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## Urban African American Women's Perceptions of Health Care Inequalities Experienced During or After Pregnancy

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# Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Janel Annette Scott

has been found to be complete and satisfactory in all respects,  
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the review committee have been made.

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Walden University  
2024

Abstract

Urban African American Women's Perceptions of Health Care Inequalities Experienced

During or After Pregnancy

by

Janel Annette Scott

MPhil, Walden University, 2021

MA, Argosy University, 2013

BS, Winston-Salem State University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

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## Abstract

African American women are more likely than Hispanic and non-Hispanic White women to die during or after childbirth from complications. Incidences of African American maternal death are especially prevalent in the urban living population. The purpose of this qualitative study was to explore the healthcare inequalities that urban-living African American women have experienced during or after pregnancy. Link and Phelan's fundamental cause theory, which states that there may be a relationship between socioeconomic status and mortality, served as the theoretical foundation for the investigation. A generic qualitative research design was used. Ten participants were interviewed and surveyed to gain insight into African American women's perspectives on healthcare services and their interactions with healthcare professionals. The collected data were analyzed following Braun and Clark's five-step thematic approach. The results highlight the participants' beliefs that there is a differentiation in health care services, a widespread view that African American women are strong and pain tolerant, and varying health care services based on environment and medical insurance. The participants also expressed that patient advocacy is important during and after childbirth. This study could contribute to positive social change through its recommendation that human services practitioners be agents of advocacy for their African American clients. The highlight of this study could effectively shift attention toward the cultural and political conditions that contribute to health care professionals' implicit bias towards this group of individuals and offer awareness of the driving factors of the social determinants of health.

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## Dedication

This process has not been easy. There were many ups and downs that I experienced during the pursuit of this time-consuming accomplishment. I would first like to dedicate this body of work to my children: Maziyah Artis, Kori Jackson, and Kali Scott. The three of you have been my biggest motivations in pursuing a PhD and why I continued this journey when I wanted to give up numerous times. Secondly, I want to send a dedicated shout-out to my sister, MaShawn Scott. You have always encouraged me to look beyond my environment and never to let what I have experienced in life be the baseline for my life. I love you girl! I want to dedicate this finished accomplishment to my parents, Mikal Muhammad and Janice Scott. Lastly, I dedicate this study and all of the insight gathered to the African American women who provided valuable insight into their experiences of health care inequalities and how we can change this system one person at a time.

## Acknowledgments

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## Chapter 1: Introduction to the Study

The health care system has been designed to play a critical role in advancing health equity by providing support during the prenatal and postpartum stages. However, the current state of health care in the United States, coupled with organization fragmentation and institutional as well as systematic disadvantages has resulted in developing inequalities that hinder the access to and adequacy of health care services (National Academies of Sciences, Engineering, & Medicine, 2019). In urban areas, inequities in the access to health resources among African Americans can create disparities in health care utilization while limiting practice-based priorities that focus on addressing and recognizing social needs in the health care setting (Muirhead et al., 2022). Also, it is suggested that unequal and unfair social justice policies as well as inadequate economic provisions can influence countless health inequalities (Brown, 2021).

Furthermore, the social determinant approach to health emphasizes that when there is improvement in conditions regarding housing, employment, education, social support, and health services in this area, then there could potentially be a positive impact on health outcomes (Muirhead et al., 2022). Evidence has shown that health inequalities and differential health outcomes exist for different races and ethnicities, which has included differences in the individual's ability to achieve optimal health and other dimensions such as socioeconomic status (SES) and geographic location (Martinez & O'Lawrence, 2020). Health care inequalities refer to the systematic and often avoidable differences in health outcomes observed between populations or social groups, generally indicating the individual's social position in that population (McCarthy et al., 2019).

Subsequently, several factors influence the racial inequalities component within the U.S. health care system. Those influential factors are the higher-than-normal representation of minorities in lower socioeconomic groups, environmental factors such as access to care, living in dangerous surroundings, and cultural values and norms (McCarthy et al., 2019). While looking further into past research, Jupka et al. (2008) explained, “African American women believe racism is common in the system and that pregnant African American women often suffer from stereotyping.”

Current research literature includes the implication that health care inequalities have an overall impact on health outcomes although there is minimal emphasis on pregnancy health care inequalities. However, there have been limited research studies that explore inequalities in health care during or after pregnancy from the personal perspective of African American women. The need for this research is very evident regarding future implications for advancement in better health care practices for African American women. Specifically, the exploration of the effect health care inequalities has on African American women’s experience during or after pregnancy while living in urban populations could assist in the understanding of African Americans’ perception of providers while increasing more productive interaction. This chapter focuses on explaining the background behind racial/ethnic inequalities in health care, addresses the problem with this phenomenon, discusses the purpose of conducting this study, and discusses the theoretical framework and nature of the study. In addition, the researcher provided insight by discussing this study's assumptions, scope, limitations, and significance within the human services field.

## **Background**

Unfortunately, the race of a person has become one of the most prominent determinants of health as it contributes to social inequalities that often shape one's health behaviors, access to health, and interactions with health professionals (National Heart Lung & Blood Institute, 2021). Informatively speaking, African American women tend to suffer from higher infant mortality rates, low birth weight, and higher incidences of maternal complications during pregnancy than their Western American counterparts (Connell et al., 2019). Often, African American mothers are less likely to receive additionally monitored care after giving birth and expressed that their concerns about arising postnatal issues were dismissed when voiced to their health care provider (Roeder, 2019). Additionally, some of these patients have described experiences of being discharged from the hospital with minimal resources to support their postpartum journey of care and with potentially harmful medical symptoms that have developed after childbirth (Roeder, 2019). Subsequently, when physicians and patients share the same race or ethnicity, the time spent together improves medication adherence, shared decision-making, wait times for treatment, and patient perceptions of treatment decisions (Imhoff, 2020). Furthermore, an understanding of how racial and ethnic variations in maternal health indicators and contributors should be recognized to achieve health equity and eliminate health disparities (Winnie & Bervell, 2023).

Njoku et al. (2023) noted that many risk factors have a role in an African American woman receiving insignificant health care services. Some health care professionals believe that such risk factors as hypertension, anemia, and gestational



diabetes are primary contributing components of causing death during childbirth for this population (Mayo Clinic, 2023). Essentially, there are several areas of reform within the health care system as well as critical steps in reducing such devastating disparities, including increased access to health insurance, quality health care, and providers that practice patient-centered and culturally sensitive care (Winny & Bervell, 2023). There is substantial existing evidence that illustrates how racial differences in socioeconomic outcomes (i.e., education and employment) and housing resources among women derived from the results of segregation, discrimination, and historical laws that were established with the sole purpose of oppressing African Americans and women in the United States (Chinn et al., 2021).

### **Problem Statement**

The problem that was addressed in this qualitative research study was the inequalities in health care services for urban-living African American women during or after pregnancy. The historical context of racial inferiority practices towards African Americans has been the major contributing factor in sexual and reproductive health care inequalities experienced by African American women (Thompson et al., 2022). Researchers have suggested that African American women are three-point three times more likely to die from pregnancy-related complications compared to their Western American counterparts (Colarossi, 2019). More than half of these deaths or near-deaths are from preventable causes and a disproportionate number of African American women are suffering (Roeder, 2019). Both societal and health system factors contribute to higher rates of poor health outcomes and maternal mortality for Black women, who are more

likely to experience barriers in obtaining quality care and often face racial discrimination throughout their lives (Bleich et al., 2019). These difficulties are likely to lead to African American infants in the United States being born too small, prematurely, or dying in the period around delivery, sometimes twice as often as White infants (Moore & Engbreton, 2019).

There has been significant research regarding an African American woman's experience before, during, and after pregnancy with their health care providers. However, I have found limited research that has examined prenatal or postnatal care experiences for African American women living in urban areas as it relates to their perspectives on perceived health care inequalities. Correspondingly, this lack of substantial research proves a need for this study. Essentially, the type of health care services provided to African American women during pregnancy impacts the adverse health care risks that are already a significant problem of racial and ethnic health care disparities regarding childbirth fatalities among African American women (Mayo Clinic, 2023).

### **Purpose of Study**

The purpose of this generic qualitative study was to provide additional research about the inequalities faced by pregnant African American women living in urban areas while receiving health care services. The targeted participants for this study were African American women who had experienced pregnancy, childbirth, infant mortality, and miscarriage. By examining the perspective of African American women receiving prenatal or postnatal care and how they identify health inequalities, this study offers insight into the role health and human services providers have in the contribution of

African American women's perception of inequalities and their self-worth. Furthermore, the fundamental process of how providers intentionally or unintentionally reinforce societal messages regarding minority women's self-reliance, value, competence, and deservingness of poor services were unlocked. Essentially, the goal was to identify the points that influenced the risk of African American women dying or being in near-death circumstances during childbirth or after childbirth.

### **Research Question**

The research question in this generic qualitative study was, How do African American women living in an urban area perceive inequalities in health care services received during or after pregnancy?

### **Theoretical Framework**

The theoretical framework that guided this study was Link and Phelan's fundamental cause theory (1995). The fundamental cause theory is centered on the notion that there may be a persistent and direct relationship between SES and mortality despite improvements in medical conditions. There is strong evidence that links the connection between social conditions and illness. Link and Phelan (1995) explain that social conditions can be fundamental causes of disease as the health effects of cause cannot be eliminated by addressing the mechanisms that link them to diseases. It was also argued that the fundamental cause theory illustrates an assumption that there is a strong association between poverty and health with support for this assumption coming from the link between individuals residing in dire housing conditions and having poor work conditions, enduring lower income, and failing health (Link & Phelan, 1995).

Additionally, there is a persistent association and essential feature of the fundamental social cause theory that centers on the involvement of the ability to access resources that have the power to assist in the avoidance of risks or to minimize the outcomes of disease when it occurs (Link & Phelan, 1995).

According to Phelan et al.(2010), there are four essential features of the fundamental social cause of health inequalities: (a) the fundamental cause of health inequalities influences multiple diseases and their outcomes, (b) there are multiple risk factors that play a part in the health outcomes, (c) there should be access to resources that can be utilized to avoid risks and/or minimize consequences of disease if and when they occur, and (d) the overall association between fundamental cause and one's health may replicated over time if the replacement intervention mechanisms are not updated subsequently. Additionally, this theory attempts to resolve the perplexity of why social inequalities exist in health care despite improvements made with medical innovations and the elimination of diseases (Riley, 2020). However, growing evidence has suggested that an individual's SES of an individual or group of individuals can be the root cause of health inequalities for that population (Lago et al., 2018). In context, the argument is that SES entails an array of systems such as finances, knowledge, power, and social connections that can assure good health for a group of individuals no matter what influential factors that are relevant at the time (Qasim, 2016).

I used this theory as a lens to explore how African American women living in urban housing areas handled perceived health care inequalities while experiencing pregnancy and/or childbirth. Previous research has suggested that one's health success

can be impacted by inadequate medical care, lower household income, poor nutrition, unemployment, racial background, and hazardous living circumstances (William et al., 2010). Essentially, the fundamental cause theory places a strong inference on how socioeconomic maturity or immaturity functions as a catalyst for the cause of disease because SES involves the individual having access to important resources to avoid negative health outcomes and their consequences (Chang & Lauderdale, 2009). An assumption of the fundamental cause theory is that more resources can afford a person the best care and they are able to take advantage of new medical developments because the social and economic assets are transportable from one situation to the next (Chang & Lauderdale, 2009). By using this theory, I sought to understand whether people with less advantaged neighborhood resources, lower SESs, and African American backgrounds experience disadvantaged health care services due to those circumstances or if other influential factors determine one's health potential (Phelan & Link, 2015).

### **Nature of the Study**

This study was conducted using the generic qualitative inquiry approach. Generic qualitative inquiry is often conducted when a researcher investigates a participant's account of their subjective opinions, attitudes, beliefs, or reflections of their experiences on things experienced in the world (Kennedy, 2016). When using a generic qualitative approach, the motivation should be to thoroughly explain one's theoretical position that motivates the undertaking of the study. The strategies utilized to establish rigor in a generic qualitative inquiry should address personal assumptions and participation validation regarding the researcher's interpretation of data and create a system of data

saturation while detailing the research procedures (Kennedy, 2016). The generic analysis model encompasses the following seven steps: (a) variation, (b) specification, (c) abstraction, (d) internal verification, (e) external verification, (f) demonstration, and (g) conclusion (Kennedy, 2016). This model centers on the researcher analyzing the data to locate recognition patterns and make sense of the participant's expressed experience. In using a generic qualitative research design, I explored perceived experiences of health care inequalities for African American women and their pregnancy outcomes. The overall basis of this study was to delve into the perceptions of these women regarding their understanding of perceived health care inequalities. This notion is further illustrated by Kahlke (2014) as it is noted that a generic qualitative design aims to provide a rich descriptive understanding of the phenomenon under investigation.

I conducted interviews with African American women who may have been currently pregnant, have formerly been pregnant, and/or have experienced a miscarriage or infant mortality. All participants were noted to have currently lived or formerly lived in an urban area at the time of pregnancy or childbirth, as that is one of the main criteria for this study. The interview process was semi-structured, meaning the questions were structured with room for adaptation to allow the participants to provide a more personal approach to answering each question. Semi-structured interviews should be personal and intimate encounters with open and direct verbal questions that can be used to evoke detailed narratives (Whiting, 2008). Also, when using semi-structured interviews, an interview guide can be utilized to focus on each participant's responses while constituting the overall structure of the interviews, as the researcher has to have objective versus

subjective knowledge of their experiences (McIntosh & Morse, 2015). Turner (2010) describes that an interview guide approach gives the researcher the ability to promote the same general areas of information collected; however, this approach provides a degree of freedom and adaptability in getting information from the participants. Also, in qualitative research, interviews are often audiotaped in a semi-structured or unstructured manner, which was employed in this study (Cooper & Endacott, 2007). This assisted in the collection of each participant's responses to identify categories and themes for the data analysis phase of the study.

### **Definitions**

*Health disparities:* Preventable and unnecessary differences in the rates of disease incidences, prevalence, mortality, morbidity, or survival rates in one population compared with the health status of the general population (Center for Disease Control and Prevention, 2023). Disparities can differ across racial, ethnic, and/or socioeconomic groups.

*Health inequalities:* The systematic differences in the health of individuals or groups that can be avoided by reasonable means (McCartney et al., 2019).

*Maternal morbidity:* The short- or long-term health problems associated with pregnancy, delivery, or postpartum complications. These medical events often start during the pregnancy or delivery and negatively impact the women's well-being or daily functioning (World Health Organization, 2024).

*Maternal mortality*: The death of a mother while pregnant or within 42 days of the ending of a pregnancy regardless of the death being caused by or aggravated by the pregnancy (Collier & Molina, 2019).

*Maternal mortality rate*: The number of maternal deaths per live infant birth (Collier & Molina, 2019).

*Urban (living)*: In this study, a geographical location with limited access to health care services, which can result in disparities (National Geographic, n.d.).

*Socioeconomic status (SES)*: A concept that has a multifaceted definition; however, for the purpose of this study, it refers to a range of factors such as economic resources, power, and/or prestige that influence one's health at different times throughout one's life (Antonoplis, 2023).

