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Maternal and Child Health Access Disparities Among Recent African Immigrants in the United States

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Abstract

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MSc, Makerere University, 2011

BA, Makerere University, 2004

Dissertation Submitted in Partial Fulfillment
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Doctor of Philosophy
Health Services

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Abstract

Health care disparities are U.S. national public health concerns that disproportionately affect minority populations. The focus of published studies on the health of larger immigrant populations from Europe, Asia, South America, and the Caribbean has revealed a knowledge gap on the health of African and other minority immigrants. The purpose of this phenomenological study was to explore disparities in access to maternal and child health (MCH) care as well as the causes and effects of such disparities to care-seeking experiences of recent African immigrants. Andersen's behavioral model of health services use provided the theoretical lenses to interpret study findings. Eleven recent African immigrant mothers living in metropolitan Boston, Massachusetts, participated in semistructured questions that generated data used in this study. NVivo 11 was used to manage data, which enabled convenient use of Colaizzi's data analysis technique to identify themes and subthemes that were synthesized into final findings. Study results indicated that although participants used MCH care services, factors such as racial/ethnic discrimination, insurance differences, immigration, and socioeconomic status marred the process of seeking care, with notable access disparities that negatively affect MCH care experiences. The field of health for African immigrants is ripe for research. Other researchers could replicate this study elsewhere in the United States and other traditional immigrant-destination countries. Study findings could benefit health care providers, public health professionals, researchers, and immigrant populations. Actions for sustainable positive social change may result in the form of improved health care access and health outcomes for minority immigrants in the United States and beyond.

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Dedication

This dissertation is dedicated first to Almighty God, my savior, my redeemer, my strength and my all in all, for His divine mercies, grace, and favor that saw me through thick and thin to the completion of this remarkable milestone. I also dedicate this dissertation to my parents. Dad, I wish you were here to celebrate this achievement with me, but I know that I have made you proud where you are in Heaven. Mom, words cannot express my gratitude to you. You have been a constant source of encouragement and great cheer at every step of the journey. Thank you for believing in me and training me to believe that everything is possible in life. And finally, to my wife Franklyn and our lovely children—the JBMs—Josiah Brandon Mukasa, Joslyn Bethel Mukasa, and Joshua Blessing Mukasa: I know you were too young to understand the daily sacrifices I made to complete this journey, but your innocent smiles and hugs always lifted me up, gave me a reason to hope, and kept me motivated even when I felt like giving up on this dream.

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Also, I wish to extend my gratitude to the mothers who voluntarily offered to participate in this and graciously shared their experiences that formed the only source of data used in this research. Thank you for sacrificing your time and resources to travel to and from the interview venue. Without your input, this study would not have been a reality today.

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Chapter 1: Introduction to the Study

Introduction

Maternal and child health (MCH) access disparities are significant health challenges experienced by recent immigrants to the United States. Minority populations such as African Americans, Latino Americans, and immigrants experience adverse health outcomes resulting from disparities in access to health care services prevalent in the United States (Belue, Degboe, Miranda, & Francis, 2012; Blair, Steiner, & Havranek, 2011; Edberg, Cleary, & Vyas, 2011). According to the Association of State and Territorial Health Officials (ASTHO, 2012), health disparities disproportionately affect mothers and children, and they explain why improving maternal, infant, and child health outcomes are major public health goals in the United States. Researchers acknowledge that the well-being of mothers and their children greatly influences future generations' population health outcomes (Teitler, Hutto, & Reichman, 2012). Hence, the current quality of MCH services enjoyed by the nationals of a particular country can help to inform future public health predictions.

Some population subgroups in the United States experience more barriers to care, receive poorer quality of care, and report poor health outcomes compared with other groups (Agency for Healthcare Research and Quality [AHRQ], 2015). On average, 26% of African Americans, 35.2% of Latino Americans, and 36.6% of the population with family income below the federal poverty level reported having barriers that restricted their access to care in 2011 (AHRQ, 2015). African Americans and Latino Americans received worse care than Whites for 40% of all quality measures, and people with lower incomes received worse care than high-income people—defined as those with family income four times the federal poverty level or greater—on 60% of all quality measures (AHRQ, 2015). In addition, available literature shows that African immigrants are one of the medically underserved population subgroups in the United States (Filippi et al., 2014). Like other minority population subgroups, African immigrants experience worse socioeconomic status (SES), less access to and use of health care services, and poorer health outcomes compared to nonimmigrants (Edberg et al., 2011; Hossain, Ehtesham, Salzman, Jenson, & Calkins, 2013).

Research findings show evidence of commitment to programs promoting women and infant health from local, state, and federal governments to address health care access inequalities and to improve MCH outcomes (Bekemeier, Grembowski, Yang, & Herting, 2012; Tylor & Nies, 2013). Such programs include the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Head Start; Healthy Start; Children’s Health Insurance Program CHIP; Medicaid and Medicare, and other services delivered by local health departments (LHD) that target vulnerable populations. Evidence suggests persistent access disparities in MCH services received by different population subgroups in the United States (Bekemeier et al., 2012; Taylor & Nies, 2013), particularly by children from immigrant families (Belue et al., 2012).

This chapter includes the background of the study, the problem statement, the study purpose, the nature of the study, and research questions. In addition, Chapter 1 highlights Anderson's behavioral model of health care use, the theoretical foundation guiding this study. Other areas covered in this chapter include the scope, significance, assumptions, limitations and delimitations of the study, and definitions of key terms commonly featured in this study.

Background to the Study

Health care disparities are national public health concerns mainly affecting minority population subgroups such as African Americans, American Indians, refugees, and new immigrants. Although health care disparities have a long history in the United States, interventions to address them are more recent. Notably, the first coordinated initiative to draw national attention to the need to tackle racial and ethnic disparities in access to and use of health care to promote equity in health outcomes was in the publication of the Healthy People 2000 in 1991 (Bekemeier et al., 2012). Twenty-four years later, health disparities persist and remain one of the toughest health challenges facing the strongest economy, the United States. Other landmark efforts to address health disparities include the 2002 Institute of Medicine (IOM) report on health care disparities, titled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," published by IOM following the 1991 congressional request (IOM, 2002). This report pointed to evidence of bias, prejudice, and stereotyping on the part of health care providers as contributing to differences in care (IOM, 2002).

Although several definitions of health care disparities exist, for the purpose of this study, I adopted the definition of Healthy People 2020 (2015), which defines *disparities* as:

> ... a particular type of health differences that is closely linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial/ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (para. 5).

Health disparities are complex and diverse in nature and are predisposed by varied factors, including SES, geography and environment, education levels, insurance status, discrimination, biology and genetics, and social support (ASTHO, 2012; Bloom, 2011;). In several studies, researchers highlighted evidence of disparities based on immigration status (Belue et al., 2012; Lum & Vanderaa, 2010; Morrison, Wieland, Cha, Rahman, & Chaudhry, 2012). In a pilot study that examined health priorities of Somalis living in Kansas City, Kansas Filippi et al. (2014) posited that African immigrants are one of the medically underserved population subgroups in the United States.

Recent immigrants often have to deal with poverty, marginality, and limited access to social benefits and health services, especially during the early stages of settling in new environments (World Health Organization [WHO], 2008). Discrimination is one of the leading causes of health inequities among immigrants, according to the WHO (2008), along with income inequalities and unequal access to education, employment, and immigrants' lack of social support networks as they try to settle in their new host countries. Researchers note that greater disparities in health care access and the poor health outcomes among immigrant populations, including MCH, result in large part from the magnitude of socioeconomic inequalities in the United States (Belue et al., 2012; Blair et al., 2011; Taylor & Nies, 2013). With no employment and in most cases entirely depending on government welfare programs, new immigrant populations—especially refugees and asylum seekers—tend to have lower SES.

Improving MCH outcomes is a top priority for both national governments and international development and donor agencies. Programs such as WIC, EPSDT, Head Start, Healthy Start, CHIP, Medicaid, and Medicare are part of the United States' policy initiatives to promote MCH outcomes (Belue et al., 2012; Healthy People 2020, 2015). Similarly, WHO's maternal, newborn, child, and adolescent health programs aim to address access barriers in MCH services. The focus of the United Nations' Millennium Development Goals (MDGs) Numbers 4 and 5 (i.e., reducing child mortality and improving maternal health respectively) also is to improve MCH outcomes (Taylor & Nies, 2013). Without knowledge of the experiences of health care disparities among different population subgroups, the existence of programs alone may not help to promote equality in access and use of MCH.

Despite all policy and program interventions at local, state, federal, and international levels, studies indicate that disparities continue to exist in MCH services received by different populations (Belue et al., 2012; Taylor & Nies, 2013). MCH access disparities experienced in the United States include variations in access to (a) family planning services, (b) prenatal and postnatal services, (c) newborn screening, (d) nutrition and breastfeeding access to antenatal and postnatal care, (e) hospital maternity beds after giving birth, (f) insurances, and (g) well-baby check-ups.

There is existing literature on MCH disparities in access, use, and health outcomes in the United States (Belue et al., 2012; Taylor & Nies, 2013). Researchers contend that several factors, such as race and ethnicity, SES, insurance status, geographical location, and immigration status, are key drivers of MCH access disparities. Less literature focuses on the health of African immigrants, particularly access and use disparities experienced by recent African immigrants. Given the growth in diversity and composition of immigrants in the U.S. population and the increasing acknowledgment of the importance of early-life intervention on population health outcomes, the need for scientific evidence on the health needs of the different population subgroups is inevitable.

This qualitative, descriptive, phenomenological study provides a detailed understanding of experiences of recent African immigrant mothers in relation to MCH access disparities. Possible social change implications of this study include increased awareness of the challenge of MCH disparities experienced by recent African immigrant mothers and their children. Dissemination of study findings may inform policymakers and lead them to design evidence-based policy and program interventions aimed at addressing MCH challenges experienced by recent immigrants. This study addresses the current information gap about the MCH disparity challenges experienced by recent African immigrants.

Problem Statement

To build a generation of healthier Americans, the U.S. health care system needs to develop and implement strong policy and program interventions that focus on early life development. Growing evidence suggests that early-life intervention significantly influences health outcomes of adult populations, creating the need for policy and program interventions that address early-development health challenges. For decades, MCH has been recognized and used as an important health indicator for measuring and comparing health outcomes of different population groups across time and space (Bloom, 2011). The central role of MCH is further supported by the increasing acceptance among scholars and health professionals that early development interventions significantly contribute to health outcomes of the adult population (Bellis, Lowey, Leckenby, Hughes, & Harrison, 2014; Teitler et al., 2012). For instance, the MDGs Numbers 4 and 5, and Healthy People 2020 identify improvements in MCH as a potential area for enhancing the overall health of U.S. citizens (Healthy People 2020, 2015; Taylor & Nies, 2013).

Researchers report evidence of persistent MCH disparities among different population subgroups (Taylor & Nies, 2013), as a factor partly responsible for the continued poor health outcomes and devastating global health status ranking of the

United States. Children from immigrant families experience higher disparities in receipt of preventive health care services compared to their counterparts from nonimmigrant households (Belue et al., 2012). The U.S. health care system has not devised an effective intervention to advance equal access to and use of MCH services across the increasingly diverse U.S. population.

Prior studies conducted on the health of immigrants in the United States majorly focus on larger ethnic populations such as Latinos, Asians, and Europeans, but rarely on African immigrants. The concentration of immigrant health research on larger immigrant populations has created a gap in knowledge about the specific health needs and challenges affecting minority immigrants, including as African immigrants. As a result, despite increases in the population of children born to African immigrant in the United States, no corresponding research efforts are focused on understanding MCH experiences for this population. Even a heightened awareness of how early life development affects adult population health outcomes (Bellis et al., 2014; Teitler et al., 2012) has drawn less attention among researchers to investigate MCH of minority immigrants. In my literature search, I did not find a single study that specifically examined MCH access disparities experienced by recent African immigrants, a fast-growing population in the United States (Venters & Gany, 2011). The lack of scientific evidence regarding unmet health care needs of different subpopulation groups creates a gap in designing, framing, and implementing effective policy interventions to address them.

Purpose of the Study

The purpose of this inquiry was to (a) understand the disparities in access to MCH services experienced by recent African immigrant mothers in the United States, (b) explore circumstances that led to MCH access disparities experienced by this population, and (c) understand how access disparities affected participants' overall experience of seeking MCH care services. Earlier studies of immigrants' health focused on larger immigrant populations, such as Latinos, Asians, and Europeans, which left health needs and challenges of minority immigrants less known (Filippi et al., 2014). Thus, the information generated in this study potentially fills a gap in the literature on access disparities in MCH of minority immigrants and may contribute to better MCH outcomes for this population.

Research Questions

In phenomenological studies, the primary research question develops from the researcher's personal interest in a particular problem (Hageman & Frederick, 2013). My passion for promoting positive social change in lives of people from backgrounds similar to mine, hence immigrants, influenced my interest to study recent African immigrants' MCH experiences. Phenomenological study research questions aim to uncover and obtain the detailed understanding of the participants' lived experiences of the phenomenon of study (Hageman & Frederick, 2013). Unlike quantitative studies where research questions attempt to measure quantitative factors and to determine causal relationships (Claydon, 2015), phenomenological research questions aim to explore the qualitative essence of the meaning of human experiences (Hageman & Frederick, 2013). With these constructs in mind, I formulated three phenomenological study questions, which I used to obtain the responses needed to understand the phenomenon of access disparities in MCH care among recent African immigrants in the United States.

RQ1: What are the access disparities in MCH care services experienced by recent African immigrant mothers?

RQ2: What are the circumstances leading to MCH access disparities experienced by recent African immigrant mothers?

RQ3: How do access disparities affect the overall experience and perceptions of recent African immigrant mothers towards seeking MCH care services?

