420219), I posted flyers around African business stores to recruit participants for the pilot study. Interested participants contacted me for a phone interview to confirm eligibility and schedule interviews. The pilot study included three participants. I followed the protocol outlined by the IRB by starting with the consent form, and continued after participants gave consent. Interviews took about 40 to 45 minutes, and I asked if questions were clear and understandable. I conducted all three meetings virtually because participants felt the option was more flexible, and they could schedule later in the evening. I summarized interviews and asked participants if I had articulated the meaning of their lived experiences. I also performed member-checking. The pilot study showed the instrument needed no changes.

Setting

After completing the pilot study, I posted flyers around African businesses (such as hair salons, grocery stores, and clothing stores) and churches with a sizeable Congolese congregation to recruit participants. Just as in the pilot study, I screened interested participants by phone to make sure they qualified for the study. Options for one-on-one interviews were either in person, virtually, or by phone. Most interviews were done virtually to accommodate fluctuating schedules. Only two people chose to be in person in a location of their choice. Interviews took 40 to 45 minutes. I conducted interviews until I felt that data had reached saturation. All participants lived in North Carolina. A gift card of $15 was given to participants who volunteered for their time and efforts.

Demographics

All participants were female and between the ages of 26 and 45. The majority had associate degrees that were completed in the DRC. All participants were married and had at least two children, except one. Each participant had been in North Carolina for at least 6 years. Participants lived in the U.S. for 5 or more years and were familiar with the U.S. healthcare system. Eleven women were originally recruited, but one did not complete the interview, and her data were not used.

Table 1

Demographics

Participants	Pseudonyms	Education Level	Marital Status	Age Category	Number of Children
Participant 1	Favor	Associate's	Married	26-35	4
Participant 2	Natasha	Associate's	Married	26-35	2
Participant 3	Alice	Associate's	Married	26-35	4
Participant 4	Rachel	Master's	Married	26-35	3
Participant 5	Pamela	Bachelor's	Married	26-35	2
Participant 6	Delilah	Associate's	Married	36-45	4
Participant 7	Ophelia	Associate's	Married	36-45	2
Participant 8	Nelly	HS Diploma	Married	26-35	3
Participant 9	Tia	HS Diploma	Married	26-35	1
Participant 10	Irene	Master's	Married	36-45	2

Data Collection

Final data were collected from 10 women. I assigned pseudonyms to protect identities. Qualitative data were collected through in-depth semi-structured one-on-one interviews. Most participants preferred virtual interviews through Zoom, and only two were done in person. Before proceeding with interviews, I reviewed the informed consent form, reiterating that participation was voluntary and information was confidential. For in-person interviews, I handed participants a consent form to sign. For virtual interviews,

I asked them to state the words, "I consent." Before starting interview questions, I asked participants demographic questions (see Appendix D). I then described the purpose of the research and interview process and allowed them a chance to ask any questions. I took some notes during interviews but not too much to avoid distracting participants. After interviews, I took more observation notes which served as a reflective diary. I began interviewing for the pilot and main study during December 2022 and finished in March 2023.

Data Analysis

I used manual transcription because a third party might struggle with accents and phrases. Interviews were transcribed verbatim via Microsoft Word by listening and reviewing audio multiple times to ensure I captured all information and answers. I conducted member checking by sending participants a summary of their interviews to verify whether I had understood their experiences via email. I then imported all transcripts to NVivo v.12 for analysis. Thematic analysis was used. I built themes from multiple codes. This approach allowed me to identify, analyze, and interpret patterns of meaning as lived by participants (Maguire & Delahunt, 2017).

I first had to familiarize myself with data, including demographic documents, interview notes, transcripts from audio recordings, and field notes. I later used them for codes and bracketing. As I was reviewing, I highlighted statements that I believed were essential to participants' experiences and stood out. I added notes to margins of transcriptions for later reference in my analysis. During the second phase, I started to generate initial codes. I again highlighted any words and statements that were interesting.

The third phase consisted of searching for themes. This was achieved by finding repeating statements and observations of similar contexts. I then reduced statements to categories and eventually developed brackets of understanding. During the fourth phase, I reviewed potential themes. I started eliminating, moving, or changing my mind about sorting concepts. The fifth phase was defining themes, explaining them, and ensuring they reflected my research questions. The final phase consisted of writing a report to explain the lived phenomenon from data with quotes to support each theme.

Based on the analysis, five themes arose from the data: complexity of the U.S. healthcare system, familiarity with healthcare providers, immigrant status, perceived understanding of family planning, and factors associated with procurement.

Evidence of Trustworthiness

Credibility

Credibility allows the researcher to remain accurate in the data collection and analysis, safeguarding against subjectiveness in the study. I ensured credibility through member checking to promote collaboration between myself and the participants (Korstjens & Moser, 2018). I made a summary of the interview and checked with each participant to make sure that I understood their perspectives. Since English is not their native language, meanings can be misinterpreted while explaining experiences and telling a story. All analysis was done after I received confirmation from participants that their words were well summarized.