### **Assumptions**

I assumed that the participants recruited for this study would have experienced some form of health care inequality due to their geographical location, racial/ethnic background, and/or SES. Cyr et al. (2019) explained that there is a common assumption that racial/ethnic inequalities access to health care are experienced mostly by African American and Hispanic individuals who often live in areas with higher rates of poverty. Also, there was another assumption that the participants of this study would be willing and able to describe their account of the health care treatment they received before or after pregnancy. It was also assumed that the participants would be truthful about these experiences as a way to deepen the understanding of health care inequalities endured by African American women. Last, I assumed that the interview atmosphere would be free



of influences and effective in eliciting rich responses while providing a place of comfort for the participants to be able to communicate their lived experiences.

### **Scope and Delimitations**

The scope of this study focused on the phenomenon of factors that contribute to health care inequalities experienced by African American women living in urban areas during or after pregnancy. Members of minority racial and ethnic groups have essentially suffered from health inequalities in the United States over the years, and this disadvantage has mercilessly gotten worse. According to Schell et al. (2020), social inequalities experienced by people living in urban areas stem from historical or contemporary imbalances of power that produce damaging effects. It is important to note that structural racism exists and operates by establishing laws and policies that allocate resources through means that will disempower as well as devalue one racial/ethnic group compared to other racial/ethnic groups, and this results in inequitable access to adequate quality health care (Yerby et al., 2022).

The scope of this study was limited to only African American women ranging in age from 18 to 50 years old who have experienced pregnancy, miscarriage, and/or infant mortality, as well as those participants who may be currently pregnant during the study. In addition, the participants would have needed to have lived or currently lived in an urban area as historically; institutional laws and policies have been established for this community that have limited necessary resources. It should be noted that institutional, environmental, and structural racism has been a powerful social determinant of maternal health and has deep-rooted development in a historical system of oppression among

women of color that still has subtle regards in health care practices in modern times (Taylor, 2020). That said, there was no focus on experiences from other racial or ethnic groups. This also meant that the participant pool would be limited to a small and specific group, which could make it difficult to transfer the results.

### **Limitations**

Qualitative research approaches can bring about many forms of limitations within one's study. A suggested limitation of this study was the potential lack of diversity in the participants' detailed lived experiences or in the participants' honesty in their experiences as they would be disclosing vulnerable information during the interviews. Essentially, there could have been limitations in the understanding that this study would be conducted to establish cause and effect connection as a conclusion within this study. Also, the study would not be utilized to make a general assumption about an entire population. Last, I anticipated that there could be foreseen issues within the recruitment phase for this study as the purposeful sampling method was utilized. This method of gathering participants functions on the basis that a certain criterion has to be met for participation.

### **Significance**

The potential contributions of this study to the human services field would benefit the African American Policy Forum. This organization establishes frameworks and strategies that address a vision of racial justice that embraces the intersections of race, gender, class, and the array of barriers that disempower those who are marginalized in society (African American Policy Forum, 2020). However, another organization that would benefit from this research is the Black Women Health Imperative. This

organization has been at the forefront of women's health issues through the use of education and policy reform initiatives (Black Women Health Imperative, n.d.).

According to De La Sablonniere (2017) and Form and Wilterdink (2024), social change is associated with the onset of revolutions, social movements, and critical technological changes, and these social change efforts can be completed by an entire group, community, institution, nation, or society on different societal levels. With this in mind, the significance of this study from a community and social services perspective has been to bring awareness of perceived health care inequalities towards African American women. I sought to highlight the necessity for African American women to receive better health care services and/or have more professional health care providers especially while pregnant or receiving prenatal care to avoid health care inequalities. Furthermore, the findings from this study could lead to positive social change in the acknowledgment and understanding of how communities with minority citizens often experience more barriers to quality health care access and receive lower quality health care services in their neighborhoods (Akobirshoev et al., 2020). In addition, the data from this study could assist human services professionals in finding more appropriate government and/or private assistive programs that understand the needs of African American women living in urban communities.

### **Summary**

This chapter provided a rationale for the focus of this study through a thorough explanation of the background of the mentioned phenomenon and stating the study's overall purpose. The risk of pregnancy-related complications has an increased rate of

expectancy for African American women compared with White women in the United States. This is an alarming and undervalued issue that needs to be explored more in-depth within the human services field. Therefore, in this generic qualitative study, I explored the perception of the health care services this population receives during or after pregnancy, as the experiences of this community are worthy of being studied for future implications of advancement. In Chapter 2, I aimed to include a more in-depth analysis of this phenomenon by constructing a literature review of factors contributing to health care inequalities for African American women. That chapter comprised a comprehensive exploration of this study's theoretical foundation/research approach and the strategy utilized to research concepts for this topic.

## Chapter 2: Literature Review

### **Introduction**

The health care system in the United States continues to have a disproportionate effect on the African American community and more specifically African American women. Health care inequalities for African Americans contribute to a significant gap in quality health care insurance, adequate access to services, and ultimately negative health care outcomes (Connell et al., 2019). Additionally, African Americans living in urban areas often come from families of lower SESs and receive health care services that are passable at best (Cyr al., 2019). According to Cyr et al. (2019), early development of health care research and economic access factors have shown that individuals of high SES or those living in an affluent community are predisposed to better health care services. Negative societal and health care factors contribute to the frequency with which African American women are placed at a greater risk of experiencing poor health outcomes and/or maternal morbidity compared to their racial/ethnic counterparts during prenatal and postpartum care (National Heart Lung and Blood Institute, 2021). Statistically, African American women are 3.3 times more likely than their Western American counterparts to experience maternal mortality as a result of pregnancy-related complications (Colarossi, 2019).

Additionally, researchers have suggested that racial disparities exist in risk factors related to pregnancy and are exacerbated by stress related to racial inequality and often inadequate health care, which is counterproductive to the needs of African American women (Winny & Bervell, 2023). Often, there is trouble for African American women

with advocating for their care, communicating with providers, seeking assistance, and learning about their own health needs during pregnancy and childbirth (Njoku et al. 2023). In this research study, I aimed to examine the perceptions of prenatal or postpartum health care inequalities experienced by urban-living African American women to identify social, racial, and ethnic determinants that may assist in improving health care practices and policies for African American women.

In this chapter for the literature review, I provided an exploration into the historical context of how reproductive health care limitations are experienced through racism, which has shaped how African Americans view the necessity of health care services. In addition, I discussed the factors that contribute to negative birth outcomes, environmental and SES influence on pregnancy services rendered, and how health care inequalities influence the pregnancy experience for African American women. Furthermore, this literature review should assist in answering questions about how health care inequalities have impacted maternal/infant mortality.

### **Literature Search Strategy**

The literature review for this research study focused on articles that integrate several concepts involving African American women and health care inequalities. The search for peer-reviewed articles as well as books included searching multiple databases such as Google Scholar, Sage Journals, SocIndex with Full Text, Thoreau, and ProQuest through Walden University Library. The initial search into these databases included the keywords *African American women* and *pregnancy*. However, I narrowed the search more specifically to yield the desired information. I began to search the keywords *health*

*care inequalities, African American women, and pregnancy*, and I found numerous articles I could use for this study. However, I began to revise this study's focus, which prompted me to include keywords such as *socioeconomic status, urban living, racial inequalities, maternal mortality, infant mortality, perinatal, postnatal, prenatal, and environmental resources*. These key terms also assisted in locating the theoretical framework for this study.

### **Theoretical Foundation**

Society's less privileged or poorer citizens frequently live in impoverished health conditions and face mortality at a greater rate than those people who have been afforded a more privileged environment (Phelan et al., 2010). The concept of this phenomenon was illustrated with the emergence of the theory of fundamental social causes of health inequalities developed around the 1990s as a powerful risk-factor approach to epidemiology (Phelan et al., 2010). Link and Phelan (1995) established the fundamental cause theory to explain the association between SES and mortality even when there have been radical changes in the diseases and/or risk factors that are presumed to explain the disease. According to Rydland et al. (2020) there have been several attempted explanations of how social inequalities in health were formulated using a materialist theory, psychosocial theory, and behavioral-cultural theory which picked up general assumptions that inequalities are patterns of behavior. Rydland et al. (2020) explained that the theoretical perspective of health determinants can be defined by conditions that are presumed to be a general influence on someone's health longevity, level of ill health, and whether determinants are unevenly distributed within the social structures.

Consequently, flexible resources have centralized the fundamental cause theory functions from an individual and contextual level. At the individual level, resources can be conceptualized as the “cause of causes” or “risk of risks” that often shape whether a person knows about, has access to, can afford, and/or receives support with engaging in health protective behaviors, according to Phelan and Link (2013). In contrast, within the contextual level, flexible resources often influence the access to broad contexts that vary in association with risk profiles and protective factors among the participants (i.e., a person with a higher SES can live in an area where there is minimum crime or violence and be able to have access to the best health care facilities). Furthermore, Link and Phelan proposed that the association between these two elements has resulted from an understanding that SES can be embodied by an array of resources such as money, knowledge, prestige, power, and/or social connections (see also Phelan et al., 2010). These resources provided a sense of protection around health despite mechanisms that are relevant to the disorder. Essentially, those who can take advantage of these resources have the ability to benefit from newer health-enhancing capabilities that would subsequently lower mortality and morbidity rates; however, health care disparities can form as a result (Phelan & Link, 2010). Subsequently, the fundamental cause theory provides additional analysis in understanding that there is a meta-mechanism of action among institutions that emphasizes how a dynamic based on action among different institutions can treat people differently according to their SES in a way that affects health inequalities (Phelan et al., 2013).



The fundamental cause theory involves four major elements: (a) the assertion that socioeconomic gradients exist across multiple health outcomes, (b) fundamental cause of health differences are presumed to operate through multiple risk factor mechanisms, (c) this theory can reliably reproduce through new intervening mechanism, and (d) the ready access to flexible resources can produce health advantages (Master et al., 2015). These elements continuously shape the relationship between SES and health outcomes that are observable and testable in diverse conditions. With this notion, the fundamental cause theory has been investigated across different gradients. Link and Phelan (2010) highlighted that there are three facts that past studies have established about the fundamental cause theory. Those facts consist of the notion that there has been repeated evidence of mortality rates from preventable causes of death declining at a more rapid rate than those of less preventable causes, as well as the evidence that links SES gradient in mortality rates from preventable causes of death (Master et al., 2015).

### **Literature Review Related to Key Variables and/or Concepts**

The focus of this study was to explore how the perceptions of health care inequalities experienced by African American women that are pregnant affect their pregnancy outcome. Historically, the imbalance of adequate health care treatment provided to African American women centers on the SES of that individual as well as the environment in which that individual resides and works. Many African American women who live in poorer, urban areas have extreme difficulty in receiving the best care before, during, and after pregnancy and childbirth. The literature focused on examining the influence of health care inequalities in regard to racism and reproductive health,

inequalities with a more extensive look at health care inequalities by race and gender, and maternal mortality rates among African American women.

### **Historical Context of Racism and Reproductive Health**

To examine how health care inequalities have affected African American women regarding pregnancy, it is necessary to glance back into history for context. The historical context of pregnancy among African Americans has been a long-debated issue. For years, African Americans have been subjected to institutionalized racism as well as oppression regarding reproduction. Essentially, African Americans experienced limitations on the access to adequate reproductive health care and higher rates of reproductive health concerns and are disproportionately influenced by the restrictions placed on family health services (Thompson et al., 2022). Thompson et al. (2022) examined the historical context of racism among African American women and their reproductive health. They explained that racism is one of the fundamental determinants of the health status among African Americans as racism often contributes to social inequalities that influence one's health behavior, access to health care, and interactions with health care professionals.

According to Treder et al. (2022), there has been a limited number of studies that explored and documented how the history of racism and ongoing discriminatory practices can alter reproductive health decision-making. Treder et al. (2022) conducted a study to explore how U.S.-born Black women's lived experiences of racism affected their reproductive decisions and health care experiences. For this study, the recruitment consisted of participants of African American descent ranging in age from 18 to 45 years old in the Boston, Atlanta, and Chicago areas. The study was conducted by interviewing

each participant to gather some perception of their experiences and the interviews were conducted by a Black obstetrician-gynecologist. Treder et al. (2022) explored a theoretical framework that described institutionalized, interpersonal, and internalized levels of racism and the Everyday Discrimination Scale. The findings from this study suggested that racism affected the participant's reproductive health and health care in a variety of ways (i.e., early sexualization of Black women, heightened awareness of reproductive health inequities, and knowledge of reproductive oppression) (Treder et al., 2022). Additionally, there were some primary themes taken from this study, such as reproductive health racism across the life course, anti-Black racism within the reproductive health care system, and self-protective actions when interacting with the reproductive health care system (Treder et al., 2022).

To further illustrate the impact that racism has placed on the reproductive health of African American women, Prather et al. (2016) outlined three levels of racism that have affected this population. The first level is known as institutional racism. It is characterized by organizations that often impose practices that affect health services for African Americans and result in the quality of health care that is different from other racial groups (Prather et al., 2016). Next there is personally mediated racism. This form of racism will occur when an African American person encounters a health care provider who has preconceived notions about a particular racial group and projects those notions within the type of service they have provided to the individual (Prather et al., 2016). This results in the provision of substandard health care services. Last, the authors introduced the term *internalized racism*, which involves the embodiment and acceptance of labeling

messages brought on through society that often oppresses African Americans. The introduction of these three levels of racism in health care assisted in addressing other underlying determinants, such as social and socioeconomic factors, that directly or indirectly support the development of reproductive health disparities.

### ***Institutional Racism in Health Care***

It is primitive knowledge that racism has had a long-standing influence on the complex arrangement of social structures, interpersonal interactions, and beliefs by which the group in power often categorizes others by race and it creates a racial hierarchy. This hierarchy can lead to racial and ethnic minorities operating on the notion of disempowerment and devaluation, as well as being denied access to resources. Often characteristics of racism have been structurally and ideologically present in governmental and institutional policies and procedures. Yearby et al. (2022) argued that structural racism operates through laws and policies that allow resources in a manner that disempowers and devalues minority groups in the form of access to high-quality care.

In further examination of this concept, it is imperative to understand that institutionalized racism in health care dates back to the 1900s with the structuring and financing of health care facilities. In 1946, the Hill-Burton Act was passed, which provided the blueprint for the construction of public hospitals and long-term care facilities for all Americans regardless of race (Yearby et al., 2022). However, this act unknowingly allowed states to build racially separate and unequal facilities, as there were no specific provisions in place. In addition, there have been several medical programs formulated within the government system that were created for poor Americans.

However, since many of these poor Americans were, in fact, African Americans, those programs were often underfunded, with limited participation from states with large African American populations. With the lack of support regarding health care coverage and the acknowledgment by the federal government of inadequate health insurance coverage as one of the barriers regarding health care access for African Americans, there have been fundamental moments of exclusion of adequate health care services for this population. Another legislative initiative to assist inequality for African Americans was the Civil Rights Act of 1964. This act was an attempt at granting African Americans health care services that were equal to those of White Americans. However, African Americans continued to receive poorer quality medical care as well as being uninsured more frequently than their counterparts (Prather et al., 2018).

Institutional racism often reinforces someone's personally mediated racism as well as internalizes the racism by promoting policies and practices that provide advantages to White Americans while disempowering African Americans or other minorities. If those policies are more conducive, government policies and procedures can be instrumental in developing social change in health care equity and positive health care outcomes for African Americans. Additionally, the acknowledgment of how racially discriminatory policies have a direct influence on health care access, treatment, and the delivery of adequate care as well as insurance, employment, and educational opportunities for African Americans could lead to more afterthought in the implementation of laws catering to assist this population and not to dismantle them.