Theoretical Framework

Andersen's behavioral model of health services use (ABMHSU, Aday, & Andersen, 1974; Andersen, 1968, 1995; Andersen & Newman, 1973, 2005) is the theoretical framework guiding this study. Andersen developed the model in the late 1960s to (a) facilitate the process of understanding why families use health services, (b) define and measure equitable access to health care, and (c) assist in the development of policy interventions for enhancing equitable access to health care (Andersen, 1968, 1995; Andersen & Newman, 2005; Rigg, Cook, & Murphy, 2014). ABMHSU suggested the existence of factors that enable or impede an individual's use of health care services (Andersen, 1995). Andersen grouped these factors into three categories: (a) predisposing characteristics, (b) enabling resources, and (c) perceived and evaluated need (Andersen, 1968).

I explored the three concepts of health beliefs, enabling resources, and perceived needs and how they influence an individual’s health care use as described in ABMHSU framework (Andersen, 1995) to understand MCH access disparities experienced by recent African immigrant mothers. The three concepts enabled me to form constructs relating to the phenomenon of access disparities in MCH care and to address my study questions. Specifically, the concept of potential and realized access, as defined in ABMHSU framework (Andersen, 1995; Stein et al., 2007), helped me to understand the factors leading to disparities in access to MCH services as narrated by the study participants.

Although researchers have used other approaches to studying access to and use of health care services, such as sociocultural (Bailey, 1987) or socio-demographic (Weiser et al., 2012) approaches, ABMHSU was preferred for this current study. ABMHSU was not only relevant to the conceptualization of this study, but is a commonly used framework for studies that focus on understanding individuals’ access to and use of health care services (Andersen, Rice, & Kominski, 2011; Chiu & Eysenbach, 2011; Fleury et al., 2012; Holtzman et al., 2015; Ye et al., 2012). In this study, I sought to understand access disparities experienced in the process of seeking MCH services among recent African immigrants in the United States.

Nature of the Study

This is a qualitative study in which I used a descriptive phenomenological approach. The choice to use a descriptive phenomenological approach was in line with the purpose of this research: to understand MCH access disparities experienced by recent African immigrant mothers in the United States. As asserted by Klinke et al. (2014) and Lee et al. (2014), qualitative investigators used phenomenology to study lived experiences of participants in relation to a given study phenomenon. Using semistructured phenomenological interview questions allowed me to collect massive amounts of data from participant responses, which I analyzed using Colaizzi's seven-step technique. Use of phenomenological open-ended interview questions enabled me to probe and evoke detailed responses, giving study participants an opportunity to respond in their own words that were meaningful and culturally salient to them (Lee et al., 2014).

I purposively selected study participants to ensure that only those recent African immigrant mothers who experienced the phenomenon of access disparities in MCH care and were willing to articulate their lived experiences voluntarily participated in the study. I collected data through a face-to-face interview conducted in a private office to ensure privacy and confidentiality of the study participant. Face-to-face interviews enabled me to explore views, experiences, and beliefs of participants, which established a basis through which to understand the phenomenon under study through the lens of the participants, as highlighted by Shosha (2012).

I used Colaizzi’s seven-step descriptive phenomenological data analysis technique as used by Alnazly and Samara (2014) and explained by Shosha (2012) to document, extract, organize, and analyze the collected data. I also used NVivo 11, a computer-assisted qualitative data analysis software to organize and analyze the collected data (CAQDAS; QSR International, 2013; Saillard, 2011). Colaizzi’s data analysis technique enabled me to elicit an exhaustive description of the phenomenon under investigation as described in Shosha (2012).

Operational Definitions

In this section, I define and elaborate on the meanings of the key terms and phrases frequently used in this study.

Health care access: Healthy People 2020 (2015) argues that access to comprehensive, quality health care services is a fundamental step towards achievement of health equity and promoting overall population health outcomes. Measuring access to health services involves four major indicators, which are coverage, services, timeliness, and workforce. In this study, *health care access* refers to the availability of affordable, quality health care in terms of coverage, services, timeliness, and workforce, when and where needed.

Health disparities: The terms *health disparities* and *health inequalities* are used interchangeably in this manuscript to mean the same thing. Although a corpus of literature exists on health disparities/inequalities, little consensus exists regarding the meanings of these terms (Dehlendorf, Bryant, Huddleston, Jacoby, & Fujimoto, 2010).

Although the term *disparity in health care* is often interpreted to mean racial/ethnic disparities (Healthy People 2020, 2015), in this study, *health disparities* refer to the definition provided by National Institute of Health (NIH), which states that "[H]ealth disparities are gaps in the quality of health and health care that mirror differences in SES, racial and ethnic background, and education level" (NIH, 2015, para. 4). In addition, the NIH notes that health disparities may stem from many factors, including variations in SES and access to health care (health care access disparities); increased risk of disease from occupational exposure; geographical locations; and increased risk of disease from underlying genetic, ethnic, or familial factors.

Immigrant health: For the purpose of this manuscript, the term *immigrant health* means the attributes of the health of immigrants, including but not limited to their health status, health care needs and the challenges they face in accessing health care services.

Immigrants: As stated on the Department of Homeland Security (DHS) website (DHS, 2015), the Immigration and Nationality Act (INA) broadly defines an *immigrant* as any alien in the United States, except one legally admitted under specific nonimmigrant categories (INA section 101[a][15]). In this study, *immigrant* refers to foreign-born persons who move to the United States to stay permanently. Thus, visitors who come to the United States for a short period of time are outside the scope of this study. This study was limited to legal immigrants.

Migrant: A migrant is a person who leaves his/her country of origin to seek residence in another country (DHS, 2015).

Maternal and child health (MCH): *Maternal health* encompasses family planning, preconception, prenatal, and postnatal care. The WHO (2015) defines *maternal health* as the health of women during pregnancy, childbirth, and the postpartum period. On the other hand, *child health* is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity (WHO, 2015). According to Healthy People 2020 (2015), many factors affect pregnancy and childbirth outcomes, including preconception health status, age of parents (especially mothers), poverty, and access to appropriate preconception and interconception health care. Similarly, sociodemographic factors such as family income and parents' level of education influences infant and child health outcomes (Healthy People 2020, 2015). Thus, improving the well-being of mothers, infants, and children plays an important role in determining the well-being of the next generation and can help predict future public health challenges for families, communities, and the health care system (Healthy People 2020, 2015).

Minority populations or the minorities: The terms *minority populations* and *minorities* interchangeably represent vulnerable or underserved or less privileged or underprivileged populations and mean the same thing in this manuscript. In this study, *minority populations* refer to those living in the United States without adequate access to health care services. In addition, to qualify as a minority, a person must experience one or more of these attributes: lives in poverty; is uninsured; has limited English language proficiency; has lack of familiarity with the health care delivery system; lives in areas where it is hard to access care, or where providers are not readily available to meet their needs (U.S. Department of Health and Human Services [HSS], 2008).

Recent African immigrants: In this study, the term *recent African immigrants* refers to all persons of African origin who migrated directly from one of the African countries and have not stayed for more than 4 years in the United States. The purpose of limiting the stay to 4 years is to control for the influence of acculturation on the study and its related effects. As highlighted by the WHO (2008), recent immigrants often deal with complex issues including poverty, marginality, and limited access to social benefits and health services, especially during the early period of trying to settle in new environments.

Socioeconomic status (*SES*): *SES* is “a composite measure that typically incorporates economic, social, and work status. Economics, social, and work are measured by income, education and occupation respectively” (Center for Diseases Control and Prevention [CDC], 2014, para. 14). In this study, *SES* refers to the measurement of an individual's economic and social position in relation to others based on income, education, and occupation. SES groups people into three broad categories: high, middle, and low SES status (Heimer, 1997). This study focused on the population at the lower end of the socioeconomic ladder. In the following section, I highlight assumptions that formed the basis of this study.

Assumptions

Underlying this study was the assumption that availability of scientific evidence about MCH access disparities experienced by recent African immigrants in the United

States would enable understanding of maternal and early-life health needs of this group. The study assumed that study participants voluntarily shared their lived experiences as pertaining to the phenomenon of access disparities in MCH care through providing honest answers to all interview questions. Also, I assumed that ready availability of literature on the phenomenon under investigation would help to inform development and implementation of effective policy and program interventions to address root causes of health access disparities, such as socioeconomic inequalities. Such interventions would improve equity in access to and use of MCH services, which, in turn, would lead to overall improvement of health outcomes for all U.S. citizens. Also, I assumed that lack of clear understanding of the nature and effect of access disparities was responsible for the poor MCH outcomes among recent African immigrants in the United States.

Given the availability of considerable literature supporting the notion of investing in early life care programs as means for reducing poor adult health outcomes (Bloom, 2011; Taylor & Nies, 2013; Vafaei, Rosenberg, & Pickett, 2010), I assumed that disseminating findings of this study would make MCH access disparities among African immigrants more visible on the government's policy agenda. In turn, policymakers and health professionals could become aware of the need to urgently address the challenge of health inequalities. This study was assumed to be in line with the United States' national priority of reducing disparities in access to health care to promote better health outcomes for all U.S. residents.

Scope and Delimitations

This study was limited to exploring details of MCH access disparities experienced by recent African immigrants in the United States. The focus of this study arose from findings indicating that African immigrants were one of the medically underserved population subgroups in the United States. Despite ongoing efforts to address health disparities in the United States, study findings indicate that African immigrants experience more difficulties in accessing health care and report poorer health outcomes compared to nonimmigrant Americans (Belue et al., 2012; Blair et al., 2011). In my literature search, I did not find a qualitative study that focused on exploring the challenge of MCH access disparities among recent African immigrant mothers in the United States. The lack of details about MCH access disparities experienced by African immigrants in available literature was the primary rationale for the focus of this study.

This study was conducted in the Boston–Cambridge–Newton, MA–NH metropolitan statistical area (BNMSA), the sixth most popular destination for African immigrants in the United States after New York, Washington DC, Atlanta, Minneapolis, and Dallas (Migration Policy Institute [MPI], 2014). Estimates showed that between 2008 and 2012, Greater Boston had approximately 50,000 immigrants from sub-Saharan Africa (MPI, 2014). As an immigrant living in Boston, I closely interact with the population that is the focus of this study, which allowed me to recruit the required number of participants quickly. Easy access to the study population reduced both the cost and time of completing this study. Study participants included 11 self-identified, foreign-born, legal

African immigrant mothers with children between 6 months and 2 years of age. Focusing this study on children aged between 6 months to 24 months excluded mothers in the vulnerable postpartum phase.

The screening process for study participants excluded mothers with children younger than 6 months and those who were pregnant according to their understanding. The rationale for this exclusion was because this study involved asking deep emotional questions about MCH experiences that pregnant women or mothers in the postpartum period may not have been able to respond to honestly or comfortably. I assumed that 6 months after giving birth, mothers were in a better position emotionally to recount and discuss their MCH experiences. On the other hand, exclusion of mothers with children older than 2 years was based on the assumption that a longer period after accessing MCH would limit the accuracy of how mothers recount and discuss their MCH experiences. Accordingly, this study excluded African immigrant mothers without proper documentation of their legal stay in the United States not only because of concern that this study may be jeopardized, but also to ensure that all included participants were legally eligible for care.

Further, to avoid the influence of acculturation on the phenomenon of access disparities in MCH care, this study focused on recent African immigrants. As defined for the purpose of this research, recent African immigrants are people who had migrated directly from any African country and had lived in the United States for not more than 4 years by the time of data collection. According to the theory of acculturation, when immigrants spend more time in their host countries, they become assimilated and begin to experience life like native-born populations (Kim, Heo, & Park, 2014; Lum & Vanderaa, 2010). With time, immigrants learn the languages of the host countries, gain an education, and obtain better jobs, which changes their SES and their health outcomes (Lum & Vanderaa, 2010). Thus, it was assumed that including acculturated African immigrant mothers in this study would undermine the potential to understand MCH access disparities experienced by newer immigrants.

Given the characteristics of the sample size I used in this phenomenological study, it might be difficult to generalize findings to other similar populations outside the scope of this study. Participants lived in Massachusetts, a state that offers health insurance to all its residents and implement the new Affordable Care Act (ACA) of 2010. Hence, findings from this study may not be generalizable to recent African immigrants in states with different health insurance policies, including states that opted out of the ACA. Also, due to the influence of culture on health seeking behaviors, findings from this study that focused on African immigrants may not inform the overall MCH access disparities across the entire immigrant community in the United.

Limitations

Study design, time, and resources were the three major limitations of this descriptive, qualitative phenomenological study. The responses from the 13 study participants who were purposively selected to participate in this study may not represent the global experience of MCH access disparities among all recent African immigrants in the United States. As any other qualitative study, this phenomenological study generated varied forms of unstructured, voluminous data, which made the process of managing, organizing, storing, analyzing, interpreting, and presenting final study findings a time-consuming exercise. My familiarity with the phenomenon investigated in this study (MCH access disparities), coupled with my central role in sample selection and being the primary study instrument, posed a risk for biases in this study. I used the technique of reflexivity to address the concern of researcher biases. Reflexivity provided me with the chance to step back and critically examine how my assumptions, perceptions, preexisting understanding and new understanding of the phenomenon of study would influence the overall research process and findings (Shelton, Smith, & Mort, 2014).

Significance of the Study

This qualitative study is important because it generated detailed data and findings that may help fill the literature gap pertaining to the health of minority immigrants, specifically concerning MCH access issues among recent African immigrants. The study focused on an understudied population of recent African immigrants in the geographic location of Boston, Massachusetts. Thus, the knowledge generated in this study may add to current understandings of MCH access issues experienced by minority immigrant populations in the United States. Such understanding may, in turn, lead to design and development of evidence-based policy and program interventions tailored to the needs of minority immigrants from Africa. The possible social change contributions of this study may involve increased understanding of the MCH challenges (i.e., access disparities) experienced by African immigrants in the United States, which, in turn, may inform policy interventions that may result in improved MCH outcomes for recent African immigrants in the United States.

Disseminating the findings from this study may help to provide a better understanding of how recent immigrant mothers feel about the process of seeking and using MCH in the United Sates. This descriptive, qualitative phenomenological, study gave study participants an opportunity to provide detailed information about their lived experiences with health care access disparities, specifically in MCH arena. This information may potentially allow opportunities for future research to investigators interested in studying health care access concerns among recent African immigrants in the United States. Also, findings from this descriptive, qualitative phenomenological, study may help to put health needs of minority immigrant mothers and their children on a more visible and higher political agenda.