Transferability

Even though generalizability is not expected in qualitative research, various methods exist to demonstrate applicability of the study. The process allows other researchers to evaluate concepts of this study that can be applicable for other situations. I demonstrated transferability by keeping a thick description to retain a detailed account of my experience during data collection, analysis, and final report (Cypress, 2017; Korstjens & Moser, 2018).

Dependability

I used journal notes during and especially after the interviews to document participants' interesting statements or gestures. I noted any observations during interviews and questions I wanted to follow up on from a participant's answer. Also, I used an audit trail to document my process of identifying unique codes and theme development. I maintained a log of all the coding in NVivo (Korstjens & Moser, 2018).

Confirmability

I used a reflective diary to ensure that the experiences described in the study reflect the views of the participants and not mine as a researcher. I took notes of any biases and insights I gained after an interview; I asked participants to clarify any statements that were not clear to me. Keeping a reflective diary allowed me to put my biases aside so that they do not influence the findings and interpretations (Cypress, 2017; Guba & Lincoln, 1982; Korstjens & Moser, 2018).

Results

The interviews began by asking participants about their overall experience with giving birth in the United States. Participants shared their experience with birth delivery in a new country as I felt it was necessary to understand their experience with postpartum care and as an initiation to the overall U.S. healthcare system. I then discussed their experience with postpartum family planning counseling and their general perception. I concluded the interviews by asking participants about their interaction with the healthcare system for the procurement of contraceptive methods. I used meaningful statements as in vivo coding, and they became the baseline to develop themes.

RQ1

This question was intended to gain an understanding of the experience of Congolese women during postpartum family planning counseling. Three themes emerged in answering this question using interview questions 9, 10, 11, and 12 (Table 2).

Table 2

Emerging Themes for RQ1

Research Questions	Interview Questions	Emergent Themes
RD1. How do Congolese immigrants perceive their experiences with postpartum family planning counseling?	1. Can you tell me about yourself and your experience with giving birth here in the United States? 2. Can you describe to me an instance when you went to a postpartum family planning counseling visit?	**Theme 1: Complexity of the US healthcare system** Subtheme 1: The U.S. Healthcare System is Highly Organized Subtheme 2: Obligation to See a Healthcare Provider Subtheme 3: Packed Information in a Short Amount of Time

3. What was your experience with your healthcare provider during postpartum family planning counseling?	**Theme 2: Familiarity with Healthcare Providers**
4. How did your status as an African immigrant contribute to the service you experienced?	**Theme 3: Immigrant Status**

Theme 1: Complexity of the Healthcare System

Theme 1 yielded three subthemes as women talked about their experience with giving birth in general, then explained some surprising elements associated with receiving counseling within the healthcare system.

Subtheme 1: The U.S. Healthcare System is Highly Organized. Participants were asked about their overall experience with giving birth in the United States to set the stage for understanding their encounter with reproductive health services. All ten participants agreed that their stay in the hospital was a positive experience when compared to how things are done in their home country, DRC. For example, words like "comfortable," "safe," "private rooms," and "organize" were often mentioned. Natasha elaborated on her first experience giving birth in the United States. She talked about all the prenatal visits and the health portal that allowed her to check everything from her phone. Pamela commented on how safe she felt being at the hospital for delivery. She

added that nurses were “caring and protective of my health and the baby’s, especially when visitors were there.”

Subtheme 2: Obligation to See a Healthcare Provider. As participants began to describe an instance when they went for a postpartum family planning visit, all women noted the need to see a doctor whenever they needed to decide on reproductive care. Natasha stated “I did not go to my first postnatal at six weeks because I was so overwhelmed. I was still in discomfort from my c-section and did not want to go outside. But then, when I was interested in birth control, I realized I must go to the hospital. Well, this is the reality here: you must see a doctor for everything. For the second baby, I went to postpartum 6-week visits to talk about my contraception needs. I felt it would help reduce the number of times I need to see a doctor.”

Delilah mentioned that choosing a contraceptive method can also dictate how often you need to see a doctor. Some contraception methods, such as the IUD, can be provider-dependent. Alice said “The problem with the IUD is that you must see the doctor every time there is an issue. If you think about having it removed, well…it’s another trip to the hospital”.

Subtheme 3: Packed Information in a Short Amount of Time. Another subtheme that emerged as all participants talked about their experience was the overwhelming amount of information given in a short time. In this subtheme, women reported feeling that everything in the United States always felt like a hurry, with doctors and nurses packing a lot of information quickly. Like the hospital stay after a baby's delivery, postpartum family planning counseling visits are short despite important details

needing to be discussed. Tia said “It was just like when I gave birth at the hospital. Nurses kept coming into the room with much information and paper for you to sign. Sometimes, you don't even remember the instructions they give you…When I scheduled a contraceptive visit, it was only for 30 minutes, and you must discuss everything in less than 30 minutes because you also have to do some hospital administration stuff.”