### *Personally Mediated Racism in Health Care*

When speaking on racism in health care, there should be an examination of personally mediated racism. This form of racism illustrates how someone's intentional and/or unintentional attitudes or beliefs can affect the quality of care someone receives mainly from their health care provider (Thompson et al., 2022). It is the assumption that a health care provider with preconceived notions or stereotypes about their patient would not provide the best recommendations and treatments for the totality of care for that patient. This concept is significant for African Americans as this group of individuals tends to face discrimination that causes a delay in the receptiveness of necessary testing, treatments, and medications to sustain their quality of life. Correspondingly, with a long-standing history of racism and medical mistrust among African Americans for health care professionals, the need to examine how health care providers influence health care inequalities are evident.

Personally mediated racism can manifest in the form of bias (explicit and implicit) towards a particular group of people. Vela et al. (2022) defines explicit bias as a prejudice a person is fully conscious of, whereas implicit bias is an unconscious form of prejudice geared towards someone. Afulani et al. (2021) supports this claim by stating that implicit bias operates unintentionally and does not require the person to believe or devote attention to it. However, implicit bias is often activated by situational cues such as one's racial make-up, cultural background, and/or SES. The authors also noted that explicit bias could be reflected in an intentional manner that often comes through in the person's beliefs and attitudes demonstrated to a particular group of people. Explicit bias

can be manifested through outright discrimination of that group based on the perceptions that have been preestablished about the group of individuals that are being discriminated against (Vela et al., 2022). In addition, Vela et al. (2022) points out that health care providers with preconceived biases, prejudices, and/or stereotypes against their patients show these attributes in the difference of care provided. However, the health care provider may have good intentions. Health care providers who have implicit bias are more favorable towards their European American patients than their African American patients, and this bias can negatively impact clinician-patient interactions as well as contribute to unfavorable health outcomes. In addition, a significant influence on health care inequalities may exist in part due to the notion that health care providers are less likely to provide African American patients with the most advanced medical care (Connell et al., 2019).

Statistically, African Americans make up roughly 4% of American health care providers in the United States; however, majority of the patients being seen are African American (Thompson et al., 2022). Connell et al. (2019) explained that African American women have differences in their health status as a result of the negative attitudes and experiences exhibited within the health care system specifically from their health care providers and these experiences often influence health-seeking behaviors. Shepherd et al. (2018) pointed out that the differential component in care and treatment decisions can manifest through displayed biases due to beliefs or attitudes held by health care professionals based on the patient's racial or ethnic background. It is also suggested that the negative perceptions about health care professionals stem from a patient's prior

experiences of discrimination with receiving services, differences in health beliefs, and/or the patients/providers' differences in the expectations of care (Shepherd et al., 2018).

Arguably, Njoku (2022) noted that roughly 20% of African American patients preferred the same-race physician when receiving health care services. Likewise, there is evidence that if there is an increase in diversity in the health care workforce, it can improve health care delivery for African American patients (Marcelin et al., 2019).

### ***Internalized Racism in Health Care***

In learning about internalized racism regarding health care practices, this concept is suggested to center around a stigmatized person or group's acceptance of stereotypes or prejudices about themselves. Internalized racism has a way of manifesting itself in African Americans through feelings of helplessness, devaluation, or the limiting of their ability to make good decisions for themselves (Connell et al., 2019). In addition, internalized racism allows African Americans to develop ideologies, theoretical beliefs, and actions/behaviors that will support preconceived notions of racism about this population. This population began to limit themselves within their form of systematic oppression by becoming a product of stereotypical behaviors or attitudes. Thompson et al. (2022) explained that when it pertains to health care services, African Americans have a decreased ability to question the treatment that is being given or speak up for themselves towards their physicians as well as present a poor physical representation in front of their health care providers.



## **Inequalities in the Health Care System**

The health of everyone is fundamental to the attainment of security and peace, and it depends on the full cooperation of American citizens and states (World Health Organization, n.d.). Health care has continued to be a central topic across the United States, and with illnesses becoming a big problem, the need for adequate and stable access to health care services is more prevalent now than ever. Reilly (2021) explained that health care access is broken down into three different components: availability, acceptability, and affordability. Availability is a self-explanatory concept; however, when using it in this concept, it refers to the amount and/or access to specific health care services necessary for a targeted population. In the literature, Reilly (2021) referenced that acceptability is the notion that the attitudes and beliefs of the providers about the people to whom they provide services have to be accepting and understanding regardless of the person's ethnicity, age, gender, or religion. However, affordability needs to be factored in as health care access is often hindered due to the population not being able to afford quality services. Expressly, there has been limited access to health care services for individuals living in urban areas. Access to health care services and providers for urban areas is often affected due to the increased level of poverty and unemployment, the lack of education, not having health insurance, the lack of competent care providers, stigmas that are often associated with individuals living in an urban area, and the shortage of health care providers for that area (Reilly, 2021). Additionally, Sutton et al. (2021) further justify this point by outlining that African American women have a disproportionate risk in reproductive health access and outcomes that expand beyond the

individual level of risk and these factors include social and structural influences that can range from fewer neighborhood health services, decreased access to economic attainment, and practitioner racial bias and stereotyping.

In addition, Phelan et al. (2010) noted that the fundamental social cause of health inequalities has four basic features. These features have been identified as (a) the fundamental cause of health inequalities influences across multiple diseases and their outcomes; (b) multiple risk factors play a part in the health outcomes; (c) there should be access to resources that can be utilized to avoid risks and/or minimize consequences of disease if and when they occur; and (d) the overall association between fundamental cause and one's health may be replicated over time if the replacement intervention mechanisms are not updated subsequently. Substantially, a person with greater resources will avoid the areas where inadequate health care practices are being used as well as where health care inequalities are rampant. In addition, in relation to highly resourced communities, the development of health care inequalities is prohibited as there is the working knowledge that higher socioeconomic individuals have more influence in ensuring that their community medical providers provide the best medical treatment to them. In retrospect, SES has become a persistent association factor with the overall health outcome for many patients, specifically in lower income societies. Regarding this study, the fundamental cause theory provides evidence in relation to how health care inequalities among urban living African Americans hinder sustainable access to health care services and qualified providers as the influence relies on the individual's SES.

### ***Health Care Inequalities by Race***

The health care system in the United States is afflicted by inequalities that affect African Americans and other marginalized groups at a disproportionate rate. These inequalities have been known to contribute to gaps in medical insurance coverage, limited abilities to access appropriate medical services, and below-par health outcomes. The Center of Disease Control and Prevention (2023) referenced that health disparities are often preventable differences in the burden of disease, injury, violence, and/or opportunities to achieve optimal health that are experienced by a socially disadvantaged population. However, McCarthy et al. (2021) note that health inequalities are systematic and avoidable differences in health outcomes that can be observed between populations of different social groups and are often ranked by social positions. Research has indicated that ethnic minority groups generally report having poorer health and higher risks of serious illness as compared to the ethnic majority group with the two most acknowledged and prominent explanations for this difference in health being SES and perceived discrimination of ethnic minority groups (Njoku et al., 2023). Moreover, research has shown that being exposed to residential environments that are racially segregated has a primary influence on the fundamental cause of racial inequalities in health as well as being the cause of elevated-risk diseases (Connell et al., 2019).

Racial and ethnic inequalities in health care pose significant moral and ethical dilemmas for the U.S. health care system. Health care has become a resource that has been tied to various notions of social justice concerns and associated with the quality of life a person could experience. The rate of death for African Americans remains higher

than other populations, and it does not help that the minority population remains grossly under-represented in the health care professional workforce (Riley, 2021).

### ***Health Care Inequalities by Gender***

Health care inequalities have frequently been discussed and studied as a racial and ethnic issue; however, health care inequalities can exist among different genders as well. Gender inequalities manifest in regard to disparities in roles, characteristics, and/or behaviors that are displayed by men and women and are grounded within the norms of society. National Heart Lung and Blood Institute 2022) explain that several studies have suggested that gender inequalities often have a negative influence on the reproductive health practices and/or outcomes of women as these inequalities limit their access to information, increase their vulnerability to gender-based violence, and can limit a women's access to health services. In addition, the U.S. health care system places a significant emphasis on gender norms that can be misconstrued into gender stereotypes as well as influencing the clinician interaction between men and women. For example, in U.S. society, women continue to be viewed as fragile or overly emotional; therefore, when said women makes a complaint about a health issue, it can be misinterpreted as exaggerated, and the woman's physical symptoms can be attributed to be psychosomatic rather than physical causes.

### **Maternal Mortality Among African American Women**

Maternal mortality has become an increasingly alarming problem in the United States. Maternal mortality is defined as the death of a woman due to pregnancy-related issues during pregnancy or a period after childbirth (roughly 3 months after birth).

Roughly, 700 women are dying on the path of motherhood annually in the United States making it the deadliest place to be pregnant and/or give birth (Bridges, 2020). This is alarming to most, considering that a significant amount of financial compensation is used to ensure that the health care system operates smoothly, especially the health care services offered towards pregnancy and childbirth. According to MacDorman et al. (2016), “maternal mortality is an important indicator of the quality of health care both nationally and internally as the death of the mother during pregnancy, childbirth or post-partum is one of the greatest tragedies that can occur.” A woman’s risk for experiencing maternal mortality can be impacted by several factors, including her pregnancy/birth experience, the conditions to which she gives birth, and her overall health before, during, and after pregnancy. However, the risk increases for women of minority backgrounds with limited resources in their community.

Njoku et al. (2023) illustrated this point by explaining that “Non-Hispanic Black women are three to four times more likely to die from pregnancy-related causes than Non-Hispanic White women.” Whereas the National Partnership for Women & Families (2018) noted that African American women often face an imbalance of below-average maternal health outcomes within the United States that have caused an alarming reality of disproportionate death rates. The inadequacy of the health care services received by African American women has contributed to unforeseen complications during pregnancy and childbirth. In addition, Phelan and Link (2005) have suggested that there could be a strong and well-established link between morbidity and mortality and the educational attainment, occupational standing, and income of people in any culture. The social

causation explanation for this phenomenon is that the stress of adversities, genetic vulnerabilities, lower SESs, and one's racial make-up are all influential factors in the contribution of the persistent increase in health care disparities that can cause mortality. Additionally, it should be noted that maternal mortality is a preventive occurrence and should not be examined in the context of a medical problem as it has become more so a social, cultural, and political problem.

Further understanding concerning maternal mortality rates among African American women requires the examination of systematic racism and the perpetuated inequalities in the quality of health care services. Saluja and Bryant (2021) explain that racial disparities in health care often exist based on the bias a provider has regarding his/her patient. Often, the bias can be displayed through the health care provider's perception of the patient, the provider's decision-making skills, the creation of inequalities in the access to health care services, the interactions between the provider and patient, and health outcomes (Saluja & Bryant, 2021). Some researchers have argued that race and ethnicity are debatable influences on the existence of maternal mortality. However, there has been an increase in the number of women who are dying due to complications experienced during pregnancy or after childbirth. In addition, Saluja and Bryant (2021) noted, "minorities, particularly African Americans, tend to be more often socioeconomically disadvantaged and therefore less likely to receive regular prenatal care and might even be skeptical of what professional health care has to offer especially if previous experiences have been suboptimal." Combining this knowledge with the understanding that African American women are at an alarming rate of developing

various pregnancy-related complications makes the burden of maternal mortality among this group of women significantly disproportioned.

### ***Infant Mortality Among African American Mothers***

With knowledge about the increased rate of maternal mortality among African American women, it becomes imperative to explore infant mortality and its effects within the African American community. Infant mortality has become less about the death of a small child and more about the circumstances that triggered this death. Infant mortality has been the measure of the well-being of a population group and the reflection of that measurement of well-being with the negative social and medical treatment experienced by the mothers (Jang & Lee, 2022). From this information, it is important to note that African American women have experienced significantly higher rates of infant mortality compared to White women. Effiong et al. (2020) infers that this may be due to African American women birthing babies with low birthweight although these women receive prenatal care during pregnancy. Correspondingly, there has been some evidence that links racial and SES to a mother giving birth to a baby with an appropriate birthweight needed to survive outside of the womb (Effiong et al., 2020). In addition, Jang and Lee (2022) have suggested that poverty has been identified as a primary indicator of the societal differences in the rate of infant mortality. Additionally, the reduction in social disparities of infant mortality depends on the definition of the population at risk, the factors that make this population at risk (i.e., environment, society, and behaviors), the plan established to reduce the risk (i.e., the elimination of poverty, improvement of social

conditions, better access to health care) and the understanding of the behaviors that make them at risk (Effiong et al., 2020; Jang & Lee, 2022).

Effiong et al. (2020) illustrate the point that racial disparities seen in adverse birth outcomes are often larger as a woman's sociodemographic status, medical status, and behavioral status change. Effiong et al. (2020) argue that African American women have a greater experience of being exposed to acute and/or chronic stressors including racism, which play a part in the culmination of susceptibility to preterm delivery and/or infant mortality. An additional interpretation of the cause of infant mortality was illustrated by Jang and Lee (2022) who suggested that the relationship between societal factors and infant mortality can be defined by the translation of societal institutions (i.e. political, educational, economic) and human interaction. Furthermore, there has been significant progress being made in understanding how race, birth weight, and infant mortality correlate; however, there is still a challenge in identifying and eliminating this disparity for minority women regarding their overall health.

### **Summary and Conclusions**

This literature review was developed with the basis to explore components that have influenced the construct of health care inequalities for African Americans. The topic of health care inequalities for African American women has been a long-debated issue dating back many years. Within this literature review, I explored the historical context of racism and how the reproductive health of African American women has been a constant debate even within today's society. Additionally, the topics of institutional racism, personally mediated racism, and internalized racism were discussed in this review. The



burden of these health outcomes often reflects the structural inequities in the American health care system as it continues to contribute to the current crisis of neglectful maternal health in urban areas. Another topic of discussion in this review was the inequalities in the health care system and how these inequalities are examined from a race and gender perspective. Last, the issue of maternal health components about health care services and the lack of adequate treatment during this time. In addition, there continues to be an increase in negative health outcomes for African American women in comparison to women of other ethnical backgrounds. These outcomes often include maternal mortality, infant mortality, and/or the development of chronic health conditions, which were also discussed in this review.

Chapter 3 focused on the methodology component of this study, with emphasis on the research question and purpose of this study. This chapter outlines the qualitative research design chosen, the role of the researcher, and different inclusions to the research methodology, such as participant selection, recruitment, and saturation. In addition, in Chapter 3, I explore the instrumentation and data collection and analysis techniques, and I discuss trustworthiness and ethical considerations.

## Chapter 3: Research Method

### **Introduction**

The purpose of this generic qualitative study research design was to provide additional research about the inequalities faced by African American women living in urban areas while receiving health care services during or after pregnancy. By examining the perspective of African American women receiving prenatal or postnatal care, there can be some improvement in the practices and policies implemented within the health care system. Consequently, with additional inquiry into the risk factors associated with African American women and negative pregnancy-related outcomes, there could be better interactions between this population and health care professionals. In this chapter, I discussed the qualitative research design that would be utilized my role during this research study and the identified population. Furthermore, information was presented to address the data analysis plan, trustworthiness, and ethical procedures.