Summary

Health care disparities are a national public health concern that disproportionately affect underserved, minority population subgroups (Hossain et al., 2013), such as African Americans, American Indians, refugees, and new immigrants. African immigrants are one of the medically underserved population Subgroups in the United States (Filippi et al., 2014). They suffer from adverse health conditions and inequitable access to quality health care services in the United States (Belue et al., 2012; Blair et al., 2011; Edberg et al., 2011). Although several policy interventions at local, state, and federal levels address the challenge of health disparities, studies indicate evidence of persistent health care access disparities between immigrants and nonimmigrants in the United States (Bloom, 2011).

This descriptive phenomenological study provided study participants (recent African immigrant mothers) an opportunity to express their opinions about their experiences seeking MCH services in the United States. Chapter 1 provides an overview and a background to the challenge of health care disparities in the United States, the problem of study, the purpose of the study, the nature of the study, and research questions. Also, Chapter 1 highlights how ABMHSU used to study lived experiences of recent African immigrants in relation to MCH access disparities. Finally, key terms are defined along with the study's scope, significance, assumptions, limitations, and delimitations.

Chapter 2 presents a detailed review of various research findings pertaining to health outcomes of immigrants in the United States. This chapter clearly highlights the current literature gap on MCH care for minority African immigrants. Further, I provide additional insight on ABMHSU and how it informs MCH access and use behavior of recent African immigrant mothers. Chapter 3 presents details of the methodology chosen for this study, Chapter 4 presents study results, and in Chapter 5, I discuss study findings, make conclusions, and provide recommendations.

Chapter 2: Literature Review

Introduction

MCH access disparities are among the major health challenges experienced by recent immigrants to the United States. Minority populations such as African Americans, Latino Americans, and immigrants experience adverse health outcomes attributed to disparities in access to health care services in the United States (Belue et al., 2012; Blair et al., 2011; Edberg et al., 2011). Researchers note that policy interventions to address the challenge of health care disparities have focused on upstream risks and social determinants of health, such as SES (Lum & Vanderaa, 2010; Morrison et al., 2012). Studies investigated the effects of health care disparities on particular population Subgroups, such as African immigrants, remain scanty. In a pilot study examining health priorities of Somalis living in Kansas City, Kansas, Filippi et al. (2014) proposed that African immigrants are one of the medically underserved populations in the United States.

African immigrants' poor health outcomes are primarily attributed to this populations' low SES (Belue et al., 2012; Blair et al., 2011; Edberg et al., 2011; Taylor & Nies, 2013). In addition, little research examines health needs among recent African immigrants focusing on specific demographics, such as gender and age. Lack of reliable literature undermines efforts to develop effectively, evidence-based policy interventions tailored to address health needs of the growing population of African immigrants in the United States.

African immigrants experience tougher health conditions and disparities in access to care when compared with native-born Americans. The United States has experienced rapid demographic change, due especially to the influx of immigrants who leave their native countries for a range of reasons that often include political and economic difficulties (Geist & McManus, 2012). According to Venters and Gany (2011), African immigrants represent one of the fastest growing population subgroups in the United States. For example, Africans immigrating to the United States increased by 166% between 1990 and 2000. With the rapid growth in the number and diversity of African immigrants in this country, a clear need to understand health challenges experienced by this minority population exists.

Recent research on health care disparities continues to indicate inequalities in access to and use of care persisting among different population subgroups (Wilson et al., 2012). Ethnic and racial backgrounds, variations in SES and education levels, and geographical location are among the frequently cited leading causes of health care disparities in the United States (Morrison et al., 2012). Minority populations such as African Americans, Latinos, Indian Americans, and immigrants are susceptible to conditions that lead to health care disparities (Derose et al., 2011; Wilson et al., 2012). In particular, Belue et al. (2012) noted that children from immigrant families experience higher disparities in receipt of preventive health care services compared with their counterparts from nonimmigrant families. Thus, a clear need for comprehensive health policy interventions tailored to meet health needs of specific population subgroups exists.

Although prior studies examined the health of immigrants in the United States, most of the focus has been on larger ethnic populations such as Latinos, Asians, and Europeans, but rarely on African immigrants. A gap in knowledge about health needs and challenges affecting minority immigrant populations such as African immigrants exists. Despite an increase in the number of children born to African immigrant in the United States, no corresponding research efforts focus on understanding MCH experiences of this population. Even with the heightened awareness of the influence of early life development on adult population health outcomes (Bellis et al., 2014; Teitler et al., 2012) little attention has been drawn to researching MCH of minority immigrants. In my research thus far, I have not found a single study that specifically examines MCH access disparities experienced by the rapidly growing population of recent African immigrants in the United States (Venters & Gany, 2011). The lack of scientific evidence about different population subgroups' unmet health care needs creates a gap in designing, framing and implementing effective policy interventions to address these requirements. This phenomenological study allowed me to generate the necessary detailed information about MCH access disparities experienced by recent African immigrant mothers in the United States to bridge the current knowledge gap.

The purpose of this phenomenological qualitative study was to (a) understand the disparities in access to MCH services experienced by recent African immigrant mothers in the United States, (b) explore the circumstances leading to these MCH access disparities, and (c) learn how access disparities affect the overall experience and perceptions of recent African immigrant mothers toward seeking MCH services. I anticipated that the detailed descriptions of access disparities as narrated by the study participants (recent African mothers) would argument the current literature gap on the topic. In addition, the dissemination of findings from this study might add to the understanding of health care professionals and scholars about the health of minorities and African immigrants in particular. Such understanding could lead to design and development of evidence-based policy interventions tailored to the needs of the study population. Thus, this research could enhance positive social change and result in improved health outcomes for African immigrant mothers and their children.

This literature review drew on crosscutting and major studies in MCH, health care access disparities, and immigrants in the United States. Studies indicated that challenges of MCH access disparities continue to exist in the United States, particularly among different population subgroups (Belue et al., 2012; Taylor & Nies, 2013) and that disparities disproportionately affect children from immigrant households when compared with their counterpart from nonimmigrant U.S. families (Avila & Bramlett, 2013; Belue et al., 2012). The frequently reported access disparities in the literature reviewed in this study include (a) family planning services, (b) prenatal and postnatal services, (c) newborn screening, (d) nutrition and breastfeeding access to antenatal and postnatal care, (e) hospital maternity beds after giving birth, (f) insurances, and (g) well-baby check-ups (Bloom, 2011; Bromley et al., 2012). Disparities were also reported in MCH outcomes, such as variations in maternal and infant mortalities along racial/ethnic and income lines, and between immigrant and nonimmigrant children (Avila & Bramlett, 2013; Belue et al., 2012; Bromley et al., 2012; Taylor & Nies, 2013). In essence, I drew the reader's attention to current health care access disparities, how they affect different population subgroups—particularly recent African immigrants, and the need to address them.

Other researchers argued that health care disparities in immigrant health are not a new concept but rather a fairly studied problem in the United States (Belue et al., 2012; Lum & Vanderaa, 2010; Mehta, Lee, & Ylitalo, 2013; Morrison et al., 2012). Authors noted that several policy interventions to address health disparities, including federal government programs such as WIC, Head Start, Healthy Start, Medicaid, and Medicare, among others, exist (Taylor & Nies, 2013). But for decades, the focus has been on disparities related to racial and ethnic grounds and health of larger immigrant populations from Europe, South America, and Asia, leaving an enormous unmet gap in the literature regarding the health of minority immigrants from African countries.

Available research shows that even with heightened evidence of access disparities among immigrants in the United States, fewer studies focus on the health of African immigrants. No single study explored MCH access disparities experienced by recent African immigrants in the United States. Also, studies indicated that the average lower SES of African immigrants, like that of poorer nonimmigrant minorities, results in poor health outcomes (Blair et al., 2011; Taylor & Nies, 2013). No substantial comparative research explores in detail the health needs and of African immigrants versus other immigrant population groups in the United States.

Literature Search Strategy

I searched, gathered, and reviewed literature younger than 5 years and relevant to the study problem of MCH access disparities among minority immigrant populations. I reviewed peer-reviewed journal articles, information from government agencies, private and nonprofit foundations' official websites as well as other related publications, including conference papers on MCH, health disparities, health access, immigrants' health, minority health, and African immigrants. Online databases of peer-reviewed publications including MEDLINE with full text, ProQuest Central, ProQuest Health and Medical Complete, ProQuest Nursing and Allied Health Source, CINAHL, and PubMed. Also, I searched relevant journals, including *Journal of Immigrant & Minority Health*, *Journal of Health Disparities Research and Practice*, *Journal of Racial and Ethnic Health Disparities*, *Journal of Pediatrics and Child Health*, and *Journal of Child Health Care.* Finally, I searched government agency websites such as the United States Department of Health and Human Services (HHS), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Healthy People 2020, Massachusetts Public Health Department (MPHD), and Boston Public Health Department (BPHD). I also used online search engines such as Google Scholar, Google, and Yahoo.

To ensure sources were both current and relevant, I limited my search to materials published within the last 5 years, except when researching historical events such as theoretical and research methods foundations. Also, I referenced older sources to emphasize that disparities are not a new phenomenon in the history of the United States health care delivery system. Because there are fewer studies available focusing on MCH health among African immigrants in the United States, I primarily reviewed studies on health care access disparities among other immigrants and minority population Subgroups who share similar characteristics with immigrants.

To limit my search results and increase access to literature and information relevant to this study, I used the following keywords and search terms combinations: *health, disparities, immigrants, health care access, health care disparities, health disparities*, *health inequalities, maternal health*, *mothers' health*, *child health*, *maternal and child health*, *African immigrants, immigrants from African countries, people of African origin*, *immigrants' health*, and *minority health.* In addition, I used the following phrases: *child health access disparities in the United States*, *disparities in maternal and child health services in the United States*, *health of immigrants in the United States, immigration status and access to health care*, *barriers to health care access,* and *disparities between health of immigrants and nonimmigrants*.

Theoretical Foundation

Theories, theoretical frameworks, and models help researchers to ground their studies. Conceptual/theoretical frameworks are tentative theories of the phenomenon we are planning to study (Bradbury-Jones et al., 2014; Green, 2014). Researchers use experiential knowledge, existing theories, exploratory research, and thought experiments to formulate conceptual frameworks used to guide their studies (Bradbury-Jones et al., 2014). Qualitative researchers use conceptual/theoretical frameworks to support their research arguments, develop sound study questions, and justify the choice of methodology selected for a particular study (Bradbury-Jones et al., 2014).

Qualitative research occurs within a theoretical context, but at varying degrees (Bradbury-Jones et al., 2014). This is especially the case on the different approaches. For instance, while researchers use existing theories to understand the phenomenon under investigation in phenomenological studies, researchers using grounded theory are interested in generating new theories. It is argued that consistent use of theory acts as a chain that links study different parts together (i.e., the problem statement, study purpose, research questions, literature review, methods, and results) to enhance coherence (Bradbury-Jones, et al., 2014).

Andersen's Behavioral Model of Health Services Use (ABMHSU)

ABMHSU (Aday & Andersen, 1974; Andersen 1968, 1995; Andersen & Newman, 1973, 2005) is the theoretical framework I used in this study. Ron Anderson developed the model in the late 1960s to (a) facilitate the process of understanding why families use health services, (b) define and measure equitable access to health care, and (c) assist in the development of policy interventions for enhancing equal access to health care (Andersen, 1968, 1995; Andersen & Newman, 2005; Rigg et al., 2014). The ABMHSU suggested the existence of factors that enable or impede how individuals use of health care services (Andersen, 1995). Andersen grouped these factors into three categories, which are: predisposing characteristics, enabling resources, and perceived and evaluated need (Andersen 1968). Later modifications to the behavioral model of health services use include environment and provider-related elements (Aday & Andersen, 1974; Andersen, 1995; Andersen & Newman, 2005; Andersen et al., 2011). Thus, the revised ABMHSU model uses a systems perspective to integrate a range of individual, environment, and provider-related variables associated with decisions to seek care.

As defined by Andersen (1968, 1995) and Andersen and Newman (2005), predisposing factors include biological factors that may influence the likelihood an individual needs a health service, social structure that may affect how an individual can cope with health problems and health beliefs that may influence an individual's perception of their need for a health service. According to Hughes and Wingard (2008), predisposing factors include demographic characteristics and socio-structural characteristics such as education level, race and ethnicity, and family size. Health beliefs are an individual’s knowledge and values about health care that might influence their perceived need of care and the actual usage (i.e., demographic information, and social structure). Andersen’s model assumes that the associated perceived benefits influence individuals' health seeking behavior, so exploring the predisposing factors of health beliefs as constructed in the model can help explain how willing recent African immigrant mothers are to access MCH services. Thus, the ABMHSU may be used to explain recent African immigrant mothers’ health behaviors in the presence of perceived disparities to accessing MCH services.

Enabling resources are all those factors that facilitate health care use, including access issues, income, health insurance, and availability of providers and the essential components of a health care facility (Andersen, 1968, 1995; Andersen & Newman, 2005). The construct of enabling resources assumes that an individual's experience of health care is determined by his or her access to particular resources that grant them health care access. For instance, recent African immigrant mothers' access to health insurance, good income, and availability of women and child health specialists may define the nature of access disparities this population may face in the process of seeking MCH services.

Finally, perceived needs pertain to an individual's assessment of the importance of seeking professional help while evaluated need refers to a diagnosis made by a health care professional that leads to further treatment and care (Andersen, 1968, 1995; Andersen & Newman, 2005). The perceived needs of individuals may include attitudes, values, and knowledge about health problems and services that affect their perception of whether they do or do not need health services. The perceived MCH needs of recent African immigrants may influence the perceived inequalities this population experiences in the process of seeking MCH services in the United States.

To illustrate further how the categorized factors that influence health care services use among individuals, Andersen incorporated the concept of mutability in the ABMHSU model (Andersen, 1968, 1995; Aday & Andersen, 1974). Andersen and colleagues define as mutable those variables that can be easily changed to promote equal access to health care services and that can result in behavioral change (i.e. enabling factors, such as income, health insurance). On the other hand, demographic characteristics (i.e. age, sex) are of low mutability because one’s sex and age are inalterable or difficult to alter (Andersen, 1968, 1995). Thus, the factors that cause MCH access disparities experienced by recent African immigrant mothers can be explored using ABMHSU’s model to determine, which can be easily altered (mutable) to address and find solutions to changeable inequalities, versus those that are not changeable. Such categorization of causes of MCH access disparities among recent African immigrant mothers may allow development of effective policy interventions tailored to address inequalities in access to MCH services in this population.