At postpartum counseling sessions, women reported experiencing the same dump of information as during delivery. Rachel added “The nurse had to go through so many methods in a short amount of time that all she kept giving me was their percent effectiveness. The first time I went to my contraception counseling, I thought it would be more like a conversation. I did not want it to be like a list of dos and don’ts. It was all technical.”

Theme 2: Familiarity with Healthcare Providers

Participants were asked about their overall experience with their healthcare providers during a postpartum family planning counseling session. Findings on this theme were mixed, with four participants remembering a positive experience with their healthcare providers. Alice said “I became more comfortable with my provider by the second baby. I felt comfortable talking about my feelings and emotions and felt like I could go back to her with any questions”.

Three participants reported a negative experience with their healthcare providers, with some feeling like there was no closeness with the provider, so it was challenging to open up too much about any concerns. Nelly added “When I had my first baby, I never had the same Ob/gyn during my antenatal visits, at delivery, and when I went for

postpartum family planning counseling. The process did not allow me to become familiar with a provider and voice all my concerns".

For one participant, the experience was plain "horrible," feeling the healthcare provider's disrespectful and condescending attitude. Pamela said "I told my provider that I wanted to stop using the patch because it was bothering me, making me feel angry all the time. But she did not believe me. Then she was like, oh well, whatever you want". Pamela summarized that an exchange like this makes the conversation less enjoyable and leaves one wanting the counseling session to end.

Theme 3: Immigrant Status

When participants were asked if their status as an African immigrant woman contributed to their service experience, interviewees thought their ability to speak English and communicate their needs were paramount. All participants felt their status as African immigrants did not affect their experience and answered "no" to this question. However, three women expressed how fluency in English could impact how you receive counseling. Tia, who mentioned having used some interpreters when she first arrived in the United States during hospital visits, said "I'm glad I do not need interpretation services because some providers do not like to go through them."

RQ2

Table 3

Emerging Themes for RQ2

Research Questions	Interview Questions	Emergent Themes
RQ2. How do postpartum family planning counseling experiences inform their	5. How did the information received during	**Theme 4: Perceived Understanding of Family planning**

decision-making processes?	postpartum family planning counseling influence your decision to use contraception?	Subtheme 1: Perceived Side Effects and Subtheme 2: Importance of Birth Spacing
	6. Before receiving postpartum family planning counseling in the United States, did you know about family planning methods before?	Subtheme 3: Previous Knowledge as an Empowering Tool

Theme 4: Perceived Understanding of Family Planning

There were three subthemes that best summarized how family planning counseling sessions informed women's decision-making.

Subtheme 1: Information on Side Effects. Participants were asked how the information from the postpartum family planning counseling sessions helped inform their decisions. Irene stated "I wanted to make sure that the method I chose will help me easily resume trying to conceive. My friend had the injection and said that when she wanted to get pregnant again, she couldn't, and she was never able to get pregnant again. That's why I went with the patch."

Women felt like side effects were not explained correctly. Discussing side effects was often overlooked, and information focused mainly on the method's effectiveness. Tia said "they said that the IUD makes you stop bleeding every month after some time. I did not feel comfortable with that. I am not sure if it is good for your body to stop bleeding." Alice added "With the IUD, my bleeding was slightly unpredictable." Favor also

confirmed “I had the IUD after the third baby, but I had to ask them to take it out because I was feeling unstable. My mood changed too much”. Pamela said, “I had the patch, and often I was easily irritable, always dealing with mood swings.”

Subtheme 2: Importance of Birth Spacing. Along with the importance of the information received from postpartum family planning counseling sessions, birth spacing was cited as an essential factor for choosing contraceptive methods for nine women. Favor explained “I already had a method in my mind because I had a timeframe of when I want to get pregnant again. I just wanted to make sure that I choose a method that I can discontinue quickly and resume fertility”. Alice said, “I wanted to have IUD put in after my 2nd child because I decided to go back to school to receive an associate degree”. Only one woman, Ophelia, mentioned that birth spacing was not important for her because here goal was to limit births. She said: “I did not have counseling with my first baby because I was ready to have another one. But I chose a permanent method for my second because I wanted to focus on my career”.

Aside from pursuing a career, three women wanted to talk about birth spacing as a way to recover and be healthy for another pregnancy. Nelly argued: “Many of my friends told me that the long method made it difficult to get pregnant again. I just wanted contraception because I had a c-section and wanted to make sure I didn’t get pregnant immediately, you know, to allow my wound to heal”.

Subtheme 3: Previous Knowledge as an Empowering Tool. This subtheme emerged from asking participants if they knew about family planning methods before receiving postpartum counseling in the United States. Six participants had received some

education about contraceptives in the past. They mentioned that the forms of contraception discussed in the visits were not so foreign to them. This knowledge was, for some, a motivator to go for counseling and contraceptive uptake. Natasha said "A group of educators used to come to the university to talk about contraception. Since I was young and not planning to get married soon, I did not ask many questions. However, I was aware of most contraceptive methods". Rachel added "At our church, we had ladies' meetings where they used to address contraception to space births. Because maternal mortality is so high back in the country, we were encouraged to discuss contraception with our physician after getting married".