### **Research Design and Rationale**

I conducted this study to answer the following research question: How do African American women living in an urban area perceive inequalities in health care services received during or after pregnancy? Several research methodologies could be used to conduct a study such as quantitative, mixed methods, and qualitative. Quantitative research employs the process of collecting and analyzing numerical data that can be used to identify patterns and averages, make predictions, and find causal relationships while answering the “what” and “how” questions (Goertzen, 2017). Qualitative research differs from quantitative research as this research design seeks to explore the “why” factor rather

than the “why” factor of social phenomena, as well as rely on direct human experiences (Ahmad et al., 2019). Qualitative research designs were formulated to provide a systematic inquiry about a phenomenon in a natural setting. According to Jamshed (2014), “research methodology is a comprehensive strategy that silhouettes the use of a specific method relating to the anticipated outcome.” However, the choice of research methodology should be based on the research problem. Often, researchers find themselves with research questions that do not fit within the confines of a single established methodology. Generic studies allow researchers to play with these boundaries, use the tools established methodologies offer, and develop research designs that fit their epistemological stance, discipline, and particular research questions (Creswell et al., 2007).

With this research study being exploratory in nature, a generic qualitative research design was an appropriate choice; however, under the umbrella of qualitative research are several research designs such as case study, narrative, grounded theory, phenomenological, and ethnography. In exploring which methodology would be beneficial to use to conduct this study, I began to research each design for appropriateness. The case study methodology is appropriate when a researcher seeks to understand the how and/or why of a phenomenon that could highlight conclusions that were made or share how these conclusions were implemented for further research (Aberdeen 2013). In contrast, grounded theory has been focused for use when a researcher would like to formulate a new theory that is grounded in the field of study; however, the context of the theory has been created from existing theories, although the

testing of existing research situations is not utilized (Dunne, 2011). Moving from grounded theory and case study, ethnography research was analyzed next as a possible research design for this study. However, ethnography research has the central aim of providing a holistic insight into the nature of one's views and actions through the collection of detailed observations and interviews with less emphasis on testing out a research question rationale (Grossoehme, 2014).

Another methodology that was explored was phenomenological. In a study conducted by Logan et al. (2021), the researchers presented a similar study as they were seeking to describe the lived experiences of family planning care and how it affects young Black women. As with my study, the participants will describe their lived experiences with perceived health care inequalities; however, the difference would be that the participants would provide their perceptions of their experiences.

Phenomenological approach to research centers on the search for meaning specifically the need to make meaning of the lived experience (Grossoehme, 2014). That was not the direction for the presented study. Last, the examination of narrative research yielded a definitive thought process of being used for this study; however, while narrative research allows the researcher to guide through a participant's detailed perception of a specific phenomenon that was not the directional design that this study (Bruce et al., 2016).

I chose the generic qualitative research design for this study. The rationale behind choosing this methodology relied on understanding what a generic qualitative research design helps to establish. Percy et al. (2015) stated that a researcher who conducts a "generic qualitative inquiry investigates a person's account of their subjective opinions,

attitudes, beliefs, and/or reflections of their personal experiences” (p.78). I presumed that the participants in the study would provide a firsthand account of their experiences with perceived health care inequalities during or after pregnancy and how these experiences could be avoided in the future. Additionally, the hope for this study would be to gain insight into what contributes to health care inequalities faced by African American women specifically during treatment services for pregnancy and childbirth. There has been a growing epidemic of African American women dying during or after childbirth after not receiving the proper medical treatment; therefore, this is an exploratory concept. Generic qualitative research can assist the researcher in testing boundaries, using research tools that have been preestablished by other methodologies, and developing a research design tailored to their specific research question and philosophical stance (Kahlke, 2014).

### **Role of the Researcher**

Many researchers often utilized qualitative methodology to gain insight into their participants’ feelings and thoughts about their experiences, encounters, or phenomena. The basis for the role of a researcher is to attempt to assess the thoughts and feelings of the study participants (Sutton & Austin, 2015). I am an African American woman who falls in the categorical age range of 18 to 50 years old. In addition, I have endured the horrible tragedy of suffering a miscarriage as well as experiencing a full-term pregnancy with labor complications. Furthermore, I have my own account of perceived health care inequalities while receiving prenatal and postnatal care while living in an urban area that has inadequate health care services with the majority of doctors being a person of non-

African American background. Due to my personal experiences that were brought into this research study, it was important that I remained objective and monitored my beliefs, thoughts, and feelings as to eliminate bias.

In order for a research study to be successful in nature, the research demanded detachment from the topic. In working on a topic that is so close to my heart, I had to implement an objective viewpoint to avoid researcher's bias as well as ensuring that I was being ethical throughout the study. To ensure that there would not be any issues of researcher's bias, the practice of bracketing was implemented. Fischer (2009) explained that bracketing refers to the researcher's identification of a vested interest or personal experience that could potentially influence the study; thereby the researcher practices the technique of placing these influences in brackets in order to view the data through a fresh perspective. In placing my personal thoughts and feelings to the side, it allowed for me to develop the interview questions that would be most beneficial in assisting with gathering the interviewees' perceptions on what they considered health care inequalities as well as how they personally felt about their experiences throughout the process as well as how they viewed their health care providers. Furthermore, the overall focus of for this qualitative research study was the understanding of the aforementioned phenomenon being explored rather than solely focused on the researcher and/or participants being interviewed (Kahlke, 2014).

Ethics is considered a normal practice of conducting oneself in a moral way. However, the interpretation, application, and balance in understanding ethical norms can vary based on a person's views and life experiences. From an ethical standpoint, the role

of the researcher would be to ensure that I am following all current ethical standards in conducting the interviews as well as during the analysis of the collected data. I have also to ensure that I am protecting information presented during this study as the participants will be discussing very vulnerable information. To protect the participants, I employed the practice of using numbers (i.e. P1, P2, S1, or S2) for each participant's interview. This concept assisted in ensuring trust between the participants and myself as well as provided ease during the transcribing process.

## **Methodology**

### **Participant Selection Logic**

When selecting participants for a qualitative research study, the participants should bring purpose to the study as their participation has the ability to inform the research question best as well as enhance the understanding of the phenomenon (Sargeant, 2012). Also, the participants sampled for the study should be able to articulate important facets and perspectives relating to the subject matter being studied (Sargeant, 2012). With the understanding that this study will focus on perspectives from a specific group of individuals, I created and implemented a specific criterion for being considered for selection for the study. The participants for this generic qualitative study had to be African American women ranging in ages of 18 to 50 years old. These participants had to live in or formerly lived in an urban area during their pregnancy or miscarriage. In addition, the basis for participating in this study was centered on each participant either recently given birth, suffered from a miscarriage or infant mortality, and/or are currently in different stages of pregnancy during the time of the interview.

### *Sampling Strategy*

Sample of participants for qualitative inquiry are generally presumed to be selected purposefully to yield cases that are information rich (Palinkas et al., 2015). To obtain the participants needed to conduct this study, I employed the use of purposeful sampling. The objective of purposeful sampling was to produce a study sample that could logically provide a representation of the targeted population. Furthermore, the sampling method utilized helped to identify and select individuals that were knowledgeable about or experienced in the area of childbirth (Palinkas et al., 2015). It was the strong hope of the researcher that each participant selected had a willingness to participate as well as the ability to communicate her experiences in an expressive manner.

Qualitative researchers need tools to evaluate their sample sizes when planning a study then utilize the research process to appraise sample size continuously (Malterud et al., 2015). Malterud et al. (2015) also suggest that the size of a sample with sufficient information power depends on the aim of the study, sample specificity, use of established theory, quality of dialogue, and analysis strategy. The sample size that I initially anticipated for this study was between 8-12 participants and after the conclusion of the study, the participant size was 12 participants. Vasileious et al. (2018) stated that “samples in qualitative research tend to be small in order to support the depth of case-oriented analysis that is fundamental to this mode of inquiry” (pg. 2). Given that qualitative research studies are purposive and are conducted with the virtue of providing richly textured information that is relevant to the investigation providing a large number of participants could cause this study to produce repetitive data.



### ***Saturation***

Qualitative research studies often have smaller sample sizes compared to those of a quantitative nature which is in part due to the researcher not wanting to oversaturate the data. Data saturation is commonly indicated when the data that has been collected and/or analyzed enough to where further data collection or analysis becomes unnecessary (Saunders et al., 2018). According to Hennick and Kaiser (2021), achieving saturation is considered the guiding principle for assessing how adequate the use of purposive sampling can be within the qualitative research study. Data saturation for this study was evident when the data analysis became counterproductive because the data presented by the participants did not provide any more insight into the phenomenon; instead, the information became repetitive in nature. In addition, having achieved data saturation for this study added the functionality for the researcher to capture the diversity, depth, and nuances of the phenomenon as well as demonstrate the validity of the information. Furthermore, the importance of reaching data saturation lies in the understanding that the failure to reach this point will have a major impact on the quality of the research conducted. Additionally, through the assessment of the research data and the gauging of saturation for the data set, the data allowed for the establishment of codes and themes to answer the research question.

### **Instrumentation**

Instrumentation is critical in qualitative research as it takes knowledge and practice to develop open-ended questions for interviewing that will flow effortlessly and keep the interview from transitioning into a close-end question interview due to

resistance from the participant (Chenail, 2011). The participants were given background information on the purpose of the study through the use of an interview guide. Turner (2010) describes that an interview guide approach gives the ability of the researcher to ensure that the same general areas of information are collected. However, this approach provides a degree of freedom and adaptability in getting the information from the participants, and before any interview was conducted, each participant was assigned an anonymous identifier (i.e., P1, P2, P3, etc.). By using an anonymous identifier, it was the goal of the researcher not to have the information traced back to the participant as the information that was divulged was sensitive in nature. Saunders et al. (2015) explain that anonymity has to be a continuum in all matters, and the research should illustrate a balance between maximizing protective factors for the participant's identities as well as maintaining the integrity and value of the data.

### ***Interview Process***

Using a qualitative method such as interviewing would enable the researcher to produce a holistic understanding of contextual, unstructured data that engages the conversation with the participant in a natural setting (Jamshed, 2014). In understanding this concept, I decided that initially I would be using interviewing as the research method of choice. Since informed consent is the cornerstone of any research study, I emailed each participant the informed consent form which contained information about the procedure of the study such as any risks associated with the study as well as benefits, proposed length of each interview, the person to contact after the study if questions or concerns arise, information on how the study will be voluntary and they can withdraw

consent during any part of the interview, and how their confidentiality will be maintained throughout the study. Each participant had to read and reply back to the email with “I consent” before moving on to the interview phase of the study. The interviews were conducted in a semi-structured format as this format allowed for the adaptation within the interview for each participant to provide a more personal approach to answering each question as the objective of the study will be to gather the participant’s perspective on health care services and perceived inequalities experienced before, during, or after childbirth within the realm of receiving those health care services.

### ***Interview Question Development***

I developed a semi-structured interview guide that created questions garnered on the alignment with the objectives outlined in the research question, problem statement, and propose of this study. The interview guide had questions that were designed in a manner based on the researcher’s overall understanding of health care inequalities and pregnancy. Additionally, by creating interview questions that were in-depth and open-ended, this allowed for the participants’ responses to be more thorough in answering each question. Overall, the goal of the interview questions was to acquire understanding of their understanding of health care inequalities as well as the lived world perspectives of the participants as they are communicated in their own words with specific details discussed with the researcher (Roberts, 2020). However, Yeong et al. (2018) suggests that interview questions should be developed with the understanding that there is a need to be comprehensive enough to accommodate different cultural backgrounds and sensitivities. Thereby, the interview questions will be consistent of two parts:

introductory/background questions then in-depth subject based questions. The background questions will provide information about the participants as well as facilitate conversational interaction (Yeong et al., 2018). After the conversational interaction has been established then that will lead to the introduction of the subject based questions. In addition to the introduction of those questions, the participants were informed prior to conducting the interview that it would be recorded to assist in ensuring all of the information presented is captured. Rutakumwa et al. (2020) argues that recording devices have a place in the interview and have an influence on the data as it assists in capturing detailed information that could be missed by the interviewer.

## **Procedures for Recruitment, Participation, and Data Collection**

### ***Recruitment and Participation***

In recruiting the participants for this study, I initially created a flyer (see Appendix A) that included information such as the name of the study, purpose of the study, the criterion for participation in the study, and my contact information. These flyers were distributed across social media platforms such as Facebook, Twitter, and Instagram from my personal page as well as within the Walden University participant pool. Additionally, I tried reaching out to the local Department of Social Services to assist in the recruitment of participants, however this yielded no results of assistance. With this research topic being sensitive in nature, I had to pay special attention to my recruitment strategies as well as have the understanding that the potential participants may be slow to respond to the flyers. Even with using social media platforms for recruitment, the initial process of recruitment for interviews yielded 20 interested

participants. However, only 6 actually were interviewed, which prompted for a change in the recruitment and data collection method. With Walden University Institutional Review Board (IRB) approval of the change from interviews to online surveys as well as a recreated study flyer (see Appendix B), I distributed this flyer on previously used social media platforms with a link and QR code for the survey.

For participation in the interview, it was imperative that they emailed me to express interest in voluntarily participating as it assisted with any desire to remain discreet. After I was emailed with expressed interest, I followed up with each potential participant where I provided them with informed consent form. The participant had to email me back with “I consent” before I would schedule them for an interview day and time. After the preliminary phase was concluded, each participant was asked about their availability as a way to schedule the interviews at the convenience of the participant. After each participant provided me with potential dates of availability, I emailed them a Zoom link for their interview. The online survey process for participation was more anonymous in nature as the participants did not have to interact with me at all. They were able to access the link or QR code for the survey and informed consent, purpose of the study, and interview questions were all included within the study for the participants. However, I received email confirmation when a participant completed the study.

### ***Data Collection***

I used a semi-structured interview format to collect the initial data. The participants were informed prior to starting the interviews that the interviews were being recorded via Zoom for accuracy and for later use in the analysis of the information for the

establishment of any codes and/or themes. Each interview lasted approximately 30–45 min, which was outlined in the informed consent form as well as on the study flyers. The interviewers were asked to ensure that they were in a private area as well as being informed that I would be conducting the interviews in a secured area as there will be sensitive information being discussed and outside ears should not be privy to the information. When it was time for the interview, each participant logged into Zoom using the previously sent link and they were provided with a verbal walkthrough of how the interview would be conducted as well as informed that there would be a debriefing session at the end of the interview. I started each interview by asking the participant a series of demographic questions then I followed up with more in-depth questions about the research topic. After each interview was concluded, I inquired with the participants to see if they had an additional question as well as informed them that I will follow-up with transcriptions of the interview sent via email for content review and accuracy. When the research method was changed to an online survey, there was a survey link and QR code embedded into the flyer therefore the participants had no interaction with me. The data for the survey was collected via the website SurveyMonkey. The information was completely anonymous as participants were identified as Survey 1, Survey 2, and so forth. The data were transcribed as a report that was sent to my email for download.

### **Data Analysis Plan**

Data analysis for qualitative research is essentially the process of formulating one's data collection methods into a format that will allow for the arrangement of transcriptions, observation notes, or non-textual information in a way that will assist in

understanding the phenomenon (Wong, 2008). In this phase of the study, the researcher analyzed the data using a systematic approach that would be able to be duplicated by others. In order for the information presented to be properly analyzed, I re-familiarized myself with each participant's interpretation of her experience by listening to the recorded interview and rereading the survey answers. With the participant's perspectives being collected during interviews using Zoom recording, I was able to have the interviews transcribed by Zoom as well, which made the data analysis process easier. However, I did go through each interview and transcription line by line to ensure accurately the transcribed verbiage relating to the interview questions and answers. With written text varying slightly from spoken word in regard to word choice and grammar, it was intuitive that I was conscious of making a subjective decision of what to include in the transcripts as well as if I should correct any spoken word mistakes and repetitive wording (McMullin, 2021).