Following criticisms of failure to take into consideration all the relevant social networks and related issues (Bass & Noelker, 1987; Rundall, 1981), the ABMHSU model has been refined over time to accommodate changing needs in the health services field. Notably, the model shifted from focusing on families as the unit of study to individuals with particular attention to vulnerable populations (Gelberg et al., 2000). The refined ABMHSU model distinguishes between measures of potential and realized access. Moreover, the ABMHSU also accommodates environmental factors and provider-related influences, health behavior, health outcomes and concepts of equity, efficiency and effectiveness (Andersen, 1995; Gelberg et al., 2000; Phillips et al., 1998; Stein et al., 2007). The changes ABMHSU has undergone over the years have addressed many of the problematic concerns it faced earlier; making it one of the most suitable models available for studying health access and use.

Although several approaches for studying access to, and use of health care services exist, including sociocultural (Bailey, 1987) or sociodemographic (Weiser et al., 2012), the ABMHSU was preferred for this study. The ABMHSU is not only relevant to the conceptualization of the study phenomenon but is a commonly used framework in studies focusing on understanding individual access to and use of health care services (Andersen et al., 2011; Holtzman et al., 2015). This study sought to understand access disparities experienced in the process of seeking MCH services among recent African immigrants in the United States. The concepts of predisposing, enabling and need factors was relevant to understanding the lived experience of recent African immigrants about MCH access disparities. For instance, the constructs of potential and realized access in the ABMHSU framework (Andersen, 1995; Stein et al., 2007) helped to inform the barriers and enablers that influenced MCH access disparities experienced by recent African immigrants in the United States.

Access Disparities in MCH Care

The quality of MCH services plays a critical role in the overall population health outcomes and wellbeing of a nation’s citizens. Studies indicate that investing in early life development programs is the most effective intervention to reduce population health risk factors and to promote better adult population health outcomes (Bellis et al., 2014; Taylor & Nies, 2013; Teitler et al., 2012). In support of this argument, the United Nations' MDGs and the Healthy People 2020 identified improvement of MCH as one of the potential areas for enhancing the overall health of Americans (Taylor & Nies, 2013;

Health People 2020, 2015). Therefore, policymakers should prioritize equal access to and use of MCH services across the racially and ethnically diverse population of the U.S., including African immigrants. Studies showed that varied disparities continue to exist in MCH outcomes, especially among underserved population groups (Bloom 2011; Taylor & Nies, 2013; Bromley et al., 2012). Thus, to fully confront the challenge of MCH access disparities in the United States, a needs to gain an understanding of the different access disparities encountered by varied population Subgroups is evident.

Researchers indicated that mothers and children of color, persons from low-income families, those living in rural geographic locations, and newer immigrants, all experience disparities in access to care in the United States (Bloom, 2011; Taylor & Nies, 2013). The MCH disparities prevalent in the United States include variations in access to (a) family planning services, (b) prenatal and postnatal services, (c) newborn screening, (d) nutrition and breastfeeding, (e) access to antenatal and postnatal care, (f) hospital maternity beds after giving birth, (f) insurance, and (h) well-baby check-ups (Bloom, 2011; Bromley et al., 2012). Health care access disparities significantly influence the quality of MCH outcomes, such as birth weights, preterm births, birth defects, infant mortality, and maternal mortality (Bloom, 2011). Thus, addressing health care access disparities is crucial for promoting uniform MCH outcomes.

The cost of an unhealthy population as a result of health and health care disparities has both short-term and long-term social and economic costs to the nation. Thus, disparities pose a significant threat to the greatest national asset and social capital of future generations--the health of the current and future workforce (Bloom, 2011). Considering the importance of early life experience to population health outcomes and the cost of health disparities in early life development, it is imperative that the U.S. health care system commits more resources to MCH programs. There is a need to design, execute, and evaluate interventions that focus on addressing social determinants of health, and to decrease health disparities among vulnerable women and children in the United States (Teitler et al., 2012). Improving national MCH outcomes, according to Taylor and Nies (2013) requires a rounded intervention approach that addresses both clinical and socioeconomic determinants (including living and working conditions) that influence adverse outcomes. Likewise, designing and implementing policy interventions that enhance MCH outcomes requires a thorough understanding of the specific determinants of health care experiences for the targeted population (Frazer, 2013). A collaborative approach that integrates varied intervention policies and programs will bring about the synergy necessary for improving access to and use of MCH Services.

Although children of immigrants represent the fastest growing population in the United States, literature about their health outcomes remains relatively scarce. Among the many challenges faced by children born to immigrants is that they rarely have a chance to grow up under their parents' care, usually spending more time in day cares (Bloom, 2011). Immigrant children are deprived of parental care during the critical stage of infancy and toddlerhood, including a lower chance of being breastfed (Miller, Votruba-Drzal, Coley, & Koury, 2014), which negatively affects their early development and adult health outcomes. Immigrant mothers of low SES often work two or more jobs to earn a living, thus, spending less time with their children compared to mothers from high-income families or with a single professional job. Improving the MCH experience of immigrant mothers and children by addressing disparities in social determinants such as access to quality health care services, particularly preventive care, can significantly enhance the overall population health outcomes for all U.S. citizens (Miller et al., 2014).

Researchers argue that the primary immigrant-destination countries, such as Canada, Australia, and the United States, recognize that foreign-born individuals fall into vulnerable population categories (Edberg et al., 2011; Miller et al., 2014). Immigrants are at high risk of experiencing harsh socioeconomic conditions, such as living in poverty and poor neighborhoods. Also, immigrants' health care outcomes are adversely affected because they are more likely to lack health care access when compared to native-born populations. (Belue et al., 2012; Blair et al., 2011; Morrison et al., 2012). Variation in socioeconomic conditions is responsible for many of the disparities experienced by different population groups seeking and using MCH care in the United States, according to Taylor and Nies (2013). Minority populations living in underserved communities experience higher access disparities in the form of lower quality care, and postponing or missing needed treatment, compared to nonminority, wealthy populations.

Health and Health Care Disparities

Disparities in access, use, and health outcomes are huge injustices that primarily affect minority populations in 21st-century societies. Health care disparities are a national public health concern that disproportionately affects vulnerable minority populations, such as new immigrants in the United States (Frieden, 2014; Healthy people 2020, 2015; Hossain et al., 2013). Health disparities are “a particular type of health difference that is closely linked with social, economic, and environmental disadvantage” (Healthy People 2020, 2015 para. 1). Researchers indicate the prevalence of worse health care disparities among the minority populations, such as African-Americans, Latinos, Indian Americans, and immigrants compared to their White counterparts (Derose et al., 2011; Morrison et al., 2012; Wilson et al., 2012). Disparities exist when variations in health outcomes or health determinants exist between populations. According to the 2014 National Healthcare Disparities Report (NHDR), the conditions and social context in which people live partly explains the variations in the health status of the different population Subgroups in the U.S. (AHRQ, 2015).

Much literature exists on health care disparities and current intervention programs to address them, yet, inequalities in use and access to care among the United States’ diverse population continue to persist (Derose et al., 2011). Health care disparities remain a notable national health care concern in the United States’ health care delivery system (Morrison et al., 2012; Wilson et al., 2012). There was substantial literature on the subject of health and health care disparities, including the magnitude of the problem, its effect on population health outcomes, and current policy interventions (Blair et al., 2011; Derose et al., 2011). It is important to note that less focus has been paid on exploring health challenges experienced by minority populations in low SEC. For example, recent

African immigrants, who continually experience more access barriers to care, greater risk for disease burdens, and receive inferior care quality compare to those in high SES in the U.S. (Blair et al., 2011).

Determinants of Health Disparities

Equity in health, health care, and population health outcomes is of vital importance to the wellbeing of a nation. Studies attributed health care disparities to several factors, including ethnic and racial backgrounds, variations in education levels, and access to health care (Blair et al., 2011; Derose et al., 2011; Frieden 2014). The other primary determinants included the massive socioeconomic imbalances among the diverse populations in the U.S., language barriers, gender, age, disability, and geography (Morrison et al., 2012; Wilson et al., 2012). Minority, vulnerable, and underserved immigrant populations were more prone to experience disparities when compared to mon-minority populations (Derose et al., 2011; Morrison et al., 2012; Wilson et al., 2012). For instance, according to the 2014 NHDR, Blacks and Latino Americans received worse care than Whites for about 40% of quality measures (AHRQ, 2015).

The 2014 NHDR also indicates that poor people receive worse care than high-income people for about 60% of quality measures. Also, Latino Americans and Blacks have more difficulties accessing care than their White counterparts (AHRQ, 2015). Children from immigrant families experience higher disparities in receipt of preventive health care services when compared to their counterparts from nonimmigrant families (Belue et al., 2012). Minority households at the bottom of the socioeconomic ladder tended to experience higher mental, physical, emotional, and behavioral health issues when compared to their counterparts at the top (Taylor & Nies, 2013; Teitler et al., 2012). Health burdens, such as depression, obesity, and drug abuse were common among the "have nots" at the bottom of the socioeconomic ladder (Taylor & Nies, 2013; Teitler et al., 2012). According to 2010 U.S Census results, 20% of all American children live in poor households, with African American and Latino American children making up the biggest percentage (U.S. Census Bureau, 2014a; U.S. Census Bureau, 2014b).

It is evident that if left unchecked, the persistent health care disparities and the growing diversity of the U.S. population (Morrison et al., 2012; Venters & Gany, 2011) pose serious public health challenges (Cadoret & Garcia, 2014). There is a need to identify and create awareness about what causes health access and outcomes to vary across different population subgroups (Frieden, 2014). Such evidence should inform policy interventions that focus on eliminating causes of disparities, as well as promote equitable access to affordable, quality care for all Americans irrespective of their SES, race, ethnic background, or immigration status.

History of African Immigrants in the United States

There has been a surge in the number of Africans migrating to the United States, especially since the 1980s for various reasons. The number of African immigrants to the United States increased from 109,733 between 1961 and 1980 to 531,832 between 1981 and 2000 (Takougang & Tidjani, 2009). The results of the U.S. Census Bureau's American Community Survey conducted between 2008 and 2012 showed that there were

1.6 million foreign-born African immigrants in the United States, constituting about 4% of the total foreign-born population of 39.8 million (Council on Foreign Relations, 2014). By 2012, African immigrants accounted for only 4% (i.e. 1.6 million) of the total foreign-born immigrants in the United States. The 1.6 million represented a phenomenal increase compared to about 80,000 foreign-born African immigrants living in the U.S. in the 1970s (U.S. Census Bureau, 2014b; Roberts, 2014). These statistics imply that most African immigrants are newcomers, i.e., “[A]bout three-quarters of the Africa-born population came to the U.S. from 1990.”

The few African immigrants who made it to the United States in the 1960s and 1970s came mainly for educational purposes. After graduating, only a handful stayed behind, and the majority returned to their respective home countries to contribute to the national development of the then newly independent African nations (Hero, 2010; Kusow, 2014). In contrast, newer African immigrants are mainly refugees and asylum seekers who have escaped political persecution, civil wars, and natural disasters in their home countries. Others were highly skilled professionals leaving worsening socioeconomic conditions (i.e., higher unemployment or deteriorating health systems) to seek better opportunities abroad (Capps, McCabe, & Fix, 2012; Kusow, 2014; Roberts, 2014). The majority of the recent African immigrants came to the U.S. not intending to return to their motherland (Roberts, 2014); they came prepared to settle in the U.S. and build a comfortable life for themselves and their families. Once they arrived on American soil, they sought permanent residency and later acquired United States citizenship.

Many of the earlier immigrants settled in a handful of major cities that boast a large number of prominent institutions of learning, including the primary destinations of African immigrants, New York City, Washington DC, Atlanta, Dallas, Minneapolis and Boston (Kusow, 2014; Roberts, 2014). In contrast, recent immigrants settle in both large cities and small towns of states such as Iowa, Maine, and North and South Dakota—locations that were formerly alien to the minds of many immigrants back in the 1960s and 1970s. For example, during a period of 10 years (from the 1990s to 2000), South Dakota experienced a phenomenal increase in the number of African immigrant settlers, from 210 in the 1990s to 1,560 in 2000, representing an increase of 640%! Likewise, around the same time frame, the number of African immigrants in Washington State rose from 202 in the 1990s to 1,802 in 2002 (U.S. Census Bureau, 2014b). Various factors contributed to the increase of African immigrants living in nontraditional destinations, including the immigrants' desire to live and raise their children in quiet, safer environments, tolerance toward immigrants, the level of racial/ethnic discrimination, and the availability of employment opportunities.

African immigrants were eager to adjust and learn to live the American way, knowing that they had no intention of returning to their homeland (Roberts, 2014). They found every opportunity to go to school, earn a college degree, find a job, get involved in their communities, and began to participate in their new community's local politics (Takougang, 2003). Given the never-ending firearm conflicts across the African continent, and the continued economic deterioration of many African nations characterized by higher unemployment rates (Kitissou & Bong, 2014; Wood & Kathman, 2015), it is likely that immigrants will continue to flock to the United States. Africans embrace independence with hope and optimism for improved SES that never materialize, including better education, health care, and employment opportunities. After over half a century post-independence, the African continent is still lost amidst conflict and socioeconomic stagnation featuring extreme poverty, corruption, illiteracy, and ever-increasing unemployment rates across the African continent (Kitissou & Bong, 2014). Thus, the dreams many had of economic and political liberation post-independence are increasingly fading away, helping to explain a growing number of Africans migrating to the United States in search for a better life.