RQ3

One theme emerged regarding Congolese immigrant women's experiences involving procuring family planning methods (see Table 4).

Table 4

Emerging Themes for RQ3

Research Questions	Interview Questions	Emergent Themes
RQ3. How do Congolese immigrants interact with healthcare systems for the procurement of modern family planning methods?	7. Describe your experience with the healthcare system in getting any form of contraception. 8. Did this experience affect the type of contraception you decided to use? 9. How, if at all, did your type of insurance contribute to your choice of	**Theme 5: Factors associated with Procurement** Subtheme 1: Convenience of Some Family Planning Methods Procurement Subtheme 2: (Affordability) Burden of Unknown Healthcare Costs

contraceptive methods?

Theme 5: Factors Associated with Procurement

Two subthemes surfaced when participants talked about their interaction with the healthcare system, mainly pharmacies, to obtain family planning methods. They highlighted the convenience of procurement and the burden of unknown healthcare costs to afford contraceptives.

Subtheme 1: Convenience. Convenience In this subtheme, participants described their experience with the healthcare system for procurement of family planning methods and how this interaction impacted their overall decision. Seven women who chose short-term contraceptive methods felt that going to the pharmacy was convenient. Rachel said "I don't like to go to the doctor's office all the time, you know. For example, when I return to work, I must ask for time off, and I don't get paid for that day. So, I got the pills. My friend had injections and had to return to a doctor's office often. I liked the fact that you could go to the closest pharmacy, go to the drive-through window, and get it without needing to get out of the car. Whenever I need a refill, I could stop by the pharmacy after work."

Subtheme 2: Affordability. In the final part of the survey, participants were asked if the type of insurance contributed to their choice of contraceptive methods. All participants mentioned discussing cost-sharing with their healthcare providers during counseling sessions to ensure their insurance plan type had little or no out-of-pocket expense. Rachel shared this "When I had my first baby, they told me there would be a

copay with my insurance if I went with the IUD. I did not want that. Here in the United States, you always get a surprise bill after a visit to the hospital. I had to think about minimizing my expenses. But I did not care about the cost after my second baby because I was not interested in having another baby". Another woman, Delilah, expressed frustration with medical bills and did not want to deal with the out-of-pocket cost of contraception.

Summary

Five themes emerged from research questions to understand lived experiences of Congolese women going through postpartum family planning counseling and discover how counseling informs their decision-making processes. Furthermore, themes also helped to understand interaction experiences with the healthcare system involving family planning procurement. A total of 10 participants were recruited and able to share their experiences with postpartum family planning counseling and interactions with the healthcare system involving contraception procurement. Each participant answered nine open-ended interview questions following the same data collection process. Data collection and analysis followed to ensure integrity of participants' views and minimize researcher bias.

What developed from interviews is that participants felt the importance of birth spacing during their reproductive journey, which drove their decision-making processes during postpartum family planning counseling sessions. Another theme that emerged among all participants was that the U.S. healthcare system was highly organized, and most policy requirements were in place to maximize maternal and infant positive health

outcomes. The significance of themes is further discussed in Chapter 5, where interpretations, limitations, further recommendations, and implications of the study are addressed.

Chapter 5: Discussion, Conclusions, and Recommendations

This chapter includes interpretations of findings from Chapter 4. The purpose of this study was to examine lived experiences of Congolese immigrant women living in the U.S. with postpartum counseling and explore how counseling informs their decision-making processes as well as interactions with healthcare services for family planning procurement. To achieve these aims, a phenomenological approach was employed using semi-structured one-on-one qualitative interviews.

Use of postpartum family planning counseling differs among immigrant women, with this particular group being less likely to receive high-quality counseling on postpartum contraception. Consequently, there are disparities in terms of contraception uptake and maternal outcomes compared to U.S.-born women (Coleman-Minahan & Potter, 2019). Previous research has predominantly focused on Latina women, examining their attitudes, beliefs, perceptions, and experiences with family planning and counseling. However, as the number of African immigrant women in the U.S. is increasing, studies have begun to explore their family planning use patterns and experiences with postpartum services, including counseling. Most studies have primarily concentrated on refugee populations from countries such as the DRC, Somalia, or Ethiopia. Additionally, none of these studies investigated how African immigrant women navigate the healthcare system to access family planning methods. This study contributes to existing literature by addressing experiences of Congolese immigrant women from the DRC. Through interviews, five themes emerged: (a) complexity of the U.S. healthcare system, (b) familiarity with healthcare providers, (c) immigrant status, (d) perceived understanding of

family planning, (e) factors associated with procurement. This chapter not only includes interpretations of these findings but also discusses study limitations, recommendations, implications for social change, and a conclusion.

Interpretation of the Findings

The experience of participants during postpartum family planning counseling and navigating the healthcare system for procurement is discussed and compared to previous studies in Chapter 2. Given the increasing number of Congolese immigrant women and importance of promoting postpartum contraceptive use, it is crucial to comprehend the experiences of Congolese women during family planning counseling.