After reviewing the transcripts for accuracy, I coded, sorted, compared, and summarized the data for complete analysis. The technique provided me with the ability to link the data back to the original research question. According to Nowell et al. (2017) when conducting data analysis, the researcher becomes the instrument for analysis, which consists of the researcher making decisions about coding, theming, decontextualizing, and recontextualizing the data. Essentially, for this study, the data collected was prepared for analysis using the thematic analysis approach. The thematic analysis approach allows systematically identifying, organizing, and reporting patterns (i.e. themes) within collected data (Castleberry, 2018). This approach is often used to identify and make sense

of the commonalities found in spoken or written data to assist in relating the information back to the original research question and purpose (Castleberry, 2018). Additionally, the information can be utilized for the quick highlighting of similarities and differences while generating insight into summarized key features that could produce a clear and organized final report (Nowell et al., 2017).

### **Issues of Trustworthiness**

For this study, I considered credibility, transferability, dependability, and conformability in efforts to ensure the strength of this generic qualitative research study. For credibility, I was able to demonstrate this concept by linking the research findings back to the real word objective. By finding this linkage, it allowed me to use the data to demonstrate truth in the results of the study. Essentially, the method of data analysis provided the necessary assistance in establishing and maintaining credibility with coding and the formulation of themes throughout the interview process. Cope (2014) further illustrates this concept by stating, “to support credibility when reporting a qualitative study, the researcher should demonstrate engagement, methods of observation, and audit trails” (p.89). Last, research strategies that foster credibility and these include prolonged engagement, observation, and reflexivity. Additionally, Lloyd-Jones (2003) suggests that concerns should be made on the theory testing and threats to validity within qualitative research methods.

Transferability refers to the generalization of the study findings to be attempted and applied to other situations. While this concept cannot be definitively proven as the interpretation of data is not transferable, Korstjens and Moser (2018) illustrate that the



researcher should provide a detailed description of the participants and the research process to enable the reader to assess the transferability. I provided details about the participant criteria as well as how the data will be collected. Additionally, I employed the use of purposive sampling which could maximize the potential of the data finding being transferable.

Dependability and confirmability are two concepts that go hand in hand for a qualitative research study. I had to ensure that there was consistency and neutrality within this data collection and analysis methodology. Korstjens and Moser (2018) explained that the interpretation of the data should not be dependent upon my personal preferences and/or viewpoints instead it should be grounded within the data. Additionally, I utilized an audit trail to ensure that dependability and confirmability are achieved (Korstjens & Moser, 2018).

### **Ethical Procedures**

When conducting a research study, the researcher should always practice protecting each participant's rights, dignity, and well-being. Therefore, the formulation of specific ethical considerations is essential due to the nature of the interaction between the researcher and participants (Sanjari et al., 2014). Before beginning the data collection phase of this study, I received IRB approval to be able to conduct the study. By obtaining IRB approval, I was proactive in ensuring the rights, dignity, and well-being of the potential participants were being protected. Through the IRB approval process, I had to submit an informed consent form. This informed consent form was an ethical consideration of this study that needed to be established prior to conducting the study as

the form presented the participants with information about any potential risks that may be associated with the study, the general explanation of what the study entails, and their right choose to withdraw participation at any point of the study, the duration of the study, and the responsibility of the researcher in maintaining confidentiality of the participants. Within the realm of informed consent and participation in regard to ethical considerations, each participant was aware of the notion that they would have to confirm with “I Consent” in order to participate before the interviewing would take place. Essentially, I had to ensure as the interviewer that each participant was fully aware of any potential consequences for this study as well as all background information about the study.

Another important element of ethical consideration was ensuring the confidentiality of participants. The participants for this study were divulging vulnerable, slightly incriminating information in relation to their health care experiences therefore it was of great diligence as the interviewer that I protected their information. Each participant was assigned a number that will be used as the identification factor for them in the study. This number (i.e., P1, P2, S1, etc.) would follow the participant throughout the entire process of data collection, data analysis, and the conclusion of the final report. By assigning the participants with a number, it was to intentionally assist in decreasing the risk of their identities being compromised. In maintaining confidentiality, I informed each participant of how the interviews were to be stored after recorded. The interviews were stored on a password protected device and I am the only person with knowledge of the password. Additionally, the participants were also informed that the data collected

will be destroyed 5 years after the completion of the study and publication of the results. In addition, with recruitment being mostly done through the use of social media platforms, there was established ethical procedures to protect the participants and the associated university. This was through the researcher-developed flyer approved by IRB that was distributed on the selected platforms. By going through IRB approval before distributing, I ensured that all ethical considerations when using these platforms are maintained as another way of protecting each participant's privacy.

### **Summary**

This chapter identified the research method that was utilized to conduct the study as well as the rationale behind choosing that methodology. Generic qualitative research methods offer the understanding that they are not guided by any established standards of philosophic assumptions as guided in the use of other qualitative methodologies. The research presented call for unconventional guidance that was subjective within the chosen design. In addition, this chapter allowed for the examination of the role of the researcher, methodology of participant selection, instrumentation, and recruitment. This chapter also provided insight into the ethical considerations as well as issues of trustworthiness. The data analysis plan was highlighted however it will be thoroughly discussed in Chapter 4 along with the findings.

## Chapter 4: Results

### **Introduction**

This generic qualitative study aimed to explore urban living African American women's perspectives on health care inequalities experienced during or after pregnancy. This study was conducted on the principle of answering the research question: How do African American women living in an urban area perceive inequalities in health care services received before and/or after childbirth? From the findings in this study, urban living African American women perceive inequalities in health care services as the unfair treatment given to them during medical services. The participants offered insight into how this unfair treatment has shaped their overall experience with these services and what factors need to be changed to see an improvement.

I used semi-structured interviews as well as a survey to collect data that would gain insight into African American women's perspectives on their health care services and their interaction with health care professionals to understand the factors that may influence inadequate health care experiences. Understanding the viewpoint of what essentially constitutes as a health care inequality for many women as the concept can vary from person to person. Also, this study provided some understanding of how each participant views the American health care system as a unit. This chapter will focus on the review of the interview setting, demographics, data collection, data analysis, evidence of trustworthiness, and the results of the study.

### **Setting**

Each potential participant emailed me explaining their interest in participating in the study. Once that email was received, I sent out an email to the participants with the informed consent as well as thanking them for expressing interest in participating in the study. I also explained in the email that the participant had to respond stating “I consent” before scheduling a Zoom interview. After confirming with each participant their informed intent to take part in the study, each participant was emailed a Zoom link prior to their scheduled time and day of the interview. On the day of the prescheduled interview, the interviews were conducted on Zoom as a universal method of performing and audio recording the interviews as there were participants that lived outside of the state of Virginia where I reside. Additionally, the participants were informed that I would be guiding the interviews on my end from the comfort of my home; however, it would be in a secluded area of my home to exercise precautions as well as provide each participant with privacy. To ensure that the participants were in a secured, private location, I inquired with the participants about the location they used for their interview to ensure that they were exercising privacy on their end before starting the recording of the interview.

### **Demographics**

Participant selection involved purposeful sampling to recruit individuals who met specific criteria. Participants had to be of African American ethnicity, be 18–50 years old, live or had lived in an urban area, be pregnant or had experienced a pregnancy or childbirth before, and have experienced a miscarriage or infant mortality. For this study,

the age range was African American women between the ages of 18 and 50 years old. According to Indorewalla et al. (2021), the inclusion and exclusion criteria of a study can be tailored to allow the researcher to effectively examine a specific population. The inclusion criteria for the age of the participants that I used for this study was formulated based on the understanding that this age range would be beneficial in providing great insight into their life experiences in relation to pregnancy and childbirth health care inequalities. Additionally, it has been noted that qualitative studies that include African American older adults conversely reason that this population does not participate in the study due to mistrust, avoidance and fear of acknowledging problems, and/or seeing the risk of the study (Fiordelli et al., 2021). For the recruitment of participants, I used a flyer (see Appendix B) that included the participant criteria so that each participant would understand the requirements for participation. Additionally, I verified that each potential participant met the inclusion criteria prior to conducting the interview.

The participants were also asked additional demographic questions before conducting the interviews. The demographic questions addressed (a) age; (b) ethnicity; (c) current or previous residence in a region that is considered urban; (4) possession of health insurance; (d) if so, whether it is government or private; (e) highest educational achievement; and (f) economic status and current work status. The methodology changed from conducting interviews to a survey due to the lack of eligible and willing candidates to participate in the study. This created the ideology to provide demographic questions before the completion of the survey. Table 1 provides the demographics of the

participants for each data collection method. One participant was excluded because, although they provided demographic information, they did not complete the survey.

**Table 1**

*Demographics of Interview and Survey Respondents*

Participant ID	Age/age range (years)	Identified ethnicity	Private/government insurance	Educational level	Economic status (class)
P1	40	Black/African American	Both	PhD	Upper middle
P3	37	Black/African American	Government	Master's degree	Lower
P4	33	Black/African American	Government	Bachelor's degree	Lower middle
P5	36	Black/African American	Private	Master's degree	Lower middle
P6	42	Black/African American	Both	PhD	Middle
P7	36	Black/African American	Private	Bachelor's degree	Middle
S1	55–60	Black/African American	Private	Graduate Degree	Upper middle
S2	25–34	Other race	Private	Graduate Degree	Upper middle
S3	35–44	Black/African American	Government	Bachelor's degree	Middle
S5	25–34	Black/African American	Private	Graduate Degree	Middle
S6	35–44	Black/African American	Both	Graduate Degree	Middle

*Note.* P = participant; PhD = doctor of philosophy; S = survey.

### **Data Collection**

The participants for this study were recruited using social media platforms such as Facebook, Instagram, and TikTok by posting the approved study flyer (see Appendix B) to personal social media pages beginning February 2023. While on these social media platforms, I joined different support groups (i.e., Black Women's Pregnancy, For Black Women: Pregnancy and Beyond, Women's Support Group, Black and Brown Pregnancy, Birth, Infant Feeding, & Well-being, and Black Women TTC) that catered to the specifically targeted research group for this study and posted the flyer in these groups with permission from the group administrator. Using social media platforms for

recruitment yielded a diverse group of participants that I would not have been able to communicate with in my local area.

Upon approval to post in these groups, I received inquiries via personal messages or comments left under the flyer post about how to participate. Each potential participant was informed that they could send an email to my email address represented in the flyer as well as to communicate with me about the study participation. After I received an email from the potential participants expressing interest in engaging in the study, I provided them with the informed consent form via email. I explained that they would need to read it and acknowledge consent via response to the email (i.e., they would have to respond back with “I consent”) before moving forward. Additionally, the flyer was uploaded into the Walden Participant Pool and I also reached out to the local Department of Social Services. The Walden Participant Pool and contacting my local Department of Social Services did not provide me with any potential participants for the study. Therefore, I discontinued using those recruitment options.

Through social media recruitment for participants for an interview, there were 20 individuals that expressed interest in participating in the study. After giving their consent to participate, each participant was given the option to choose the date and time of their Zoom interview. I emailed each participant the Zoom link as a calendar invite so that they would remember their interview time accurately. However, once the individuals were given the consent form and they consented to participation, they essentially backed out of participation, or they did not show up for their scheduled Zoom interview. From February 2023 through October 2023, I was able to conduct 6 interviews. The interviews were



conducted in a semi-structured format that lasted between 30 and 45 min. For the interviews, the questions that were asked to the participants were the following:

1. What is your understanding of the term “health care inequality”?
2. Provide an example of a health care inequality you have experienced or someone you know have experienced?
3. What are your thoughts on cultural and ethnicity factors impacting negative health care outcomes?
4. How easily accessible is appropriate prenatal care where you reside?
5. What is the most important thing you looked for when you chose your ob-gyn?
6. How important is it for you to have a health care provider that has the same ethnicity/culture as you when receiving prenatal and postnatal care? Please explain
7. What challenges, if any, did you face when receiving care from your ob-gyn before, during, and after giving birth?
8. What were some concerns that you had while pregnant, during childbirth, and after childbirth that you feel were not handled properly by your health care provider?
9. What was that experience like?
10. How did you feel about the experience emotionally, mentally, and/or physically?

11. How did your family show support in advocating for you when you expressed your concerns?
12. How do you feel that their input impacted your health care services?
13. How did this experience impact your need to seek another health care provider?
14. In understanding your negative experience with the prenatal and/or postnatal care, what is your belief on the impact ethnicity/cultural had on this care?

After each interview, I debriefed with the participants by asking them if they had any additional questions about the study as well as thanking them and informing them that they would be able to review their transcripts of the interview for accuracy.

According to Candela (2019), allowing participants to review their transcripts for accuracy is called member checking, which contributes to the creditability of this study. Due to the lack of eligible and participating candidates for the study, I decided to revise my data collection method from interviews to an anonymous survey. The survey was created in December 2023 using the SurveyMonkey platform. After creating this survey, revising the IRB application, and submitting it for additional approval, the data collection method was essentially approved in January 2024, and the study was able to move forward. The survey allowed potential participants to read and consent to participation before engaging in the survey. Then, they were taken to the demographic section and subsequently answered survey questions. The survey questions were the same as the interview questions asked during the interview method earlier discussed. To access the survey, a research flyer (see Appendix B) was created that consisted of the survey link

and a QR code. It was distributed on social media platforms such as Facebook and Instagram. I began to collect data using that survey from January 2024 through February 2024 and this data collection methodology yielded 6 participants although one participant did not thoroughly complete the actual study. The survey was a completely anonymous data collection methodology, so I included some debriefing information in the demographic/informed consent section of the survey as I would not have been able to contact the participants after the completion of the survey.

### **Data Analysis**

I began to analyze the data using a thematic approach. This approach allowed me to identify, organize, and gather any patterns within the data with the understanding that I would be using this data to make sense of the commonalities present in the participants' given responses in relation to the research question. The data collected were analyzed following the five steps of Braun and Clark's (2006) thematic approach: (a) compiling evidence, (b) disassembling the evidence into groups, (c) reassembling the information, (d) interpreting presented information to formulate themes, and (e) making conclusions. To properly analyze the data, I refamiliarized myself with each participant's interpretation of her experience by listening to each interview as well as reviewing the responses from the online survey, which is the first step of the thematic approach. The participants' interviewed perspectives were collected using Zoom software, and I used the transcribed audio. However, I went back manually to ensure that the information was transcribed accurately. The data collected in the online survey was transcribed by the survey platform I used called SurveyMonkey. In reviewing the responses to the survey, I

had to eliminate two surveys because the participants did not complete the survey. The participants filled out the demographic information portion. However, they skipped the actual questionnaire portion of the survey; therefore, the surveys became unusable.

The second step in the process is disassembling the evidence into groups. The groups that the data were disassembled into were codes. According to Williams and Moser (2019), a code in qualitative research is often a word or short phrase that symbolically designates a summative attribute for the language base data. The use of coding allows for the progressive summation of researchers to construct meaning from the research findings through a three-phase coding method: coding, categories, and themes (William & Moser, 2019). When coding the data, I organized the data and manually highlighted keywords and/or phrases for each question answered in the interview and survey that was presented to the participants. The identification of different codes was repeated with the transcriptions across the data. The codes that were identified from the data were health care not the same for everyone, equality, deficit in health care, less accessibility, income-based care, not receiving great care, higher pain tolerance, maternal mortality, advocacy, safety, and understanding of needs. These codes are illustrated in Table 2.