In addition to push factors like Africa's unfavorable political and economic climates, pull factors such as the relaxation of United States immigration policies have also played a significant role in the increase of African immigrants (Capps et al., 2012). Both the Immigration Reform and Control Act (IRCA) of 1986 and the Diversity Visa Program that were part of the 1990 Immigration Act have contributed considerably to the recent influx of African immigrants to the United States (Capps et al., 2012). In particular, the IRCA of 1986 opened up an opportunity for undocumented immigrants (Africans) living in the United States to become permanent residents. Additionally, thousands of qualified Africans migrate to the United States each year through the Diversity Visa Program established in 1990 to promote immigration from previously underrepresented countries and regions.

Education and professional opportunities are critical pull factors that cannot go unmentioned in the discussion of African immigrants to the United States. Annually, the United States' highly regarded education system attracts a large number of African immigrants who gain visa entry to the United States as students (Capps et al., 2012). Whereas some students from Africa privately sponsor themselves to U. S. colleges and universities, a large number of students are on grants and scholarships. African students receive grants from a variety of sources, including the U.S. government, institutions of higher learning, and such independent local and international organizations/agencies as the Ford Foundation and the World Bank (Capps et al., 2012). Studies continuously indicated that a majority of Africans graduating from American universities rarely return to their homeland, and the few who returned often migrated back, citing unfavorable socioeconomic conditions in their respective African countries.

Characteristics of Recent African Immigrants in the United States

African immigrants are a relatively small population size compared to the overall immigrant population in the United States. African immigrants comprised only about four percent of the total foreign-born immigrants by 2012 (Council on Foreign Relations, 2014; U.S. Census Bureau, 2014a; U.S. Census Bureau, 2014b). Interestingly, studies continuously reported that African immigrants compare favorably to other immigrant groups such as Latinos on educational achievement, English language proficiency, and unemployment rates (Bideshi & Kposowa, 2012; Kusow, 2014). For instance, statistics indicated that on average African immigrants complete 14 years of schooling (Kusow, 2014). African immigrants not only attain more education compared to both African Americans (12.4 years) and Afro-Caribbeans (12.6 years), but also more years than the Whites (13.5 years) and Asian Americans (13.9 years) (Kusow, 2014).

Beyond comparing African immigrants on average terms with immigrants of other origins, intra-African immigrant analyzes reveal appalling heterogeneity. In particular, African immigrants represent all levels of the socioeconomic ladder (Bideshi & Kposowa, 2012; Kusow, 2014). There are notable disparities in education and income attainment among more recent African immigrants arriving from different African countries. Studies indicated that along with the relatively high overall educational and occupational achievement of African immigrants, a substantial population of recent arrivals, particularly refugees and asylum seekers, experienced harsh socioeconomic conditions (Kusow, 2014).

For instance, analysis of family incomes of African immigrants from different countries reveals significant variance. The median family income for the 2000 financial year for Kenyan, Tanzanian, and Ugandan immigrants was $43,000, $60,000, and $56,000, respectively, which is much higher than $27,000, $38,000, and $19,000 for immigrants from the neighboring East African countries of Ethiopia, Sudan, and Somalia, respectively (Kusow, 2014). The same study also indicates variations in poverty rates among immigrants from different African countries. In 2000, immigrants from Somalia and Sudan had poverty rates of 23% and 20%, respectively, which is much higher than 1.7% of immigrants from Uganda in the same year (Kusow, 2014). Educated African immigrants are professionals who work in high-level occupations and earn more relative to other immigrant groups in the United States. By comparison, uneducated African immigrants take on low-profile jobs, such as cab driving or cleaning, and live at the bottom of the socioeconomic ladder, just like other nonimmigrant minority populations (Kusow, 2014).

In summary, the United States has experienced the phenomenal increase in the number of African immigrants since the 1980s as a result of persistent push and pull factors. Deteriorating socioeconomic conditions in many African countries, including high unemployment rates and rampant corruption, fear of political persecution from tyrannical leadership, and armed conflict, push many Africans to seek better lives elsewhere (Council on Foreign Relations, 2014). In addition, relaxation in the United States immigration policies, such as the enactment of the Immigration Reform and Control Act of 1986 and the establishment of the Diversity Visa Program in 1990 increased the flow of African immigrants (Capps et al., 2012). The belief among Africans about the superiority of the United States' education system and employment opportunities is a major pull factor contributing to increased flow of African immigrants into the United States. Unfortunately, there are no signs of immediate change in the cause of the current massive exodus from Africa to the United States. It is, therefore, necessary to understand the health needs of African immigrants (Venters & Gany, 2011) and to design tailored policy interventions addressing the unique ethnic, cultural, and language diversity of immigrants from all over the African continent.

Health of African Immigrants in the United States

The United States remains a popular destination, attracting approximately 20% of the world’s international migrants while representing fewer than 5% of the global population. The rapid growth of the share of immigrants in the U.S. population, particularly people of African origin since the 1980s (Council on Foreign Relations, 2014) has made immigrant health an increasingly important public health concern. Filippi et al. (2014) argued that African immigrants are one of the most medically underserved population subgroups in the United States. Of concern is the lack of little literature on the demographics, health needs, barriers to health care access, and variations in use patterns among the rapidly growing African immigrant population (Venters & Gany, 2011). Unlike other broad health domains, African immigrant and refugee health has no standardized database. Much of the literature about African immigrants focused on infectious diseases and mental health, leaving unexplored other health risks and challenges, such as chronic diseases (Filippi et al., 2014). There is need for investigations that focus on health promotion and prevention of immigrants, including MCH.

Immigrant Health Policy Issues

An urgent need to design policy interventions and programs tailored to address health care needs of African immigrants in the U.S. exists. Research indicated that the paucity of literature on African immigrants’ health is due in part to their small population in the United States (Filippi et al., 2014). African immigrants make up only about four percent of the total foreign-born immigrants by 2012 (Census Bureau, 2014a; U.S.

Census Bureau, 2014b). Lack of scientific evidence impedes the efforts of policymakers and other stakeholders, such as providers, insurance companies, and community-based organizations, to determine appropriate health interventions to address this population's current health challenges. Most immigrant health policy interventions focus on larger immigration groups in mind, such as Latinos, and particularly Mexican immigrants in the United States (Bromley et al., 2012), often neglecting smaller immigrant Subgroups such as African immigrants.

Immigrant Health Effect and Immigrant Health Paradox

On their arrival in the United States, new immigrants experience conditions known to enhance adverse health outcomes, such as poverty, discrimination, health care access challenges, and lack of familiar social support networks. Surprisingly, scientific evidence increasingly supports the existence of a health advantage, i.e. the healthy migrant effect of newer immigrants over the native-born population (Blair & Schneeberg, 2014; Jackson, Kiernan, & McLanahan, 2012; Subedi & Rosenberg, 2014). The health advantage of new immigrants is popularly known as the immigrant paradox (John, de Castro, Martin, Duran, & Takeuchi, 2012; Thomson, Nuru-Jeter, Richardson, Raza, & Minkler, 2013; Urquia, O'Campo, & Heaman, 2012). There is growing agreement that recent immigrants tend to exhibit better health outcomes compared to native-born Americans and more acculturated immigrants (Alcántara, Chen, & Alegría, 2014; Subedi & Rosenberg, 2014; Urquia et al., 2012). Literature comparing foreign-born and native-born populations on varied health aspects reveals that despite their less favorable socioeconomic conditions, the comparable or better health outcomes typically experienced by new immigrants over native-born populations tend to diminish over time and the duration of stay in the host countries (Subedi & Rosenberg, 2014; Urquia et al., 2012).

The change in major health indicators from immigrant health advantage to disadvantage over time is associated with a number of determinants related to the duration of stay. These factors include high poverty levels, disparities in access to health care and social services, discrimination, stress of settling in a new country, and acculturation (Blair & Schneeberg, 2014; Gimeno-Feliu et al., 2015; Subedi & Rosenberg, 2014; Thomson et al., 2013; Urquia et al., 2012). The poor living conditions experienced by immigrants over time deplete the protective factors that account for their initial health advantages over the native-born populations, exposing them to unfavorable health outcomes. Researchers highlighted that as immigrants continue to live in the United States, they adopt the poor health behaviors and lifestyles of native-born citizens, such as smoking, drinking, poor diets, and inactivity (Thomson et al., 2013). Thus, the more acculturated immigrants become, the more the health advantage they held on arrival declines.

Immigrant, health investigators, indicate that the healthy migrant effect is observable in a broad range of immigrant health studies, including reproductive health, primary care use, substance use and abuse, and prevalence of chronic disease such as diabetes (Alcántara et al., 2014). Currently, it is unknown whether the healthy migrant effect observed in different studies holds true for the different health aspects of African immigrants in the United States, given the scarcity of studies that mainly investigate health in this growing population (Alcántara et al., 2014; Urquia et al., 2012). There has been a rapid increase in the number of studies focusing on the health of immigrants from other parts of the worlds, such as Latin America, Europe, and Asia (John et al., 2012). However, literature documenting the varied health risks and needs and population health outcomes of immigrants from Africa were scarce.

The healthy migrant effect and the immigration paradox are attributed to a number of factors, including the healthy selection effect that allows only healthy, financially stable people to gain entry into the United States (Blair & Schneeberg, 2014; Nuru-Jeter et al., 2013). Only those with stamina withstand the substantial physical, emotional, mental, and financial demands of the migration process get the chance to migrate while the unhealthy who fail to meet immigration requirements stay in their homeland. However, this explanation fails to account for a significant number of immigrants who come to the United States involuntarily as refugees and asylum seekers, often after experiencing worse health challenges in their home countries.

Second, the presence of strong social ties and extensive social networks among immigrants (Thomson et al., 2013) is another common explanation for the immigrant health effect. Studies indicated that people in societies with greater social cohesion, such as in Sweden, Japan, and Latin America, tend to experience better population health outcomes compared to less caring, individualistic communities (Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012; Rios, Aiken, & Zautra, 2012). Social cohesion explains why on arrival in the United States, newcomers tend to settle in traditional immigrant destination communities. In heavily immigrant settled areas, newcomers can easily access social support from relatives or friends who migrated earlier to the U.S. (Council on Foreign Relations, 2014).

Further, the immigrant health advantage is attributable to lifestyle and healthier behaviors immigrants develop while growing up in their home countries. For instance, many African cultures discourage smoking and alcohol consumption as unacceptable and unhealthy behaviors, especially among females (Blair & Schneeberg, 2014). In contrast, physical activity and low fat/low calorie diets are common characteristics of lifestyle in Africa (Blair & Schneeberg, 2014). In addition, African parents tend to be strict with their children to prevent them from getting involved in bad health habits such as substance abuse. Strict lifestyles enhance children's early life development and affect their health outcomes later in life, contributing to the health advantage African immigrants carry to their host countries. However, as they stay longer and become more acculturated, immigrants adapt to the cultures and unhealthy behaviors of their American-born counterparts and end up experiencing similar poor health outcomes.

Effect of Immigration Process on the Health of Immigrants

For decades, political crises and unfavorable socioeconomic conditions in home countries, and the desire for a better life have been the motivators for people migrating to the United States. A large number of African immigrants enter the United States as refugees or asylum seekers who were forced to migrate to escape harsh political and economic conditions in their home countries (Asgary & Smith, 2013). Immigrants leave behind their previous achievements and statuses as well as their social support networks from family and friends. Asgary and Smith (2013) note that refugees and asylum seekers typically arrive in the United States with complex social and medical problems, including chronic diseases, HIV/AIDS, severe mental health disorders (especially PTSD), and depression. Such complications worsen by the intricacy and toil of the immigration process. Professionals and the Electronic Diversity Visa Lottery winners have a chance to plan their migration to the United States ahead of time (Asgary & Smith, 2013). Refugees and asylum seekers leave their home countries involuntarily, subjecting them to unexpected life changes and put them at risk of health complications such as depression, mental health disorders, and other chronic illnesses (Asgary, Charpentier & Burnett, 2013).

The increase in the size and diversity of the African immigrant population in the United States (Venters & Gany, 2011) and the gap in the literature about their health needs (Wilson et al., 2012) indicate the need for an urgent call for action. There is very little information focusing on African immigrants about chronic diseases and their management, including diabetes care and cancer screening and behavioral health concerns such as obesity, and substance use and abuse. Also, there were insufficient studies on the main health indicators such as mortality rates, life expectancy, pregnancy, and MCH outcomes among recent African immigrants in the United States.

The health of immigrants has a huge effect on the overall population health results of the U.S. population (Subedi, & Rosenberg, 2014). Thus, understanding the health and health needs of African immigrants is critical to the overall performance of the United States' health care system and contributes significantly to the formulation of appropriate policy interventions specific to a particular population subgroup (Subedi, & Rosenberg, 2014). Particularly, there is a need for studies aimed at exploring how African immigrants experience various national health problems (i.e. the persistent health and health care disparities) and the policy interventions for addressing them. In the following section, I review the salient, recent published literature on the phenomenon of access disparities in MCH care experienced by different population Subgroups in the United States.

Review of the Current Related Studies

The increase in the population size and diversity of African immigrants in the United States justifies the need for research intervention that focuses on various aspects of this underserved population. Although literature on immigrant health remains limited, there is increased interest in the study of health needs, health determinants, and health outcomes of this population in their host countries (Edberg et al., 2011; Miller et al., 2014; Teitler et al., 2012; Urquia et al, 2012; Venters & Gany, 2011). For decades, intensive studies demonstrated the persistence of health and health care disparities among different population Subgroups (Bekemeier et al., 2012; Derose et al., 2011). Disparities exist in access to and use of preventive and other health care services, including MCH, and are seen in population health outcomes between immigrants and nonimmigrant communities (Avila & Bramlett, 2013; Bromley et al., 2012; Jackson et al., 2012; Taylor & Nies, 2013; Vanthuyne, Meloni, Ruiz-Casares, Rousseau, & Ricard-Guay, 2013).

The systematic review performed by Taylor and Nies (2013) to examine the effect of federal programs targeted reducing health disparities and enhancing better population outcomes of underserved populations. The study indicated that the effect of MCH programs varied by setting and populations served. Taylor and Nies assessed 20 peer-reviewed articles published between January 2006 and June 2011 to evaluate four major federal programs that target disparities in MCH outcomes: Head Start, Healthy Start, WIC, and Medicaid. The studies were categorized by the type of outcome examined; 14/20 focused on maternal, child and infant health outcomes. The concentration of federal programs focusing on MCH indicates the importance of early life in enhancing public health outcomes.