Theme 1: Complexity of the U.S. Healthcare System

Participants in the study highlighted challenges when interacting with the healthcare system for maternal services and postpartum family planning counseling. They acknowledged that for first-time users, the system can be overwhelming and difficult to navigate. Language barriers and insurance issues are common complexities within the healthcare system (Banke-Thomas et al., 2019; Bustamante et al., 2019; McKenney et al., 2018). Participants in this study added the quality aspect of service as another complexity, expressing concerns about rushed services provided by healthcare providers.

Interviews revealed another dimension of the U.S. healthcare system, which is the necessity of consulting a healthcare provider to obtain contraceptives. All participants emphasized that the postpartum period is already challenging due to responsibilities of caring for a newborn and fulfilling pediatrician visit obligations. However, any decision related to family planning and its uptake necessitates a consultation with a healthcare

provider. This discovery aligns with previous research on both U.S.-born women and immigrant women. For example, participants raised concerns about drawbacks of long-term contraceptive methods such as IUDs. These include the requirement to consult a doctor for the insertion and removal of the IUD, as well as any potential complications that may arise (Janiak et al., 2018; Namasivayam et al., 2022).

Participants provided further insights regarding the brevity of family planning counseling sessions, comparing them to hospital stays during childbirth. They expressed a sense of rushed visit times, leaving them with limited opportunities to ask questions or voice concerns. Because of tightly-scheduled systems, interactions between healthcare providers and patients are constrained, focusing primarily on discussing one or two family planning methods while overlooking other concerns. This issue of limited counseling duration has been identified by both U.S.-born and immigrant women (Manzer & Bell, 2022; Thiel de Bocanegra et al., 2020). It is crucial to acknowledge that nonnative English speakers often require additional time to effectively communicate their needs.

Theme 2: Familiarity with Healthcare Providers

All participants felt having the same healthcare provider for other gynecological and obstetric care, especially one who was personally chosen, made the experience with counseling positive and comfortable. Although coercion was not mentioned, some participants reported experiencing unsupportive attitudes from providers when expressing a preference for a specific contraceptive method. This negative experience often occurred when participants had to see a healthcare provider whom they were not familiar with. For

Nelly and Pamela, receiving maternal care and postpartum counseling from different healthcare providers hindered smooth patient-provider interactions. At the time, they were informed that their Medicaid coverage required them to see different providers.

By contrast, participant Alice expressed her satisfaction with her OBGYN doctor, whom she had for all gynecologic, maternal, and reproductive health care for over 4 years. Alice felt she could ask her doctors anything and send online messages via the hospital patient's online portal knowing she could trust their doctor's answers. As a result, Alice reported a positive overall experience during postpartum family planning counseling sessions. In a study by Ahad et al. (2019), African immigrant women who had consistent primary healthcare providers experienced a 15.0% increase in health literacy compared to those without a regular doctor. Although Ahad's research concentrated on primary care, shared experiences of Congolese women from this current study emphasizes the crucial role of consistent healthcare providers in empowering women to make informed decisions regarding family planning methods.

Latina women expressed a desire to consult with multiple healthcare providers, as they perceived certain providers exhibited bias towards specific methods and certain racial and ethnic communities. However, they emphasized that initiating family planning counseling during the prenatal period is the optimal time to engage with multiple providers (Sznajder et al., 2020).

Theme 3: Immigrant Status

Participants did not perceive their immigrant status as influencing their experience. Somali immigrant women were more focused on ways they were treated in

terms of their Islamic religion, which was part of their culture and beliefs, rather than being immigrants (Agbemenu, Volpe et al., 2018).

Fluency in the English language had an impact on experiences of certain participants. Regarding use of interpreters, two participants expressed their dissatisfaction, finding it unpleasant. Kolak et al. (2022) indicated immigrant women felt uncomfortable discussing contraception due to its private nature and believed interpreters were not conveying everything accurately. Gele et al. (2020) claimed some Somali-born women desired the presence of professional interpreters. This study's findings contribute to existing research by demonstrating that counseling experiences involving postpartum family planning may not necessarily differ based on immigration status, but rather culture and comfort with the English language.

Theme 4: Perceived Understanding of Family Planning

Side effects were extensively discussed during individual interviews. Participants acknowledged that certain side effects, such as mood swings or irregular periods, were anticipated. Nevertheless, they expressed their dissatisfaction with healthcare providers who often failed to provide comprehensive information about these side effects and how one might feel about them, particularly due to appointment time constraints. Additionally, some participants mentioned instances where healthcare providers disregarded their concerns or displayed a dismissive attitude when providers believed the side effects were unfounded.

Participants reported a positive experience with postpartum family planning counseling and contraceptive decision when the conversation was centered around birth

spacing rather than limiting births. Women recognized the significance of family planning methods due to reasons such as emergency c-sections (which required some time to recover from the surgery before another pregnancy). In this case, they preferred counseling that focused on short-acting methods rather than long-acting methods like IUDs if they wanted a relatively shorter interbirth intervals. When women had the desire to pursue education or employment opportunities, they were fine with IUDs. This finding aligns with previous studies that highlight how Somali women's perceptions on the importance of family planning methods for birth spacing changed after immigrating to the United States as they became aware of reality of the new host country (Olorunsaiye et al., 2023; Robinet et al., 2023; Zhang et al., 2020).