**Table 2***Codes and Illustrative Responses*

Participant	Example quote	Code
P1, P3, S5	<p>“There's a deficit in health care for one group of people. Something does not measure up the same across the board for everyone.”</p> <p>“Everyone should be able to receive the same type of care.”</p> <p>“Regardless of how much money you make, you still should receive the same kind of medical care.”</p> <p>“It should be the same across the board you should receive the same type of treatment, same care. Nothing should be held back, or you should anybody should be mistreated by health care professionals.”</p>	Health care not the same for everyone, equality, deficit in health care
P1, P3	<p>“Health care is less accessible to people of color and people with fewer financial resources.”</p> <p>“There should not be any kind of disparities based on, even if your income is different.”</p> <p>Women who are of a lower income, or who may be on Medicaid. You know [those on] government-assisted insurance have a greater risk of not receiving the best care in your area.”</p> <p>“Oh, they have Medicaid, they're poor disadvantage, low income and they are treated differently.”</p>	Less accessibility, income-based care, not receiving great care
P4, P1	<p>“African American women we can tolerate pain like our feelings.”</p> <p>“How we were the ones that they were use when it was time to learn about certain practices because they felt like we couldn't feel pain.”</p>	Higher pain tolerance
P1, P3, P4	<p>“There are higher rates of maternal deaths with African American women in the community.”</p> <p>“There would be less deaths for moms.”</p> <p>“There would be less deaths in cultured people in general a lot of times.”</p>	Maternal mortality
P3, S5, S3, P5	<p>“Black, obedient doctor is going to look out for me more than a White ob-gyn.”</p> <p>“For my situation it was important, I felt like it was easier to talk to someone that looked like me.”</p> <p>“I feel safer and trust that my well-being will be taken seriously and treated with the appropriate care.”</p> <p>“I feel like they understand me as a Black woman better, and they understand the need for more supportive care.”</p>	Advocacy, safety, understanding

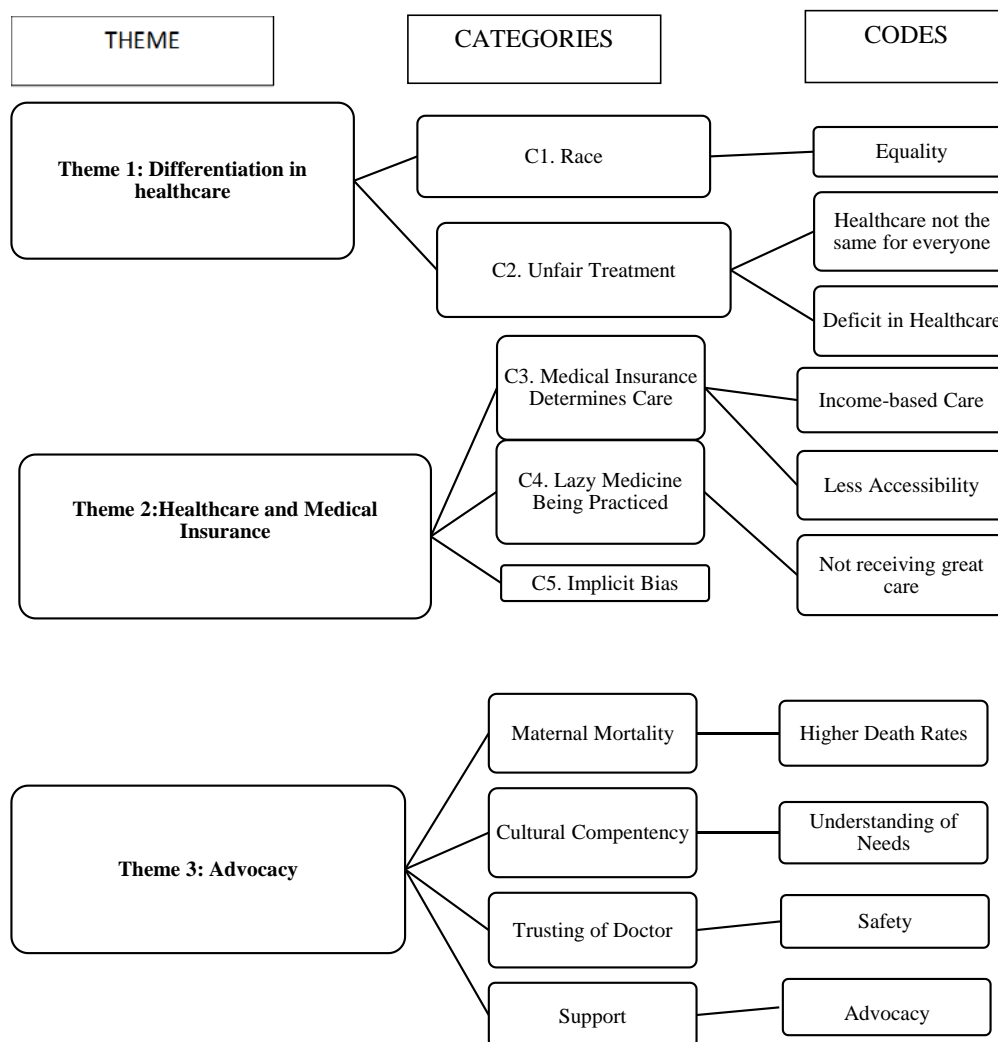
Next, I moved into the third step of the thematic analysis, which is reassembling the information. After highlighting and identifying keywords and/or phrases within the data, the information was grouped into categories. Using the results from the coding helped to compile a list of characterized categories that were produced to explain the content of the codes. The categories are identified in Table 3.

**Table 3***Categorization of Codes*

Participant	Quote	Code	Category
P1, P3, S5	<p>“There's a deficit in health care for one group of people. Something does not measure up the same across the board for everyone.”</p> <p>“Everyone should be able to receive the same type of care. Regardless of how much money you make, you still should receive the same kind of medical care.”</p> <p>“It should be the same across the board you should receive the same type of treatment, same care. Nothing should be held back, or you should anybody should be mistreated by health care professionals”</p>	Health care not the same for everyone, equality, deficit in health care	Race Unfair treatment
P1, P3	<p>“Health care is less accessible to people of color and people with fewer financial resources.”</p> <p>“There should not be any kind of disparities based on, even if your income is different.”</p> <p>“Women who are of a lower income, or who may be on Medicaid. You know our government assisted insurance have a greater risk of not receiving the best care in your area.”</p> <p>“Oh, they have Medicaid, they're poor disadvantage, low income and they are treated differently.”</p>	Less accessibility, income-based care, not receiving great care	Medical insurance determines care Lazy medicine being practiced Implicit bias
P4, P1	<p>“African American women we can tolerate pain like our feelings.”</p> <p>“How we were the ones that they were use when it was time to learn about certain practices because they felt like we couldn't feel pain.”</p>	Higher pain tolerance	Strong
P1, P3, P4	<p>“There are higher rates of maternal deaths with African American women in the community.”</p> <p>“There would be less deaths for moms.”</p> <p>“There would be less deaths in cultured people in general a lot of times.”</p>	Higher death rates	Maternal mortality
P3, S5, S3, P5	<p>“Black, obedient doctor is going to look out for me more than a White ob-gyn.”</p> <p>“For my situation it was important, I felt like it was easier to talk to someone that looked like me.”</p> <p>“I feel safer and trust that my well-being will be taken seriously and treated with the appropriate care.”</p> <p>“I feel like they understand me as a Black woman better, and they understand the need for more supportive care.”</p>	Advocacy, safety, understanding of needs	Cultural competency Trusting of doctor Support

After establishing the categories of the data, I transitioned into step four of thematic analysis. This approach calls for the interpretive presentation of the information as a way to formulate themes (Braun & Clark, 2006). Interpreting the data required me to review the categories to ensure that codes were thoroughly represented then refining the data in a descriptive nature to establish themes. Data analysis yielded three themes. Figure 1 illustrates the relationships of codes, coding categories, and themes.



**Figure 1***Themes, Categories, and Codes*

## **Evidence of Trustworthiness**

### **Creditability**

The creditability of the data was established by first employing member checking throughout the conduction of the interviews as well as when the surveys were completed. The process of member checking involves the research data being returned back to the participants for fact-checking the information transcribed, the data interpretation, and the conclusions established by the study participants' perceptions (Amin et al., 2020). Using this approach enhances the creditability of the data as well as makes claims that the analysis of the data adequately represents the participants' own realities. In addition to member checking, the reviewing of the transcriptions of the interviews was completed to ensure that each participant's answers to the questions were presented accurately word-for-word. The transcriptions for the survey responses did not have to be reviewed for accuracy as the participant's answers were captured in real-time, saved, and then sent to me for review.

### **Transferability**

To build upon the concept of this study being transferable, the information presented for this research study had to be presented in a manner that provided rich, sufficient instructions that can be applicable from one context to the other (Stahl & King, 2020). For this study, I provided descriptive details about the criterion of participation in the study as well as providing an example of the criteria I posted on my flyer. Also, detailed information was provided about the research study setting as it relates to the interview process, where the interviews were conducted, and any challenges that were

experienced during recruitment. Additionally, there was an outlined approach to how the interviews were saved and transcribed using the Zoom application. More so, I provided how the process of data collection was conducted, the revisions I had to make to the data collection methodology, and the overall process of the steps I took to analyze the data collected. Ten participants' perceptions were evaluated for this study which made for an easier implementation of the research protocols due to a smaller sample size utilized. Furthermore, I presented the demographic questions and interview questions that I created and utilized for each participant for easier transferability in the replication of this study in the future.

### **Dependability**

According to Ahmed (2024), dependability refers to the unwavering nature of the research findings to endure across time through rigorous documentation of the approach, data collection, and procedures for data analysis. I promoted dependability by documenting how the data collection process was going, the failures I had with the recruitment of participants, and how I had to revise the original data collection method to have an auditing trail. I kept the emails that I had with each participant during the recruitment phase of the data collection to show how I was actively seeking participants and making arrangements for conducting each interview. Also, I communicated with my committee throughout the research study process as I encountered several problems that needed to be worked through with my committee. As discussed in the transferability section, there was a detailed description of how interviews were recorded and transcribed

via Zoom and how I debriefed after each interview versus not being able to debrief after the surveys due to those being totally anonymous.

### **Confirmability**

Confirmability is the neutrality of the researcher in interpreting the findings, which means the findings are free from bias (Nyirenda et al., 2020). I used reflexivity to create trustworthiness in confirmability. Reflexivity is when one considers and/or acknowledges how their beliefs and experiences might have an influence on the research process, the participants' responses, and the method by which the data is collected, interpreted, and analyzed (Nyirenda et al., 2020). I have a personal closeness with the research topic due to my being African American within the age range and giving birth to not one but two children during my time completing this study. In understanding the personal closeness that I have with this subject, I had to set aside any preconceived notions I had about this subject in order to be fully present in conducting the interviews and understanding each participant's perception of their experiences.

### **Results**

The last step of the thematic analysis approach, which is to draw conclusions, is achieved in this section. The conclusions presented in this section stemmed from my analysis of the experiences of urban living African American women regarding health care inequalities. I analyzed the data to formulate themes to answer the research question: How do African American women living in an urban area perceive disparities in health care services received before, during, or after childbirth? The themes are further

illustrated in Figure 1 in the Data Analysis section. Based on the data, I will explain the emergence of each theme.

### **Theme 1: Differentiation in Health Care Services**

The care provided to African American women during and after childbirth has the potential to aid in the reduction of maternal and infant complications that may arise. According to Chambers et al. (2022), despite the benefits that having care during pregnancy and childbirth possesses, racism still serves as a barrier for Black women in accessing and receiving quality care. They also noted that institutionalized racism in health care settings has contributed to African American women receiving a lower quality of care in comparison to White women. This concept of institutionalized racism has also contributed to inequalities that adversely contribute to negative maternal and child health outcomes. S2 stated that she believed “health care professionals are also likely to suffer from implicit biases which negatively affect health outcomes.”

Theme 1 relates to the research question as it provides an understanding of how the discrepancies in provided health care services can contribute to someone’s perception of health care inequalities. Additionally, this theme conveys the participants’ attitudes and understanding of health care inequalities as they relate to the care African American women receive during and after childbirth. The participants were asked about their understanding of the term “health care inequalities” and to provide an example of any health care inequality they have experienced. P7 stated that she understands that health care inequalities are “the unequal treatment of women of color in comparison to White women, disparities, and within the health care as it relates to ethnicity.” P1 stated,

“there's a deficit in health care for one group of people. Something does not measure up the same across the board for everyone.”

Health care inequalities referred to the subpar services received by the patient or lack of equal treatment for a particular racial group. Also, the conceptualization of health care inequalities was defined as the unfair treatment received during health care services or biases exhibited by one's health care provider. Again, P1 stated that “there's a deficit in health care for one group of people. Something does not measure up the same across the board for everyone.” In contrast, P3 stated that health care “should be the same across the board. You should receive the same type of treatment, same care. Nothing should be held back, or you should anybody should be mistreated by health care professionals.” The participants expressed that health care services should be equal and of the same quality no matter what a person's ethnic background is. P4 was asked about their understanding of health care inequalities and stated, “it's just showing that everyone has equal access to health care.”

The participants were also asked about any challenges they may have faced from their ob-gyn before, during, or after giving birth. S2 detailed her experience during her first pregnancy:

With my first pregnancy, I was accused of doing drugs because I had a very rare pregnancy condition (that is actually genetically predisposed toward women of color and not drug induced in any way) and was told there was no way I could have the condition. I was misdiagnosed for 12 weeks of my pregnancy due to this misconception and the lack of understanding on behalf of the provider.

S3 stated that she experienced “last minute fear tactics that influenced the decision (made by the health care provider) towards a cesarean versus a vaginal birth and refusal to support vaginal birth after cesarean.” P7 also had similar sentiments about being pushed into having a cesarean versus a vaginal birth. She explained,

Okay, so I did not want a cesarean, and my doctor was like, “well, you’re gonna have to have one, and it’s not an option for you to push.” I knew if I had a cesarean that was going to be more downtime, and I basically had a scheduled surgery. I didn’t want that, and I don’t feel like I was her priority. I knew the complications and the risk. You know, I’ve heard the stories, and I did not want to have a C-section.

The participants’ experience illustrates a concern for many women regarding childbirth: that their voice will not be heard as it relates to the care they receive during this vulnerable moment. Additionally, the participants discussed how they felt health professionals viewed their tolerance for pain and strength. These viewpoints are elaborated on in the discussion of the subtheme.

***Subtheme: Labeled Strong and Tolerant of Pain***

Numerous researchers have examined the misconception that African American patients have a greater threshold for pain tolerance. Medical professionals often believe that African Americans are biologically different and stronger than their European American counterparts (Hogarth, 2019). P4 explained,

If someone who is not White says my chest hurts, they’re not automatically kept at the hospital or seen the same day or say “oh no, you can handle more. You’re fine.

Here's some. Here's a little bit of medicine and you should be fine" but then they die and they're like "oh, my bad didn't know you were having a heart attack.

This belief provides evidence that the treatment of African American patients for anything pain related offers the notion of racial biases in the perception of actual pain levels (Hoffman et al., 2016). P1 shared her belief that health care providers believe that "African American women we can tolerate pain like our feelings." P3 shared her opinion on pain tolerance and receiving health care services. She emphasized

African American women can face not getting the right services that may be helpful for their birth. Some doctors may overlook like some concerns that Black women may address. They may say, you know, they may feel certain types of way and they may overlook you and they may think Black women are just more tolerable of pain and so they may overlook some time some comments that are made that could be addressed early on.

In contrast, P4 expressed that African Americans "were the ones that they were use when it was time to learn about certain practices because they felt like we couldn't feel pain."