Despite the federal government’s commitment to addressing disparities in MCH outcomes through interventions that enhance underprivileged people’s access to health and social services, Taylor and Neis (2013) argue that numerous inequalities still existed in health outcomes of minority mothers and children. They found that researchers attributed disparities to several factors, including racial/ethnic issues and variations in SES within the U.S. Minorities at the bottom of the socioeconomic ladders were found to have experienced worse MCH outcomes compared to their counterparts at the top. The studies included in this review highlighted the value of MCH and the effect of federal government intervention programs to address access disparities in MCH outcomes (Taylor & Nies, 2013). However, this current study was unique and differed from previous studies in that it aimed to gain a detailed understanding of MCH access disparities through the perspective of, and experienced by, the population subgroup of recent African immigrants.

In a related study, Derose et al. (2011) examined health care access disparities experienced by racial and ethnic minorities and other underserved populations. In this study, Derose et al. note that existing health care access models focusing on individual-level factors (e.g., demographics and personal health beliefs), such as the ABMHSU (Andersen, 1995) create gaps in attempts to understand and address health care disparities. Problems of health access disparities among minority populations in the United States is enormous, but documentation of effective interventions to enhance equitable access remain scanty (Derose et al., 2011). The authors argued that lack of effective policy interventions is in part due to lack of comprehensive understanding of the varied upstream determinants that underlie health disparities as the typical cause (Derose et al., 2011). In response, Derose and colleagues explored existing health care access frameworks (i.e., ABMHSU, Frenk and White’s barrier-focused framework of 1992 and the 1993 access and health outcomes relationship framework developed by the IOM) to develop a new model. The expanded model of Derose et al. incorporated the role of public health in studying health access disparities and developing appropriate policy interventions and programs to address them.

Public health programs help reduce variations in access to and use of health services through the core functions of assurance, assessment, and policy development (Derose et al., 2011), thus promoting better health outcomes for all. At a local level, public health programs play a significant role in identifying the population's health needs and work with providers and other stakeholders to ensure the availability of needed health care services. Also, public health programs play a part in setting standards that aim to ensure competency in the provision of public health and personal health care services. The set standards also act as a basis for evaluating effectiveness and efficiency of public health policy intervention (Derose et al., 2011). The authors proposed that approaching disparities in public health's perspective provide a foundation for identifying concrete actions and policy interventions toward improving access and addressing disparities in health care in ways that earlier frameworks did not (Derose et al., 2011). Although a myriad of factors underlie disparities in health outcomes, including upstream causes, the focus of the expanded public health disparity framework of Derose and colleagues is limited to health care access disparities alone. Thus, their model fails to explain the other primary determinants of health and health care disparities that go beyond access-related issues such as immigration status, socioeconomic inequalities, and environmental factors (Hossain, 2013; Urquia, 2012;). These factors are the focus of this current study.

In another study about MCH outcome disparities, Bekemeier et al. (2012) investigated MCH services provided by LHDs to identify those MCH services, which helped address variations in Black-White mortality. Bekemeier and colleagues reported that family planning and prenatal care significantly reduced Black-White mortality disparities. The team used secondary data from 558 United States counties and multicounty districts in a time-trend design to study relationships between changes in MCH activities provided by LHDs and changes in Black-White mortality disparities from 1993 to 2005. In this study, Bekemeier et al. noted that over half of the LHDs in the United States provide certain forms of MCH-related services such as immunizations, WIC, and family planning and contraceptives. It was of concern that current national public health practices put more emphasis on population-focused activities (i.e., community assessment, epidemiology, and surveillance) over individually-oriented direct services (such as prenatal care) resulting in information gaps. In addition, the authors argued that recent hard economic times triggered dramatic budget cuts in the health sector, forcing many LHDs nationwide to operate on squeezed budgets and cutting off services where resources were scarce (Bekemeier et al., 2012). With stretched health sector resources, it was imperative to investigate MCH services provided by LHDs to identify those that address disparities and promote MCH outcomes. Such findings were necessary as they could guide LHD leaders in the process of making evidence-based policy and program decisions to ensure that interventions that better lives of target populations receive priority.

Provision of prenatal and family planning services consistently reduced mortality disparities between Black and White families and resulted in a decline in overall infant mortality rates (Bekemeier et al., 2012). The authors highlighted that declines in mortality disparities attributed to family planning and prenatal care services provided by LHDs also reflect increases in the same services by other community providers during the period covered in this study, 1993 to 2005. The proliferation in the number of providers (health centers) independent of LHDs increased provision of MCH services such as prenatal care to the underserved population who may otherwise have no access MCH service provided by LHDs.

In a related study conducted by Bromley, Nunes, and Phipps (2012) to investigate disparities in health care use between Hispanic and nonHispanic White pregnant women in Rhode Island. Findings of this study indicated that low levels of health care service use contributed to adverse health outcomes in both immigrant and nonimmigrant communities (Bromley et al., 2012). The authors used records of the Rhode Island Pregnancy Risk Assessment Monitoring System (PRAMS) between 2002 and 2008 to examine variations in background characteristics and rates of prenatal and postpartum health care use relevant to maternal and neonatal care among the Latino Americans and nonHispanic White women (Bromley et al., 2012). The PRAMS is a CDC and state-sponsored, population-based surveillance system that contains de-identified, cross-sectional survey data on parameters of pregnancy and post-partum health care behaviors (Bromley et al., 2012; Perritt, Burke, Jamshidli, Wang, & Fox, 2013).

The study findings noted immense disparities in MCH outcomes between Hispanic immigrant and nonimmigrant, nonHispanic White mothers. Notably, Hispanic mothers reported less adequate and delayed prenatal care and more missed well-baby check-ups compared to nonHispanic White mothers (Bromley et al., 2012). Additionally, study findings revealed that Hispanic mothers had more risk factors known to influence health care access disparities of both mothers and newborns, including language barriers, the level of acculturation, education, income, and access to health insurance (Bromley et al., 2012). Interestingly, the authors found that, even after adjusting for the known major social determinants, disparities between Hispanic and nonHispanic White women persisted (Bromley et al., 2012). Bromley et al.’s findings (2012) supported the need for studies that can generate detailed understandings of health access disparities experienced by particular populations.

Pregnant Hispanic women were eligible for the Rhode Island State medical assistance program (RIte), which increased their insurance coverage and the health care services available to them compared to before pregnancy. Even with increased access to insurance coverage, study results indicated that statistically significant disparities in use continued to exist between Hispanic and nonHispanic White mothers (Bromley et al., 2012). The results of this study suggest other factors exist that contribute to differences in health care use rates between Latino Americans and nonHispanic White mothers beyond the focus of the PRAMS. Thus, there is need to consider unique circumstances of specific population groups, such as being an immigrant, in studies and interventions for addressing disparities in MCH services.

In a similar study based on a national survey, Avila and Bramlett (2013) investigated the influence of immigrant status and primary household language on disparities in MCH outcomes among Latino Americans and nonHispanic-White families. The authors used data from the 2007 National Survey of Children's Health (NSCH), a random-digit-dial telephone survey funded by the MCH Bureau, and conducted by National Center for Health Statistics. Using data from the two sources, the authors calculated disparities for various health indicators (i.e., overall health status, dental health status, school absences due to illness, and others) between immigrant Hispanic and nonHispanic-White children (Avila & Bramlett, 2013). The authors used logistic regression to adjust their results for socioeconomic and demographic characteristics, the primary spoken language in the household, and the child's immigrant status.

Study findings indicated that language and immigrant status significantly influenced disparities in health outcomes. A strong association existed between health outcomes, immigrant status and language variables (Avila & Bramlett, 2013). Also, the authors found out that controlling for language and immigrant status reduced health outcome disparities between the Hispanic and nonHispanic-White children (Avila & Bramlett, 2013). For instance, children from English-speaking Hispanic families and nonHispanic-White children experienced better health outcomes compared to children from nonEnglish speaking Hispanic households and those from recent immigrant Hispanic families with limited English proficiency. In conclusion, Avila and Bramlett attributed disparities in health outcomes between Hispanic and nonHispanic-White children to immigration status (i.e., newly arrived Hispanic immigrants) and language proficiency–inability to speak English as a primarily household language.

The study findings of Avila and Bramlett (2013) were congruent with other investigations on immigrant health that associate disparities in health care outcomes between immigrant and nonimmigrants for characteristics that are unique to immigrants. Factors such as level of education, language barriers, and length of residence in the host country contribute to health disparities (Blair et al., 2011; Jackson, Kiernan, & McLanahan, 2012). Although Avila and Bramlett's study attributed variations in health outcomes among children of Hispanic immigrants and nonHispanic-White families to immigration status and language barriers, study results indicated that controlling for language and immigration status did not fully eliminate disparities and suggested an available gap that needed further investigation. The justification for the current study is to explore health disparities from the lenses of those who experience the phenomenon.

In a similar study on MCH in the United States, Bloom (2011) argued that MCH is recognized globally as a vital indicator of the health status of countries. The author explained that the well-being of mothers determined the health outcomes of their offspring and the overall health outcomes of future generations. Persistent inequalities in access to MCH services is one of the major health challenges facing the United States' health care system today (Bloom, 2011; Hossain et al., 2013). Disparities in MCH were more prevalent among minorities, starting from preconception all the way to postpartum (Bloom, 2011; Taylor and Nies, 2013). Ill health of women and children, according to Bloom, costs the nation both socially and economically. Hence, health disparities pose a significant threat to a country’s greatest asset, the well-being of the people who are the economic engine of future generations.

To address the challenge of inequalities, Bloom (2011) argued that there is the need to broaden the focus beyond biomedical interventions to include what happens to people at the family, level in their homes, work-sites, schools, and communities where they spend their daily lives. Her argument concurred with contributions of other researchers (Blair et al., 2011; Bynum et al., 2013) that believed health promotion interventions should target upstream determinants of health, such as variations in SES, cultural influences, and neighborhoods. Further, Bloom emphasized that there can be no sustained solution to disparities in MCH without taking into consideration the complexity of their root causes, including women’s freedom from violence and their access to education, employment, finances, and decision-making power. Although Bloom raised a valid point–the need to look beyond biomedical interventions in the effort to address health disparities in MCH services--the article did not include perspectives of the victims. This current study explored MCH access disparities from the lenses of the people who have experienced the study phenomenon before.

Summary

Research cited in this literature review indicated that health care disparities are a national challenge and that MCH access disparities continue to exist in the United States. Despite policy and program interventions at local, state, and federal levels to promote equitable access to MCH, studies showed evidence of persistent inequalities in access to

MCH services between immigrants and native-born U.S. citizens (Belue et al., 2012; Bloom, 1013). The reviewed literature indicated that MCH access disparities severely affect children from vulnerable, minority households such as the poor and the newer immigrants in the United States (Avila & Bramlett, 2013; Hossain et al., 2013). Researchers reported disparities in access to and use of MCH services among different population Subgroups (Avila & Bramlett, 2013; Belue et al., 2012). Also, the reviewed studies highlighted disparities in MCH outcomes, such as variations in maternal and infant mortality along racial/ethnic lines, income lines, and on immigration status (Avila & Bramlett, 2013; Bromley et al., 2012; Tylor & Nies, 2013).

Further, researchers argued that health care disparities and immigrant health are not new concepts, but rather a well-studied problem in the United States' health care delivery system (Belue et al., 2012; Hossam et al., 2013; Lum & Vanderaa, 2010; Mehta et al., 2013; Morrison et al. 2012). Also, investigators noted in the review several policy interventions focusing on addressing health access disparities, including WIC, Head Start, Healthy Start, Medicaid, and Medicare. It is important to note however that there is still an enormous unmet gap in the literature on health care disparities experienced by specific populations, such as African immigrants. In my search for the studies I reviewed in this chapter, there was clear evidence of a gap in literature focusing on the health of African immigrants. Moreover, I found no study focusing on MCH access disparities experienced by recent African immigrants to the United States, the gap this qualitative phenomenological study aims to help fill.

In Chapter 2, I have reviewed available literature relevant to this current study, which sought to articulate a detailed understanding of the MCH access disparities experienced by recent African immigrants in the United States. Due to the existing literature gap regarding the health of African immigrants in the United States, I conducted an in-depth literature review on MCH disparities and immigrant health in general. Most of the literature I found focused on Latinos, thus supporting the need for further research in immigrant health with a focus on specific health aspects of minority African immigrants. In Chapter 3, I addressed the research methodology used to carry out this study, including study instruments, study population, and sampling methods. Also, Chapter 3 highlights how I collected, organized, analyzed, and planned to disseminate research findings. Further, in this chapter I covered possible study limitations and the strategies I employed to minimize them.

Chapter 3: Research Method

Introduction

The concentration of immigrant health research on larger immigrant populations has created a gap in knowledge of health needs and challenges affecting minority immigrants, such as African immigrants. As a result, and despite the increase in the population size of the children born to African immigrant in the United States, no corresponding research efforts have focused on understanding MCH experiences of this population. In this descriptive, qualitative phenomenological study, I explore lived experiences of recent African immigrant mothers pertaining to access disparities they encountered in the process of seeking MCH.

In this, I highlighted details of the research methodology I used to address the study problem and purpose. I discuss the steps I followed to explore the lived experience recent African immigrant mothers in relation to the phenomenon of access disparities in MCH care. In this chapter, I present details pertaining to research design and rationale, my role as the researcher, research questions, study context, recruitment strategy, study participant selection criteria, data collection, and analysis procedures. In addition, I highlight strategies for addressing concerns of trustworthiness, readability, transferability, dependability, confirmability, and ethical procedures.

Research Design and Rationale

In this section, I present details of the overall strategy I used to carry out this study. It is important to choose a design that aligns well with the different components of the study to ensure that study results address the central research question (Anderson & Shattuck, 2012; Barratt, Choi, & Li, 2011). Study designs hold together the different parts of the research (i.e., the research problem, purpose, questions, and methods) to enhance congruence and ensure that the study appears as a cohesive whole.