Participants with a higher level of education, like Natasha and Rachel, demonstrated prior knowledge and awareness of family planning methods. They believed that this knowledge empowered them during discussions with their healthcare provider and reduced feelings of coercion (Berndt & Bell, 2021). This observation is consistent with another study that revealed Congolese women exhibited greater familiarity with family planning methods and a higher level of acceptance compared to Somali women (Royer et al., 2020).

Theme 5: Factors Associated with Procurement

Overall, the participants expressed satisfaction with the process of obtaining family planning methods, while highlighting concerns regarding affordability. They found that the methods they desired were readily available, particularly for short-acting options like the pill. The presence of drive-through pharmacies and extended operating

hours were convenient and helped overcome certain barriers to accessing family planning methods. However, for long-acting contraceptives, acquiring them required additional visits to the doctor's office. Nevertheless, once inserted, these methods did not require any ongoing maintenance from the user.

The affordability of family planning methods posed a concern for women, particularly those with private insurance and Medicaid for Pregnant Women (also called Emergency Medicaid). Women with private insurance expressed worry about copayments and unexpected expenses, as they already felt burdened by the costs associated with hospital baby deliveries. However, when it came to choosing long-acting or permanent family planning methods after completing their desired number of children, Rachel, one of the participants, did not express any concerns regarding the expenses involved. She stated that the out-of-pocket cost for a permanent family planning method is more reasonable compared to the expenses associated with raising another child. Additionally, participants who were covered by traditional Medicaid, which continues to cover medical expenses beyond pregnancies, did not have any worries about the financial aspect. These findings align with previous studies conducted on U.S.-born and immigrant Latina women, which also highlighted the advantage of traditional Medicaid coverage when choosing any types of family planning methods (Rodriguez et al., 2022; Rodriguez, Skye, et al., 2021; Yates et al., 2022).

The inclusion of discussions on the convenience (accessibility) and affordability of family planning methods in this topic contributes to the existing literature, providing insights into the reasons behind the frequent use of short-acting as opposed to long-acting

contraceptives among African women immigrants (Agbemenu et al., 2020; Cope et al., 2019; Rodriguez, Kaufman, et al., 2021).

Interpretation of the Findings and SCT

The understanding of the results obtained in this research study is demonstrated through the application of the Social Cognitive Theory (SCT) and the incorporation of the constructs of self-efficacy and outcome expectancy. Bandura's SCT explains how personal, behavioral, and environmental factors interact to motivate individuals to adopt new health behaviors (Chess et al., 1978; Wood & Bandura, 1989). In order to support women in making informed choices regarding family planning, postpartum family planning counseling serves as an intervention that provides information to facilitate decision-making and encourages the initiation of contraceptive use. Hence, the effectiveness of counseling is crucial in ensuring satisfaction and empowering women to continue using contraception as desired (Coleman-Minahan & Potter, 2019).

Bandura's constructs of self-efficacy and outcome expectancy within the SCT suggests that individuals are more inclined to engage in a particular behavior when they possess both the belief in their ability to effectively perform the necessary actions and the expectation of achieving a desired outcome (Bandura, 2004; Chess et al., 1978). In the context of my research, all participants had made a contraceptive decision and adopted its use. The research findings highlighted factors that impacted the participants' self-efficacy and expected outcome motivators while engaging in postpartum family planning counseling and navigating the healthcare system for method procurement. These factors could either strengthen or undermine their self-efficacy. Information about these factors

can be utilized to educate healthcare providers on these factors, enabling them to enhance self-efficacy and gain a better understanding of the expectations of Congolese women when making contraceptive decisions during family planning counseling.

Self-Efficacy

Proficiency in the English language was found to enhance comfort during patient-provider interactions. Hence, it played a role in strengthening women's self-efficacy in making informed decisions, as they were able to comprehend the information provided by the provider.

The discussion regarding family planning methods and their potential side effects was deemed important by the participants, as it positively influenced their self-efficacy. Participants expressed a desire for healthcare providers to exhibit patience and attentiveness when addressing concerns about side effects, as it could impact the acceptability and adherence to the chosen method. Additionally, participants who possessed prior knowledge of contraception reported a positive experience with counseling and were able to engage in discussions about methods they were already familiar with.

Finally, the participants' self-efficacy was influenced by the procurement of family planning methods. The type of insurance they had significantly influenced their experience with the healthcare system. When women had access to their preferred method, it increased their satisfaction and confidence in using the method. Conversely, when women's contraceptive options were limited due to cost, it impacted their contraceptive decision-making.

The findings indicated that short-duration family planning counseling sessions, and unfamiliarity with healthcare providers undermined self-efficacy. Participants expressed that rushed appointments resulted in limited time for establishing trust and discussing personal concerns. Moreover, unfamiliarity with healthcare providers hindered meaningful patient-provider interactions, potentially leading to cold-toned family planning counseling.