Access to quality care and support are only a small portion of the problem of pain tolerance and health care inequalities. The treatment of the African American patient during and after pregnancy and childbirth by the medical professional shapes the health care outcomes. Essentially, treating the woman poorly allows for poor health outcomes to follow which can include lasting physical and mental traumas that could extend to her child and family (Njoku et al., 2023). The poor treatment of African American women



often leads to mistrust in the health care providers ability to effectively perform their job correctly. P7 illustrated this point by stating

Like how a lot of times for Black people, it's like we sometimes have to wait a long time to go to the doctor because we don't trust health care system. Then by the time we go they can't serve that tumor, that disease is so far along that you already stage for Stage 5, and nothing can be done about it. Just simply, just the mistrust in my community because of the health care system and not feeling like you're going to get fair treatment.

With such a disconnect in many health care professionals not having the best interest of their African American patients at heart, the need to seek an alternative medical professional has been prevalent. P6 framed this sentiment as follows:

It seems a lot of people especially African American women are moving towards midwives and doulas because they actually listen to them when they are in labor and before labor, and they give them methods to help make their labor easy.

## **Theme 2: Health Care and Medical Insurance**

This study focused on the health care experiences of African American women living in an urban area. Therefore, I asked prospective participants whether they currently or formerly lived in an area that is considered urban in nature. In their interview or survey, I asked each participant about their perception of the prenatal and/or postnatal care that they received and whether that would constitute as a health care inequality. The participants detailed the birth, hospitals, and/or environmental conditions that affected this experience as well. P4 explained that “I gave birth to two sons in North Carolina and

with the first I was placed in a room that didn't have the electricity and I was not advocated for.”

However, in some areas, the level of care varied based on the availability of the doctors. P5 shared “the only challenges were that the doctors rotated with my first...so I did not see the same obstetrician every time I went. So that was a test because once I've been to one doctor. It's like the next up there will be somebody else.” This sentiment was also expressed by S6, who stated that “if you are fortunate to be able to source it for yourself then you are ok but if not the service you receive is subpar.” In contrast, P1 mentioned that where she resides “providers don't have the most technological instruments like they're so used to doing stuff the old-fashioned way. Whatever works we're going to get it done this way and that doesn't work for me.” Although in some urban areas there are a wide variety of available doctors to provide prenatal and/or postnatal care, P2 explained that “I have yet to find a woman of color who is an ob-gyn in my area.”

In addition to the environmental factors, each participant was asked whether they had health insurance and the type of health insurance as a part of the demographics of this study. All 10 participants reported that they have health insurance currently and were receiving health insurance benefits while pregnant. Of the 10 participants, three stated that they had government insurance, whereas four participants noted that they had private insurance, and three participants had both forms of insurance. P4, who reported having government insurance, explained her experience of receiving health care services during her pregnancy as follows:

I think a lot of the military hospitals need to be improved, because in the military they try to teach you that there is no color. We're all green. We're all fighting for the same purpose. We're all doing the same thing. We're all supporting the same people but it's still very segregated amongst our health care.

Additionally, P3 stated,

women who are of a lower income, or who may be on Medicaid. You know our government-assisted insurance has a greater risk of not receiving the best care in your area...Oh, they have Medicaid, they're poor disadvantage, low income and they are treated differently.

P6 expressed how insurance and culture affect care:

I've seen a lot of times especially people who are poor or have less education, we always resort first, in a lot of times, to natural remedies which can be good but sometimes you actually need access now. I think a lot of times, we both know they resort to these natural remedies because they don't have health insurance.

Understanding the participants' different perspectives regarding the adequacy of care based on their area of living and medical insurance further provided answers to the research question as this study explored experiences from a specific living area.

### **Theme 3: Advocacy**

The third theme was the necessity of advocacy during health care services for the prevention of maternal mortality as well as having a doctor who is culturally competent.

P3 noted the importance of maternal health in the African American community, as follows:

There are higher rates of maternal deaths with African American women in the community. There's a higher rate of infant mortality with African American women, and oftentimes in the health care system there are inequalities that exist, and the way that they're treated, the way that they either receive or don't receive care that can impact their health overall.

The three interview questions that I posed to the participants were

- How important is it for you to have a health care provider that has the same ethnicity/culture as you when receiving prenatal and postnatal care?
- How did your family show support in advocating for you when you expressed your concerns?
- In understanding your negative experience with the prenatal and/or postnatal care, what is your belief on the impact ethnicity/culture had on this care?

S3 responded to the question about the importance of having a health care providers with the same ethnicity/culture by stating “extremely. I feel safer and trust that my well-being will be taken seriously and treated with the appropriate care.” However, S5 explained, “For my situation it was important, I felt like it was easier to talk to someone that looked like me.” P7 responded as follows:

That is important because then they understand the journey and the things that I'm that they're mindful of the things that I'm fearful of because they understand health care for African American women is not a priority in this country.

Other participants concurred on the importance of having a health care provider who has the same ethnicity and/or culture as them.

However, there were varying responses to the question about how the participant's family showed support in advocating for them when they expressed their concerns. Some participants stated that they did not have anyone to advocate for them during that time. Others said that they had someone with them during their medical appointment but that the person did not understand what was happening and, therefore, it was pointless to provide advocacy. P7 shared, "I didn't have anybody there to advocate for me so it was really scary." Last, in regard to their beliefs about the impact of ethnicity/culture on the prenatal and/or postnatal care they received, P1 shared, "There are higher rates of maternal deaths with African American women in the community." In contrast, S6 responded simply by stating, "it's the difference between being and not." Theme 3 furthers one's understanding of the perceived biases already implemented by African American women in relation to their understanding of healthcare disparities and their need for providers who will understand their needs before providing a service.

### **Discrepant Cases**

Within qualitative research studies, some data can be discounted due to the fact that the information presented does not align with the research question. According to Coleman (2021), validity testing requires the researcher to "seek out, examine and account for all data which might otherwise be deemed to challenge their conclusions and in so doing reduce the risk that an investigator merely sets aside such findings to strengthen their argument". During the analysis of the research data, there were no cases of discrepant or disconfirming data as each of the participants provided information that aligned with the results of this study. However, one survey participant (S1) provided their

demographic information although the participant did not complete the actual survey. The demographic information was presented in the demographic section; however, because no data were presented from that participant, I could not conclusively analyze any data to determine whether their responses would challenge or affirm the research question.

### **Summary**

In this chapter, I provided the findings of this generic qualitative research study. I explained in detail about the research setting. I reviewed the process for data collection and analysis to include the decision to change data collection methods. I discussed the evidence of how this study ensured trustworthiness. In analyzing the data, I explained how I concluded by establishing four themes from the data. For the results section, I included participant responses that were utilized to answer the research question. Moving forward to Chapter 5, I will discuss the interpretation of the findings, any limitations of the study, recommendations for further research, and the implications of social change from this study.

## Chapter 5: Discussion, Conclusions, and Recommendations

### **Introduction**

In this generic qualitative study, I explored the perceived health care inequalities experienced by urban-living African American women before or after pregnancy. This research was conducted to gain a better insight into what constitutes a health care inequality, what factors are perceived to impact the health care services African American women receive during the perinatal, prenatal, and postnatal stages of pregnancy, and examine attitudes towards having a culturally competent health care provider. The participants for this study were African American women between the ages of 18 and 50 years old who had experienced pregnancy, childbirth, or a miscarriage. By exploring urban living, African American women's specific experience with the care they received during or after pregnancy and how they perceived what constitutes health care inequality. The research could provide foundational insight to health and human services professionals on how to assist African American women in having a better experience when health care services are rendered and to avoid or decrease outcomes of adverse pregnancy and birth outcomes.

In this study, some key findings were revealed using the six stages of the thematic approach by Braun and Clark (2006). Those findings assisted with the formulation of three themes and one subtheme for this study. Those themes were (a) differentiation in health care services, (b) health care and medical insurance, and (c) advocacy. Additionally, this chapter contains the interpretations of the findings of this study, the

addressing of the limitations that have been identified, a discussion of the recommendations, and the implications of this study, along with the conclusion.

### **Interpretation of the Findings**

The research conducted within this study contributed to the field of human services and health care as it provides an understanding of the disparities faced by urban-living African American women in pregnancy and childbirth. The findings from this study align with the information presented in the literature review section of Chapter 2 of this dissertation. Additionally, these findings offer insight into how someone's SES and the geographical environment can influence the type of care and accessibility to quality health care services received during or after childbirth.

#### **Theme 1: Differentiation in Health Care Services**

Using the fundamental cause theory, this theme indicates that one's social location and identity can impact the societal patterns of health inequalities within or between different populations (Harder & Sumerau, 2019). Although there has been significant improvement in the field of health care, yet for African American women, health care inequalities continue to exist. These health care inequalities constitute a significant reflection of the disparities experienced by these women concerning a host of social and economic measures. The participants in this study were asked about their understanding of the term "health care inequality," and the answers varied from participant to participant. However, the census of understanding was that each participant expressed that health care inequalities were the unequal treatment of African American



women compared to other races and how this can cause a deficit in the quality and quantity of care received for this population.

The perceived discrimination for African American women is often manifested as negative attitudes, judgment, or unfair treatment (Washington & Randall, 2023). The differentiation in health care services for African Americans “can act as a chronic stressor that provides a negative impact on the physical and mental health as well as the quality of life” (Washington & Randall, 2023). Statistically, African American women have reported that they believe that their health care providers have mistreated them because of their racial or ethnic background. This leads to a divide in the quality of care that African American women are receiving, especially during or after pregnancy.

***Subtheme: Labeled Strong and Tolerant of Pain***

The impact of health care inequalities may show up as implicit bias or stereotyping of the consumer receiving services. The overall concept of seeking health care services is to help reduce pain or issues that cause suffering for this individual. Thereby, when health care providers engage in unequal treatment of a specific racial group, they are choosing to condone the notion of putting their patients in pain and suffering. Results from this study suggested that African American women believe that their doctors do not adequately treat them due to racial bias related to pain tolerance and strength. The participants shared beliefs that confirmed aspects of the fundamental cause theory, which explains that underlying factors could cause a disadvantage in accessing resources for protecting health and avoiding disease. Additionally, the participants expressed that many health care professionals may overlook the initial reason that an

African American person comes to the doctor due to not believing what they are experiencing is cause for concern. This leads to feelings of mistrust and devaluation by that person. A medical professional's suggestion that African Americans are strong or have a high threshold for pain illustrates the continued work in cultural competency that needs to be done within the field of health care and human services. Consequently, Subica and Link (2022) have suggested that cultural trauma is a fundamental cause of health care disparities. The disparities are formulated from many health inequalities and can impact multiple health outcomes.

## **Theme 2: Health Care and Medical Insurance**

### ***Accessibility Based on Areas***

The findings from this study suggest a significant barrier to accessing adequate health care, which is contingent upon the area one lives in or the quality of medical insurance utilized during these services. The adequacy of health care treatment for those with limited access consequentially confirmed the theoretical framework for this study, which is outlined by the fundamental cause theory. This theory is based on the premise that health disparities consist of inequities in health services that can result from the social disadvantage of a group of individuals and are often caused by social factors such as SES, stigma, and racism (Subica & Link, 2022). Each participant expressed that they were living in an urban area, and while living there, they experienced hardships with their health care services. The personal accounts of some of the conditions that were faced included not having electricity in the examination room, the rotation of doctors during every appointment, and the office not being equipped with modern technology.

Okunrinoyemi et al. (2019) noted that patients' experiences within the health care system, specifically those from vulnerable populations, remain a critical and often misunderstood aspect of health care delivery.

### ***Influence of Medical Insurance***

Aside from one's environmental location affecting access to quality health care services and treatment, this study also highlighted how the type of medical insurance influences that care. Each participant was asked if they had health insurance and what type of insurance (i.e., government or private), and the majority expressed that they had private insurance. However, some mentioned having government insurance or both. The participants who had government insurance during the time of receiving prenatal and postnatal health care services detailed their experience as not being favorable. These details supported the participant's account that they believed health care professionals associated government insurance with low-income and poor economic statuses, resulting in them not providing quality services and treatment. The findings offer insight into the impact of one's insurance on the adequacy of care received during or after pregnancy. Furthermore, it could be suggested that occupying differential social positions has granted disparate access to resources that help produce, maintain, and guard health (Harder & Sumerau, 2019).

### **Theme 3: Advocacy**

#### ***Prevention of Maternal Mortality***

According to Chinn et al. (2021), "Black women continue to experience excess mortality relative to other U.S. women, including, despite overall improvements among

Black women, shorter life expectancies and higher rates of maternal mortality.” Maternal mortality can be categorized as the death of a woman during pregnancy or after childbirth, no matter the results, period, or place of the pregnancy, from a cause that is linked to that pregnancy (Collier & Molina, 2019). Statistically, “a staggering 42.4 deaths per 100,000 live births for Black non-Hispanic women have been reported compared to 11.3 deaths per 100,000 live births for Hispanic women and 13 deaths per 100,000 live births for White non-Hispanic women” (Oribhabor et al., 2020). Alarming, when African American women hone their ability to seek, evaluate, and use information to promote their health, the incidents of maternal mortality decrease. The participants in this study were asked about advocacy during prenatal and postnatal appointments. The findings suggested that each participant did not have the support of someone to advocate on their behalf when treatment was given subpar or when they felt their decisions were not being honored. Furthermore, the findings revealed that even with someone present to advocate for the participants, the person was not knowledgeable of what was occurring to offer a valid supportive standpoint. With this knowledge, it is suggested that advocating for someone, specifically African American women, should include an advocate who has knowledge about the presenting health care issues, which will help them prevent adverse pregnancy and childbirth outcomes.

### ***Culturally Competent Doctor/Care***

Additionally, the study’s findings suggest that African American women need health care professionals who are culturally competent in meeting their needs. Given the complexity and diversity of cultural norms for African American women, it would be

beneficial to have someone provide treatment and services that will understand their norms without prejudice. The participants were asked about the importance of having a health care provider with the same ethnicity or culture while receiving prenatal and postnatal care. The responses to this question varied from participant to participant. However, the consensus was that having someone of the same ethnicity was essential as it makes the interaction safer, and a certain level of understanding was present during the care provided. Furthermore, if the health care professional is competent in cultural awareness, it could further the stance on advocacy for African American women.

### **Limitations of the Study**

Two limitations were discovered when conducting this study. The first limitation of this study happened in the recruitment phase. I utilized the purposeful sampling method to select the participants for this study. I gathered insightful information for a specific group of individuals. The participants had to meet a specific criterion, which included being African American women between the ages of 18 and 50 years old and currently pregnant/experienced a pregnancy/childbirth before or experienced a miscarriage or infant mortality. While these factors should not have been challenging to meet, some participants did not meet the criteria due to either being out of the age range or not being of the ethnic background of the intended participants.

I also used social media platforms such as Facebook, Instagram, and TikTok, and I joined specific support groups to find participants for this study. While these recruitment strategies seemed probable at the beginning of the data collection phase of this study, they became problematic when there were not enough participants to collect

data using interviews. Interviewing was the original plan for gathering data. However, when the plan to conduct interviews did not yield enough participants, I had to initiate a different data collection method. I changed the data collection plan to an online survey with IRB approval. The change to an online survey offered a limitation regarding the trustworthiness of this study. Ahmed (2024) states, “The degree to which the findings accurately reflect the reality that the participants experienced is a fundamental aspect of qualitative research.” When conducting interviews, I used Zoom and was able to gauge the trustworthiness of each participant’s responses. However, I did not know if the participants provided factual and accurate information when utilizing an online survey.