In phenomenological research, the primary research question develops from the researcher's personal interest in a particular problem (Hageman & Frederick, 2013). My passion for promoting positive social change in lives of people from backgrounds similar to mine—namely, the immigrants. Phenomenological study research questions aim to uncover and obtain a detailed understanding of the participants' lived experiences of the phenomenon under investigation (Hageman & Frederick, 2013; Zenobia, Yuen-ling, & Wai-tong, 2013). Unlike quantitative studies where research questions attempt to measure quantitative factors and determine causal relationships (Claydon, 2015), phenomenological research questions aim to explore the qualitative essence of the meaning of human experiences (Hageman & Frederick, 2013). Thus, with those constructs in mind, I developed following three research questions that guided this study:

RQ1: What are the access disparities in MCH care services experienced by recent African immigrant mothers?

RQ2: What are the circumstances leading to MCH access disparities experienced by recent African immigrant mothers?

RQ3: How do access disparities affect the overall experience and perceptions of recent African immigrant mothers towards seeking MCH care services?

These three research questions allowed me to capture detailed understanding of MCH access disparities experienced by recent African immigrant mothers in the process of seeking care in the United States.

Phenomenon

This study explored the phenomenon of access disparities in MCH care experienced by recent African immigrant mothers in the United States. Despite policy and program interventions to enhance equal access to care, studies indicated that disparities continue to exist in access, use, and outcomes in MCH between immigrants and nonimmigrant U.S. citizens (Blair et al., 2011; Edberg et al., 2011; Taylor & Nies, 2013). The purpose of this research study was to gain detailed understanding of the health access disparities experienced by recent African immigrant mothers in the process of seeking MCH care in the United States.

Research Tradition

This study followed a descriptive, qualitative phenomenological tradition. The goal of qualitative inquiry, according to Klinkle et al. (2014), is to illuminate and construe a real-world phenomenon regarding the meanings study participants ascribe to it. Phenomenology is a qualitative study approach that explores in detail the lived experience of the study participants about the phenomenon under investigation (Klinkle et al., 2014; Zenobia et al., 2013). Phenomenology allows researchers to gain a deeper understanding of the experiences, meanings, perceptions, and beliefs of study participants on a particular phenomenon through collecting detailed massive data sets from which conclusions are drawn (Klinke et al., 2014; Lee et al., 2014). Thus, use of phenomenological approach enabled me to obtain detailed information about health access disparities experienced by recent African immigrants.

Social science researchers use phenomenological approaches in studies focusing on gaining a detailed understanding of the lived experiences of study participants concerning a particular phenomenon of interest (Klinke et al., 2014; Lee et al., 2014; Martin, 2012). For instance, Martin (2012) used phenomenology to study lived experiences and perceptions of older Iranian immigrants of discrimination in the American health care system. Lee et al. (2014) used descriptive phenomenology to examine lived experiences of Chinese immigrant women in the process of accessing and using maternity care services in Toronto, Canada. Also, phenomenology is widely used in medical investigations (Klinke et al., 2014; Norlyk & Harder, 2010). For example, nurses use in-depth interviews and nonverbal observation of expressions and description of the context within an interview to gain insight into patients’ experiences during illness.

Phenomenological face-to-face interviews not only allowed the chance to obtain detailed narratives from study participants but also enabled me to observe their nonverbal responses to questions I asked. Hence, a phenomenological approach was appropriate for this study that examined lived experiences of recent African immigrant mothers. Moreover, the use of open-ended, semistructured phenomenological questions gave study participants an opportunity to share openly with me details of their lived experience about the phenomenon under investigation in a conversational manner.

The Role of the Researcher

Researchers play a central role in qualitative research. Unlike quantitative studies that assume the investigator can remain independent from the study, in qualitative investigations, the researcher is the primary study instrument and is personally involved in every step of the research process (Lee et al., 2014). In qualitative designs, such as phenomenological approach, the researcher dictates all the considerations and decisions during the study. Thus, qualitative researchers need to ensure that their prior knowledge, experience, perception and beliefs about the phenomenon under investigation do not compromise both the process and the final study findings (Lee et al., 2014). As the primary instrument, I played numerous roles in this study, including but are not limited to designing the study and developing and validating data collection tools. Besides, I was entirely responsible for selecting study participants, collecting and analyzing varied forms of data, interpreting results, and writing the final research findings.

As a researcher, I was responsible for ensuring that I remained objective and guarded myself against all possible personal biases that would influence the study process or final findings. I made sure to put aside all my preconceptions and prejudices, and I remained objective and open-minded during interviewing study participants. Also, I was responsible for ensuring that the study met IRB and federal requirements concerning the ethical treatment of human participants (Ghooi, 2014; Patel, Stevens, & Puga, 2013; Tartaro & Levy, 2015). I ensured that participants felt enthusiastic to participate and to share their experiences. I ensured privacy of all study participants and confidentiality of the information they provided before, during, and after the interview process.

Methodology

Participant Selection Logic

This study targeted recent African immigrant mothers living in the BNMSA. I used purposive sampling to select study participants. Purposive sampling was justified for this study because it allows researchers to select only those participants who have experienced the phenomenon under investigation (Cleary et al., 2014; Guest et al., 2006). With purposive sampling, I was able to select recent African immigrant mothers who had used MCH care and were willing to articulate their experiences voluntarily. Although no clear rule addresses an adequate sample size in phenomenology and other qualitative studies, Marshall, Cardon, Poddar, and Fontenot (2013) noted that qualitative researchers should continually recruit participants until the saturation point. Saturation point, according to Marshall et al. (2013) is when recruitment of an additional participant results in data replication or redundancy. In their study, Guest et al. (2006) reached saturation after analyzing interview responses from the 12 participants. In a related descriptive phenomenological study that used in-depth unstructured interviews to examine immigrant Chinese women’s experiences on maternal care services in Toronto, Canada, Lee et al. (2014) recruited 15 participants who provided adequate information needed for their study.

Based on the examples of similar studies cited above, I initially set out to recruit 10 to 15 participants, but I reached a saturation point after interviewing the 11th participant and stopped there. Participants in this study were self-identified, foreign-born, legal African immigrant mothers living in BNMSA According to Migration Policy Institute (MPI, 2014). The BNMSA is the sixth most popular destination for African immigrants in the United States after New York, Washington DC, Atlanta, Minneapolis, and Dallas metropolitan areas. The BNMSA was estimated to have approximately 50,000 immigrants between 2008 and 2012 from different parts of sub-Saharan Africa (Migration Policy Institute [MPI], 2014). During the selection process, I attempted to promote diversity to ensure that study participants represented Africa as a continent, asking potential participants about their nationality to avoid over-representation from a single African country or region.

After receiving my IRB approval number (12-23-15-0406456), I collaborated with six community partners (Appendices H, I, J, K. L, and M), four African immigrant churches, a restaurant and a grocery store that supplies African foodstuffs to recruit study participants. Churches are one of the most popular points of contact for new immigrants arriving from Africa; they go there to receive moral, spiritual, and sometimes material and financial support, but also to meet relatives and fellow countrymen. The lead pastors at the four churches were my major point of contact with these cooperating partners.

The pastors allowed me to distribute study flyers (Appendix A) at church premises, and they announced the study to their congregation during Sunday services.

Such announcements involved reading out the information on the study flyer to the congregation and appealing to interested parties to contact the researcher using the contact details provided on the flyers. In addition to publicizing my study, the lead Pastor at Victory Family Church International (VFCI) also offered a private office at the church premises where interviews were conducted (Appendix H). I chose VFCI as the interview venue because it is an African immigrant church, strategically surrounded by immigrant populated cities, and is easily accessible to both private and public transport commuters.

A local restaurant and market were the two other areas where I publicized my study. The owners of the local restaurant and market allowed me to pin up study recruitment flyers (Appendix A) on their premises in a space accessible to their clients. The local restaurant and market are two major destinations for African immigrants in the surrounding areas in Boston. On the study recruitment flyers, I included my telephone contact and email address for potential participants interested in participating or just seeking more information about the study to contact me.

Although I had planned to use other recruitment techniques as the backup, including using referrals, in case I failed to get enough responses through the initial recruitment plan, my original recruitment strategy was effective. I received an overwhelming response from qualified recent African immigrant mothers who wanted to participate in the study, and I had to turn the rest down after my interviews reached saturation with the 11th study participant. I used the first two study participants I recruited to complete a pilot study. The intent was to test the quality of my study methodology, including the study recruitment plan, data collection tools (i.e. the interview guide) and data analysis techniques. In particular, I wanted to establish whether the interview guide could generate the data needed to address the study questions. Although the pilot study was successful and needed no major changes in the proposed study methodology, it helped me to identify repetitive questions in the interview guide. I made the necessary minor modifications on the interview questions and sought approval of the revisions from my dissertation committee before I went ahead to use the tool for the primary study.

Whenever potential study participants interested in taking part contacted me, I provided them with background information about the study and conducted a demographic survey (Appendix C) and an initial eligibility screening (Appendix B). During the initial screening process, potential participants answered a few demographic and eligibility questions. After the initial screening survey, I worked with those who were eligible and still interested in participating in scheduling a date and time of their convenience to come and complete the interview at VFCI premises. I thanked potential participants who did not meet study eligibility requirements for their time and interest and informed them that I needed individuals who met specific criteria. The participants I included in this study met the following requirements:

1. Were legal, female, African immigrants (i.e., possessed a valid state-issued identification card) older than18 years.

2. Had migrated to the United States within the last 4 years as of the date and time data were collection.
3. Had a child(ren) between 6 months and 2 years of age by the date and time the interviews were conducted.
4. Had sought professional health care during pregnancy and for their child(ren) after childbirth.
5. Were willing to travel to the interview venue (VFCI) and to voluntarily speak about their experience in a private recorded interview.
6. Were able to read and speak English;
7. As required by Walden University's IRB, all participants signed a consent form (Appendix D) before participating in this study.

Instrumentation and Data Collection

Although I was the principal instrument in this study, I also used several other tools that helped me in participant selection and data collection process (Appendices A, B, C, D, and E). Selecting an appropriate method of data collection enhanced not only the quality of collected data but also the credibility of the entire study findings (Elo et al., 2014). The principal purpose of phenomenological research is to attain a deep understanding of the study participants' lived experience of a particular phenomenon rather than creating results that are replicable or generalizable to another setting (Converse, 2012; Verial, 2013). Thus, my number one goal was to identify and study a few appropriate participants who provided enough data/information to meet the saturation point (Alnazly & Samara, 2014).

Face-to-face interviews were the major data collection method used in this study. After initial eligibility screening (Appendix B), I scheduled a face-to-face interview with the potential study participants. I conducted interviews in a private room at VFCI premises to ensure privacy and confidentiality of study participants. When study participants arrived at the interview venue, I established a rapport to make participants feel comfortable and to gain their trust to allow them to disclose fully to me their experiences. Before kicking off the interview, I shared a brief background about the study, went through and signed the consent form (Appendix D) with the participants, and I asked them permission to record the interview process. In this one-on-one, face-to-face interview, I asked study participants semistructured, open-ended interview questions (Appendix: E) to collect detailed responses about their lived experiences of MCH access disparities. Using face-to-face interviews enabled me to follow up on the thoughts, feelings, and ideas behind given responses to gain a deeper understanding of the phenomenon under study (Shosha, 2012). During the interview process, I used several other data collection techniques. These included writing field notes and memos in addition to voice/audio recording. Using several data collection techniques allowed me to compare the transcribed data with other forms, such as the field notes, to ensure consistency in quality of the data through data triangulation during analysis.

Audio/Voice Recorders: Use of audiotape has become increasingly popular as a data collection tools in social science research. The rapid increase in use audio in qualitative research is in part due to increasing access to low-cost audio/voice recorders, including affordable mobile phones with high-quality sound and recording functions (Jewitt, 2012). Additionally, the popularity of using audio in qualitative studies is a result of increased availability of free, easy-to-use computer applications for editing (Høstgaard & Bertelsen, 2012; Jewitt, 2012). With participants' consent, I recorded the interviews using high-quality audio recorders. Voice recording produced the primary source of data used in this study.

Field Notes: Field notes are written, detailed, nonjudgmental, concrete descriptions of what the researcher observes in the field. Field helps to gather data that other collection techniques may not capture, such as reflections, personal reactions, and personal insights (Creswell, 2009). Field notes provide a record of observational data produced in the field during data collection (Montgomery & Bailey, 2007; Tessier, 2012). During the interviewing process, I used field notes to record participant behaviors and expressions soon after observing them. Field notes added more meaning and understanding to the phenomenon under study during analysis phase through data triangulation.

Memos: Memos are records of the researcher's developing ideas about codes and their interconnections (Montgomery & Bailey, 2007). According to Montgomery and Bailey (2007), through theorizing, researchers can transform field note descriptions into theoretical accounts. During the interviewing process, I recorded ideas that emerged through my thinking process in a memo.

Data Analysis Plan

NVivo 11 and Colaizzi’s 7-step descriptive phenomenological data analysis technique (Alnazly & Samara, 2014; Shosha, 2012) were used to organize and analyze the collected data. Colaizzi developed Colaizzi's qualitative data analysis technique in 1978. I chose to use Colaizzi’s 7-step data analysis technique because it enables researchers to elicit an exhaustive description of the phenomenon under investigation (Shosha, 2012). Following the guidelines of Colaizzi’s data analysis technique cited in Shosha (2012) and Edward and Welch (2011), I carried out the following steps during data analysis:

1. I transcribed participants’ narratives that were recorded (audiotaped) during the interview process. This was a complete word-by-word transcription to allow capturing of the essence of what participants intended to communicate;
2. For each transcript, I extracted the significant statements about the phenomenon of access disparities in MCH care as narrated by recent African immigrant mothers;
3. I interpreted and formulated meaning for each significant statement I extracted from the participant’s transcribed narrative;
4. I sorted and aggregated formulated meanings into categories of similar clusters and themes;

5. I synthesized all the descriptions of the experience of MCH access disparities as narrated by recent African immigrant mothers and recounted the results into comprehensive reports;
6. I analyzed the detailed reports of the experience of recent African immigrant mothers to identify and conceptualize the fundamental structure of the phenomenon of access disparities in MCH care;
7. Finally, rather than validating findings with each participant as described in the last step of Colaizzi's data analysis technique, I compared transcribed documents with the interview audiotapes, memos, and field notes to ensure accuracy and validity. This minor data analysis modification was made to avoid placing a further burden on study participants' time and energy. My dissertation committee and Walden University's IRB approved this change.