Outcome Expectancy

The participants shared a positive encounter, and a key motivator that influenced their decision-making was when the counseling emphasized the significance of spacing pregnancies. This was especially important for reasons such as pursuing educational or employment opportunities and recovering from a medically difficult childbirth like emergency c-section.

Limitations of the Study

Despite the rigorous application of qualitative research principles, the study had a few limitations. One such limitation was that participants needed to be comfortable conducting a 40–45-minute interview in English, which resulted in the exclusion of individuals who lacked confidence in conversing in English. This restriction may have hindered the exploration of different perspectives on women with limited English proficiency and their ability to share their stories. However, it is worth noting that the study's findings align with previous research on African immigrants in the United States, where participants were able to freely express themselves in their native language with the help of interpreters.

Another limitation is that interpretation of the findings in this study may not accurately represent the experiences of recently arrived Congolese women, as the participants had already resided in the United States for a minimum of five years. However, despite this limitation, the study's findings will still make a valuable contribution to the existing research on postpartum family planning and service utilization among African immigrant communities in the United States.

Recommendations

Conducting research plays a crucial role in improving the healthcare system and guiding clinical practice. Evidence-based research offers valuable data and findings that support healthcare providers and public health workers in developing effective interventions. With the rise in immigration and permanent resettlement of non-U.S. born women, it is imperative to establish public health policies and practices that can improve the quality of care for diverse immigrant populations. Although there is a growing body of research on family planning counseling and behaviors among African immigrant women, it is important to recognize the cultural and belief-based variations among them. Therefore, further studies are needed to explore the experiences of African women in the United States from different countries (Okeke-Ihejirika et al., 2018; Olorunsaiye et al., 2023).

The findings of this study provide valuable recommendations for future research and practice. The recommendation for future research is to focus on exploring the experiences of healthcare providers when interacting with African immigrant women, beyond the existing research on Somali women (Agbemenu, Volpe, et al., 2018; Banke-

Thomas et al., 2019; Egeh et al., 2019; Zhang et al., 2020). This research should aim to understand the challenges healthcare providers face and identify the similarities and differences in delivering family planning counseling to various African immigrant women. By utilizing the findings from these studies, policies can be developed to enhance patient satisfaction and provide cultural competency training to healthcare professionals, enabling effective communication and foster trust.

The first recommendation for practice is to increase the utilization of telehealth medicine for family planning counseling. The COVID-19 pandemic and its aftermath have led to the emergence of digital health, which has transformed the way healthcare providers can reach out to underserved communities (Keesara et al., 2020). This option is particularly beneficial for English-speaking African immigrant women as it reduces the need for frequent visits to healthcare facilities, promotes more patient-provider interactions, facilitates decision-making, and enhances the overall experience of postpartum family planning counseling. A study conducted by Hill et al. (2021) found no significant difference in the use of telemedicine versus in-clinic services among Latina women. Women who were unable to utilize telemedicine mentioned reasons such as the lack of Spanish services or translation availability (Hill et al., 2021).

The second recommendation for practice is for healthcare providers to exercise patience and empathy when discussing family planning options with patients, taking into consideration the various factors that influence their decisions. It is crucial for providers to recognize that immigrant women may prioritize their cultural values and beliefs while

also grappling with the challenges of adapting to a new country and its realities (Omenka et al., 2020).

Implications

The findings provide valuable insights for healthcare providers and policymakers in comprehending the lived experience of Congolese women in postpartum family planning counseling, as well as the factors that influence their decision-making. Additionally, it enables them to identify factors that affect their access to family planning methods in a complex healthcare system. The experiences shared by Congolese women in this study shed light on certain aspects that can enhance the delivery of services. This is of utmost importance as it aids healthcare providers and policymakers in promoting the adoption of family planning methods across diverse racial and ethnic groups to reduce disparities, while empowering women to sustain family planning uptake.

Public health goes beyond clinical settings to enhance patient outcomes by exploring community-based approaches, such as culturally appropriate education. Participants who reported having prior knowledge of family planning methods received this information as part of community programs (e.g. public health workers going to universities). Consequently, the findings indicate that community-level programs that emphasize teaching the advantages and disadvantages of different family planning methods can empower Congolese women with knowledge to increase self-efficacy and reduce the pressure to make hasty decisions during brief family planning counseling (Dolan et al., 2020; Gele et al., 2020).

Conclusions

Through this study, Congolese immigrant women have contributed their personal experiences with counseling and navigating the healthcare system for family planning methods. This study is the first to explore these aspects within a non-refugee population of Congolese immigrant women in the United States. Through a phenomenological study involving 10 participants, five themes emerged that can enhance the overall experience of immigrant women during family planning counseling. These themes include the complexity of the U.S. healthcare system, familiarity with healthcare providers, immigrant status, perceived understanding of family planning, and factors related to procurement. The participants understood the importance of confidentiality and believed that sharing their experiences would contribute valuable data to research and daily practice. This study's findings are innovative and essential to public health, as they provide unique insights from a population that has been underrepresented in previous research.