Last, the focus of this study was African American women who have lived or were currently living in what is considered an urban area. According to Yadav (2022), “qualitative research tends to come from a very different paradigmatic stance and intrinsically demands distinctive and out-of-the-ordinary criteria for evaluating good research and varieties of research contributions that can be made.” The basis of gathering insight from those participants living in an urban area or having lived in an urban area was to build upon the existing research on health care inequalities. The results may not be confirmatory for all African American women in this specific environment, leading to the understanding that the data gathered from this study cannot be generalized. Although, despite this limitation, the information does provide valuable insight into the perspective of perceived health care inequalities experienced by urban-living African American women before and after pregnancy.

## **Recommendations**

Insight from the strengths and limitations of this study and data from the literature review in Chapter 2 have helped me formulate recommendations for future research on the experiences of perceived health care inequalities for African American women before or after pregnancy. New studies in the following five categories may expand existing literature on the topic: (a) supportive pregnancy advocacy and health care professionals, (b) comparative study, (c) quantitative inquiry, (d) human services professionals, and (e) policy and research development.

### **Supportive Pregnancy Advocacy and Health Care Professionals**

Given the importance of maternal and reproductive health for many communities and families, there should be a focus on addressing the alarmingly unacceptable rates of maternal mortality, and what avenues can be put into place for prevention. Women of African American ethnicity during this study have described their experiences of being ignored in the clinical setting, having providers that withheld information about different procedures, and feeling they have experienced some form of discrimination when seeking care during their pregnancy or childbirth experience. The biases of health care providers and institutional racism within the health care system put these women and their children at a higher risk of adverse maternal and infant health outcomes (Reed et al., 2023). These issues could catalyze the foundational concerns for health care professionals and be the influence necessary to implement protocols to reduce these issues. One protocol that is suggested for implementation is the need for supportive advocacy before or after pregnancy. Supportive advocacy could be the resource that an African American mother

needs to have a safe, effective, timely, efficient, equitable, and people-centered maternal and newborn care experience.

### **Comparative Study**

African Americans often feel they do not have a voice when it comes to their health care choices. Ramezankhani et al. (2018) explained that health care practitioners should cooperate with, listen to, pay attention to, and respect the mother's voice. Such actions will help the mother make a wise decision about childbirth that ensures safety. A health care professional, doula, and midwife can be the first barrier of support for an expecting mother. They are relied upon to ensure the safety and well-being of the mother and infant. A future research study could explore the comparative nature of African American women choosing the services of midwives and doulas over those of a health care professional in a hospital setting.

To embark on this exploration, researchers can investigate the effectiveness of doula care and the medical services of a health care professional. According to Reed et al. (2023), “doula care is increasingly being promoted as an intervention, as it can potentially facilitate improved patient-provider interactions and provide birthing people crucial continuous labor support.” Doulas are essentially non-clinical birth advocate workers who provide emotional, informational, and physical support to an expectant mother before, during, and after childbirth. Furthermore, exploring how the doula’s experience in educating the client about pregnancy or birth procedures, advocating for the client’s rights to active decision-making, and how the doula facilitates communication



between the health care professional and the expectant mother can improve birth outcomes for African American women.

### **Quantitative Inquiry**

This qualitative generic study provided researchers with some in-depth data into how urban-living African American women perceived health care inequalities before or during pregnancy. However, studying the causality of health care inequalities' effect on African American women's maternal health before or after pregnancy from a quantitative approach may extend the literature on this topic as well. By utilizing a quantitative study, future researchers may be able to identify variations or commonalities in the treatment approaches for African American women that increase or decrease the risks for maternal mortality. In addition, a quantitative investigation may build upon the qualitative insight by gathering information about the social and structural determinants of inequalities in maternal health.

### **Human Service Professionals**

In the ever-growing field of human services, there is cause for practice about health care inequalities experienced by urban-living African American women before or after pregnancy. Human services professionals working in the health care field should advocate for each patient's right to access supportive services and resources. Additionally, it would be advantageous for human services professionals to continue the research presented in this study to expand beyond the scope of gathering insight from urban-living African American pregnant women. The implication for future research

could be to examine the reproductive health of African American women who have experienced health care inequalities.

### **Policy and Research Development**

Drawing from this study's findings, future researchers can actively contribute to the human services field by advocating for policy recommendations regarding improving medical insurance, supportive health care alternatives, and the overall accessibility of quality health care services. The utilization of a research-based approach could provide policymakers with empirical evidence that quality medical insurance, supportive health care alternatives, and access to adequate health care services could facilitate better birth outcomes for African American women. One crucial avenue involves human services practitioners advocating for policymakers to review current health policies on health care services and how these policies can be revised or changed to better serve the African American women's population needs. Furthermore, human services practitioners can assist in the continued formulation and implementation of research data that combat societal stigmatization and foster a system of inclusivity within the health care world for African American women.

### **Implications**

The purpose of this generic qualitative study was to gain identifiable insight into the factors that often influence health care inequalities for urban-living African American women before or after pregnancy. In understanding the purpose of this study, there have been many implications that can be drawn by the researcher at the individual, family, organization, and societal/policy levels. Having these implications rooted in the overall

broader context of social determinants of health, these conclusions can offer opportunities for positive social change within the realm of health care for African American women. For context, the social determinants of health are SES, education, physical environment, employment opportunities, one's social support networks, and access to health care services. These determinants are often influenced by the distribution of money, power, and resources to a population at the global, national, and community levels (Gomez et al., 2021).

### **Individual and Family Level**

The potential for social change for African American women who have experienced health care inequalities at the individual and family levels is a two-fold program. I identified the need for advocacy and how it can influence their social health as an implication of change on the individual and family levels. The best advocate for a cause is a person or group of people who have experienced the same or similar hardship that needs the support or advocacy (i.e., those African American women who have already experienced health care inequalities advocating for others not to experience health care inequalities). Advocacy can be defined as gaining and using knowledge to assertively communicate and make decisions that will benefit one's needs when faced with challenges (Hutchens et al., 2023). Urban-living African American women must become advocates for social change by sharing their experiences, the risk factors that may have contributed to these experiences, and how they have overcome those challenges with positive experiences. However, in recognizing the need for self-advocacy and the overall implications it can have on pregnancy outcomes, it is also necessary to

understand that there is an “imbalance in ownership and the value of knowledge that exists in a sociopolitical context, which can often diminish the women’s knowledge and lived experiences (Hutchens et al., 2023). This notion spheres the need for the family level of social change. While it is crucial for urban living African American women to advocate for themselves during or after pregnancy, having a familiar support companion to assist with this advocacy can also garner a more favorable outcome.

### **Organization Level**

In examining the social determinants of health, there is an understanding that organizations and communities have a vital role in promoting social change and establishing health equity among African American women. The study’s finding emphasized the glaring reality that there is a differentiation in health care services geared towards urban living African Americans. Many prenatal and postnatal health care services are provided in the community and organizational setting. Changing the internal structure of these environments can benefit them more positively. First, there must be the understanding that one’s physical environment and the ability to have access to quality health care services can vary from ethnicity to ethnicity. However, the intersection between the two must be carefully examined and assessed. By examining and assessing these two critical social health determinants, developing and implementing programs and interventions may improve the health outcomes for African American women and assist in striving for health equity. Health care professionals and human services professionals should develop an integral position in highlighting new and practical strategies that could

potentially provide more positive prenatal and postnatal outcomes for African American women.

### **Societal/Policy Level**

The implications for positive social change for African American women who have experienced health care inequalities are significant at the societal and policy levels. The reevaluation of many reproductive health policies must be the first step to take in the effort to increase positive social change in the realm of health care practices for African American women. Policies in health care have a long-standing history on multiple levels of being rooted in racism for this population. However, understanding this history and how it has formulated health care inequalities for African American women will provide the blueprint that is necessary to refocus and guide leadership into prioritizing policies that affirm health equity. The suggestion is that there should be solutions that “lead to increased access for women must remove social and structural barriers so that women, especially underserved racial and ethnic minority women, may access and utilize reproductive health services as needed without clinician bias or other obstacles” (Sutton et al., 2021).

### **Methodological Implications**

The methodological implications based on the findings of this study can contribute to the growing research on health care inequalities experienced by urban-living African American women. Additionally, this research provided insight into how African American women perceive health care inequalities and what they believe contributes to these inequalities regarding their prenatal and postnatal care. The contextual knowledge

base adds depth to the understanding that many African American women have begun to seek alternative health care professionals to assist them with navigating through pregnancy and childbirth. To build upon the methodological data collected during this study, it would be beneficial for a future researcher to conduct a comparative study of rural living African American women's perceived experiences of health care inequalities during or after pregnancy.

### **Theoretical Implications**

For this study, the fundamental cause theory served as the framework for developing the research and interview questions. Examining the fundamental cause theory allowed for the understanding that social conditions (e.g., SES, race, and gender) are inextricably linked to a broad and dynamic array of outcomes (Reynolds, 2021), which have been the basis for this study. The findings from this study offer a minimal look into how the fundamental cause theory explains the factors that contribute to health care inequalities for African American women during or after pregnancy. However, it is suggested that there should be future research into how the fundamental cause theories, the social determinants of health, and African American women's reproductive health coincide in this society.

### **Conclusion**

African American women are three times more likely than Hispanic women and two times more likely than European American women to die during or after childbirth from complications (Njoku et al., 2023). In this study, I aimed to provide insight into what constitutes health care inequality while simultaneously answering the research

question: How do African American women living in an urban area perceive disparities in health care services received during or after childbirth? From the data collected and analyzed throughout this study, the participants' viewpoints answered the research question by outlining their experiences of health care inequalities and how they identified associated factors contributing to adverse health care outcomes for African American women. The highlight of this study could effectively shift attention toward the cultural and political conditions that contribute to health care professionals' implicit bias towards this group of individuals and offer awareness of the driving factors of the social determinants of health. It could be argued that human services professionals should take this opportunity of informed research and further the field of human services by focusing on providing adequate resources, no matter a person's environmental location, to be the driving force to reconstruct and decrease the occurrence of health care inequalities for African American women.

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[illness#:~:text=Access%20implicit%20bias%20and%20pandemic%20lessons&text=It's%20the%20care%20itself%20she,tools%20to%20overcome%20their%20own](https://www.nhlbi.nih.gov/news/2021/systemic-racism-key-risk-factor-maternal-death-and-illness#:~:text=Access%20implicit%20bias%20and%20pandemic%20lessons&text=It's%20the%20care%20itself%20she,tools%20to%20overcome%20their%20own)

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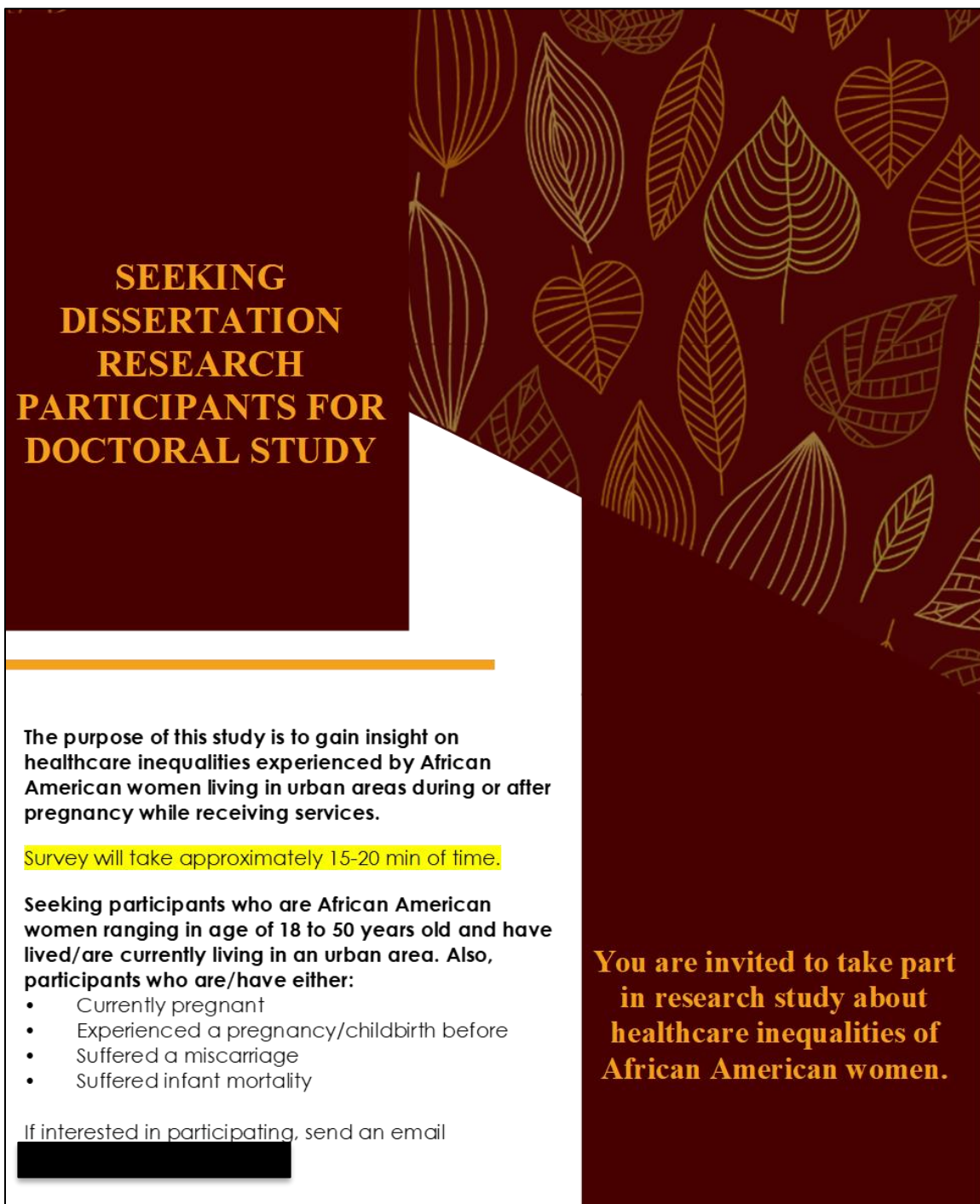
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## Appendix A: Original Social Media Flyer



**SEEKING  
DISSERTATION  
RESEARCH  
PARTICIPANTS FOR  
DOCTORAL STUDY**

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The purpose of this study is to gain insight on healthcare inequalities experienced by African American women living in urban areas during or after pregnancy while receiving services.

Survey will take approximately 15-20 min of time.

Seeking participants who are African American women ranging in age of 18 to 50 years old and have lived/are currently living in an urban area. Also, participants who are/have either:

- Currently pregnant
- Experienced a pregnancy/childbirth before
- Suffered a miscarriage
- Suffered infant mortality

If interested in participating, send an email  
[REDACTED]

**You are invited to take part  
in research study about  
healthcare inequalities of  
African American women.**



## Appendix B: Revised Social Media Flyer

**SEEKING  
DISSERTATION  
RESEARCH  
PARTICIPANTS FOR  
DOCTORAL STUDY**

**The purpose of this study is to gain insight on healthcare inequalities experienced by African American women living in urban areas during or after pregnancy while receiving services.**

Survey should take 30 to 35 mins of time.

**Seeking participants who are African American women ranging in age of 18 to 50 years old and have lived/are currently living in an urban area. Also, participants who are/have either:**

- Currently pregnant
- Experienced a pregnancy/childbirth before
- Suffered a miscarriage
- Suffered infant mortality

**You are invited to take part in research study about healthcare inequalities of African American women.**

**If interested in participating, click the link below**

**or scan QR code**