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Appendix A: Recruitment Flyer

Appendix B: Informed Consent

Informed Consent for Dissertation Research Participation: The Lived Experience of Congolese Women with Postpartum Family Planning Counseling in the United States

I, _____ _____, agree to participate in a research project regarding my experience with postpartum family planning counseling which is being conducted by Lemba Nshisso (Doctoral candidate) of Walden University. The purpose of the study is to examine the lived experience of Congolese immigrant women living in the United States with postpartum counseling and explore how counseling informs their decision-making process.

I understand that to participate in this study, I will be asked questions such as education level, marital status, number of children, employment status, insurance type, and current family planning use.

I understand that Mrs. Nshisso will only select individuals who she believes will fit best into the following criteria for participation in the study:

1. Are legal immigrants in the United States and at least 18 years old (will have a valid state-issued identification card)
2. Have migrated to the United States within the last five years
3. Have had a child born in the United States within the last five years
4. Have received postpartum family planning counseling at the hospital following a birth or at a follow-up postpartum visit
5. Have sought and tried to navigate the healthcare system for contraception procurement
6. Can speak English

I understand that if I am not initially selected for participation in the study, my information will be kept until the completion of the study should the need for additional participants arise. If more participants are requested, I will be contacted to assess my interest in participating in the study.

I understand that my participation in this study will involve answering questions provided to me as a hard copy of my experience. Participation involves being interviewed by Lemba Nshisso and will last approximately 30-45 minutes. Notes will be written during the interview. An audiotape of the interview and subsequent dialogue will be made. If I don't want to be taped, I will not participate in the study. Tapes will be transcribed for analysis and destroyed when the study is complete.

I understand that most interviewees will find the discussion engaging and thought-provoking. If, however, I feel uncomfortable during the interview session, I have the right to decline to answer any question or end the interview.

I understand that this study aims to contribute to the body of research by understanding how healthcare providers can best interact with Congolese immigrant women and discuss family planning methods during counseling.

I understand that the researcher will not identify me by name in any reports using information obtained from this interview. My confidentiality as a participant in this study will remain secure.

I understand that Mrs. Nshisso will give me an executive summary of my transcribed interview after her dissertation. I have the right to withdraw from this study at any time.

At the end of this study, I understand that all documentation that is matched with my name will be kept in a secured location along with all written documentation, computer files, audiotapes, identifying information, and all other information related to me. The reason for this is to ensure confidentiality. All materials will be destroyed after five years. Under this condition, I agree that any information obtained from this research may be used in any way thought best for publication or education, if I am in no way identified and my name is not used.

I understand that the study will be shared with Ms. Nshisso's dissertation committee at Walden University. Disguised extracts from my interview may be quoted in her dissertation or publications. I agree that any information obtained from this research may be used in any way thought best for publication or education if I remain anonymous.

I understand a gift card for $15 will be provided as a gratuity for my participation in this study. Whether I complete the research study or decide to withdraw, I am still entitled to the gift card.

I understand that minimal personal risk and no physical discomfort are directly involved with this research.

I understand that if I have any questions or problems that arise in connection with my participation in this study, I should contact Mrs. Nshisso, the researcher, at 704.787.1717 (Email at lemba.nshisso@waldenu.edu). For research problems or questions regarding subjects, the Institutional Review Board may be contacted through [information of the contact person at Walden IRB office]. Walden University's approval number for this study is [insert approval number], and it expires [insert date].

I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study. I have been given a copy of this consent form.

Date: _____ Signature of Participant _____
Date: _____ Signature of Investigator _____

Appendix C: Demographic Information and Interview Questions

Demographic Information

1. Education Level

☐ Less than High School ☐ High School ☐ Associate Degree

☐ University Degree ☐ Advanced Degree

2. Marital Status

☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Living with Partner

☐ Wish not to disclose

3. Age category

☐ 18-25 ☐ 26-35 ☐ 36-45

4. Current Employment Status

☐ Full-time ☐ Part-time ☐ Unemployed

5. No of Children

☐ 1-2 ☐ 3-4 ☐ 5 or more

6. Do you have health insurance?

☐ Yes ☐ No

7. Type of Health Insurance

☐ Private ☐ Public ☐ None

8. Currently Using Contraception

☐ Yes ☐ No

Interview Questions

9. Can you tell me about yourself and your experience with giving birth here in the United States?
10. Can you describe to me an instance when you went to a postpartum family planning counseling visit?
11. What was your experience with your healthcare provider during postpartum family planning counseling?
12. How did your status as an African immigrant contribute to the service you experienced?
13. How did the information received during postpartum family planning counseling influence your decision to use contraception?
14. Before receiving postpartum family planning counseling in the United States, did you know about family planning methods before?
15. Describe your experience with the healthcare system in getting any form of contraception.
16. Did this experience affect the type of contraception you decided to use?
17. How, if at all, did your type of insurance contribute to your choice of contraceptive methods?
18. Is there anything else you would like to share?

I would like to thank you for participation. Do you have any questions?