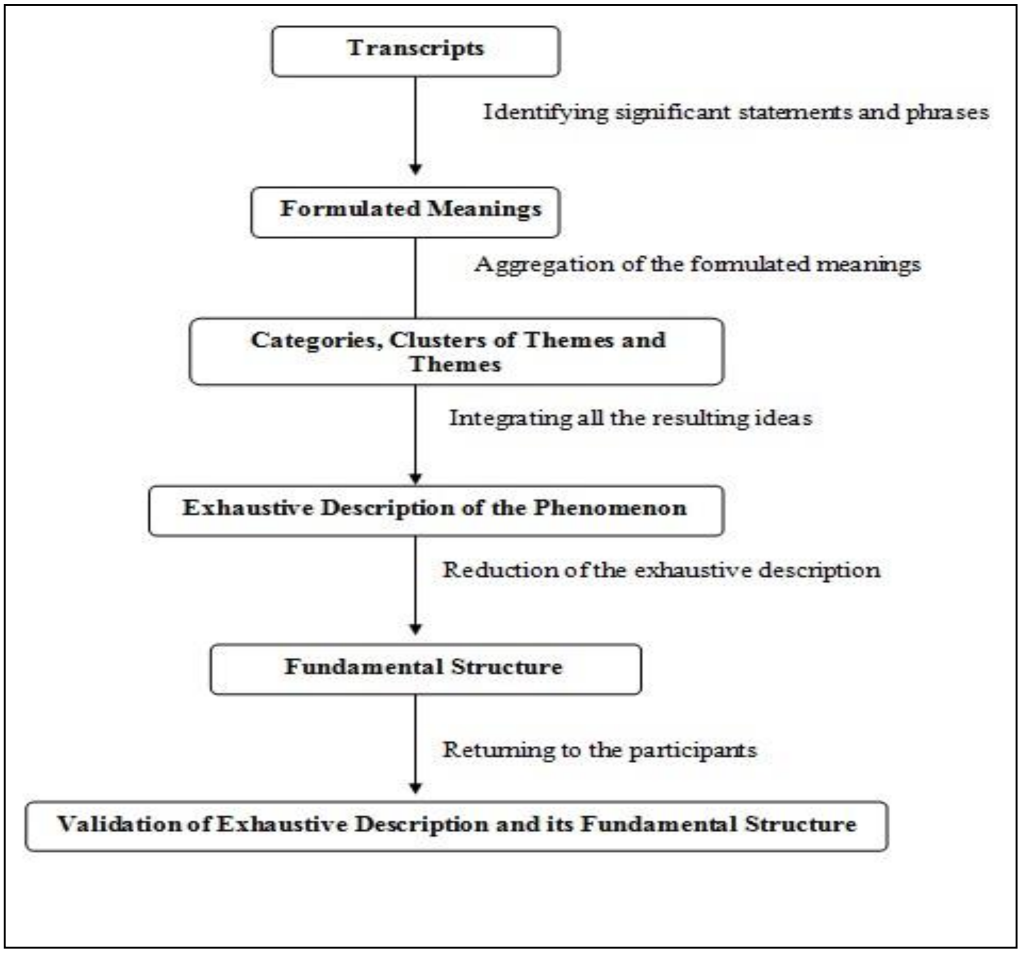

Figure 1. Graphical illustration of the process of Colaizzi's descriptive phenomenological data analysis model.

Note. Adapted with permission from "Employment of Colaizzi's strategy in descriptive phenomenology," by A. G. Shosha, 2012, *European Scientific Journal*, *8*(27), p. 34. Copyright 2012 by European Scientific Institute. Used with author's permission (see appendix A).

I used the QSR NVivo 11, qualitative data analysis software to code sentences, statements, and phrases that were significant to the phenomenon of access disparities in MCH care as narrated by study participants. NVivo 11 facilitated organization and analysis of the transcribed data into clusters and themes in a manner that made the phenomenon under study Easy to understand.

Trustworthiness

For study results to be of any relevance and or to contribute to the body of knowledge, researchers must show proof of quality for the entire study process, from the inception of the study problem to the conclusions reached thereof. Trustworthiness of qualitative inquiries depends mainly on the research skills and experience of the investigator (Thomas & Magilvy, 2011). The aspects of quality in qualitative research findings (i.e., credibility, dependability, transferability, and conformability) are largely a result of the level of rigor in the methodology, including decisions about instrumentation, sampling, the sample size, data collection, and analysis techniques.

Given that researchers are the principal study instruments and they actively participate in making important study decisions (Pope, Ziebland, & Mays, 2000), researcher biases are the greatest source of threat to trustworthy in qualitative studies. To enhance trustworthy of this study, I used reflexivity to examine myself as a researcher, including the assumptions and preconceptions I had and their possible effect on the overall study (Berger, 2015). The process of reflexivity provided me transparent information about my position and personal values and their possible influence on my objectivity during data collection and analysis (Berger, 2015).

To enhance credibility (i.e., value and believability of the findings), I carried out a pilot study to test the quality of the interview protocol. The pilot study helped me identify potential researcher biases and ensure that the planned data collection procedures were able to generate data that accurately answered the study research questions (Chenail, 2011). Also, collecting multiple forms of data, including field notes, memos, and audio, allowed me to carry out data triangulation during analysis to establish data consistency, thus strengthening the credibility of study findings (Cleary et al., 2014). Also, I applied bracketing to mitigate against the potentially harmful effects of unacknowledged prejudices related to the research (Tufford & Newman, 2012), which gave me the opportunity to sustain in-depth reflection on my study as it unfolded.

To ensure dependability and conformability, I clearly defined the research methodology and rigorously applied it throughout the entire study process. I provided a precise rationale for all methodological and interpretative judgments and decisions I implemented in this study (Houghton, Casey, Shaw, & Murphy, 2013; Thomas & Magilvy, 2011). The rationale for ensuring clarity of the study methodology was to enable readers, including those who may not share my interpretation, to discern the means by which I reached my study conclusions. I maintained audit trails to track comprehensively the contextual background of the data and the incentive and rationale for all methodological decisions taken throughout the study. As highlighted by Bergin (2011), I used NVivo’s query tools to audit findings. Also, I applied the technique of audit trails as highlighted in Miles et al. (2014) to organize, document and keep track of the data on an ongoing basis. Audit trails allowed me occasionally to summarize and synthesize data as the process of data collection progressed.

Ethical Considerations

Walden University’s Institutional Review Boards (IRB) and federal regulations require studies that involve human subjects to meet certain ethical standards to protect rights of participants (Walden University, 2012g). I complied with all ethical requirements of Walden University's IRB for all aspects of this study. I never involved myself in any form of participant recruitment and data collection until I secured Walden University’s IRB approval. After receiving IRB approval, I included the IRB approval number to all the documents I used in recruiting participants and data collection (i.e., the study invitation flyer, the consent form, and the interview protocol/guideline). Before conducting interviews, I educated and briefed potential participants about the study, including their rights to participate and to withdraw from the study and made sure that their participation was voluntary and based on informed decisions.

All participants signed informed consent forms (Appendix D) as a sign of approval to voluntarily participate in the study. I made participants aware that they had a right to withdraw at any time for any reason without any consequence. In addition, I informed participants that all the information they provided during the interviews was confidential and strictly for academic and research purposes only. To ensure the security of the participant’s information, I securely kept the collected data in a manner that ensured that I was the only person with access to these data. After a post-study period of 5 years, I will securely destroy all forms of raw data to ensure that all participant information is inaccessible by anyone after that.

To ensure the privacy of the study participant, I conducted interviews in a private office room, and a sign of “session in progress do not disturb” was placed on the door. The room I used for the interview has sound proof walls, which ensures that no one outside can hear conversations going on inside. To enhance further the privacy of study participants, I used pseudo names to identify all study participants who took part in this study. To ensure that participants were not attracted to participate in this study for other gains, a gift card of only $10 was given to each participant as a thank you for participating.

Summary

The central research question of this study concerned experiences of MCH access disparities among recent African immigrant mothers. To that end, I explored a descriptive, qualitative phenomenological approach to investigate the phenomenon of access disparities in MCH care as narrated by recent African immigrant mothers who had experienced this phenomenon and were willing to share their experiences voluntarily. In this chapter, I provided the research design and the rationale for choosing the qualitative phenomenological approach for this study. Also, I highlighted the role I played as a researcher, the logic for deciding on the sample size, sampling methods, selecting study participants, and the study instruments used to collect the data. Other aspects covered include, techniques for managing and analyzing the collected data, and how I addressed trustworthiness and ethical concerns to enhance the credibility of study findings. In

Chapter 4, I provide details of study setting, demographics of the participants, data collection, evidence of quality research, and study results.

Chapter 4: Results

Introduction

The purpose of this inquiry was to (a) understand the disparities in access to MCH services experienced by recent African immigrant mothers in the United States; (b) explore circumstances that led to MCH access disparities experienced by this population; and (c) understand how access disparities affected participants' overall experience of seeking MCH care services. I conducted in-depth, face-to-face interviews with 11 recent African immigrant mothers using semistructured phenomenological questions (Appendix E) to gather detailed data needed to answer three research questions that follow:

RQ1: What are the access disparities in MCH care services experienced by recent African immigrant mothers?

RQ2: What are the circumstances leading to MCH access disparities experienced by recent African immigrant mothers?

RQ3: How do access disparities affect the overall experience and perceptions of recent African immigrant mothers towards seeking MCH care services?

The three research questions allowed me to capture detailed understanding of the phenomenon of access disparities in MCH care experienced by recent African immigrant mothers in the United States. This chapter includes details pertaining to the pilot study that preceded the main study, study setting, demographics of the participants, data collection, data analysis, and major study results. Also, in this chapter I explained how research quality and trustworthiness were maintained.

Pilot Study

After receiving IRB approval and updating the study invitation flyer, consent form, and interview guide with IRB approval # 12-23-15-0406456, I collaborated with six community organizations to recruit study participants. I completed a pilot study with the first two study participants I had recruited. Pilot studies enable researchers to examine the feasibility of the methodology they intend to use in a particular study (Leon, Davis, & Kraemer, 2011; Whitehead, Sully, & Campbell, 2014). The pilot study helped me to test the quality of the study methodology, including the participant recruitment plan, the data collection tool (Appendix D), and data analysis techniques. In particular, results of the pilot study indicated that the interview guide could generate the data needed to address accurately the study questions.

The recruitment process was identical for the pilot study and the main study. The pilot study participants met all eligibility criteria detailed in the study invitation flyer (Appendix A). I screened participants using the initial eligibility screening tool (Appendix B), and I requested participants to complete a demographic data form (Appendix C). At the start of the interview, I read the consent form to each participant and obtained their signature as an indication of full approval and consent to participate in the pilot study. The two pilot study participants answered all interview questions with responses that explicitly addressed the three research questions.

The responses of the pilot study participants confirmed that the study flyer, demographic form, eligibility screening tool, and the consent form aligned well with the study problem and purpose. Participants did not ask for further clarification during the recruitment and interview process, an indication that all study documents were easy to understand. The voice recorders produced good sound, no background or unwanted noise was detected, which confirmed privacy of the room the interview room. Although detailed results are not reported herein, the pilot study was successful; I needed no major changes except removing questions that yielded repetitive responses from the interview guide. With approval from my dissertation committee, I modified my interview guide to remove repetitive questions. This change did not require IRB approval. The hands-on experience of completing a pilot study honed my interviewing skills, which increased my confidence during the main study interviews.

Study Setting

Participant responses to interview questions formed the only source of data used in this study. I conducted face-to-face interviews with each study participant in a private room at a local church in MA. As argued by Irvine, Drew and Sainsbury (2013), use of face-to-face interviews in a private setting enable researchers to leverage visual encounter to develop a natural rapport that allowed participants to freely share their experiences. Privacy is one of the core elements that boost participants' trust in qualitative interviews (Brandimarte, Acquisti, & Loewenstein, 2013). Participants felt comfortable to share their experiences being sure that no one else could hear our conversation. The private room I used for interviews is for counseling married couples constructed with soundproof walls to ensure. I chose VFCI as the interview venue because it is a popular African immigrant church surrounded by cities with high immigrant populations. Also, VFCI is easily accessible by public transportation and had free parking for visitors and it, which made it convenient for participants using both private and public transportation.

Days before my first scheduled interview, the lead pastor at arranged a formal site visit to introduce me to key hospitality staff members at VFCI, including the protocol officer and the receptionist. The protocol officer gave me a guided tour of the church premises and parking available for my visitors (study participants). Also, my guests were welcome to use the visitor's lounge next to the main lobby, which featured comfortable sofa sets, a television set, Christian magazines, and free drinks and snacks. The pastor briefed the receptionist about the study and asked her to give participants a warm welcome. On arrival, the receptionist received and escorted participants to the visitor's lounge and then notified me by phone. Apart from two participants who never showed up and I had to reschedule replacements, the rest kept their scheduled appointments and were treated consistently from when they arrived at the interview venue to departure.

Soon after learning about the participant's arrival, I went to receive her from the lounge to the interview room. The interview room had several seats; I gave participants the opportunity to choose where to sit. Before the interview started, I used a few minutes to interact and build a rapport with each participant to make them feel comfortable. In line with the assertions of Irvine et al. (2013), the warm welcome and the rapport helped me to earn participants' trust, which enabled them to share freely their lived experiences during the interview process. At this moment, I gave participants the $10 gift card as an assurance that they did not have to complete the interview to be compensated. Also, I offered study participants bottles of sealed drinking water for refreshment during the interview.

As the case for pilot study participants, before commencing the interview, each participant filled out the demographic form, signed a consent form, which highlighted (a) the study background and purpose; (b) the voluntary nature of the study; (c) sample interview questions; (d) possible benefits and risks; (d) privacy, confidentiality and rights of study participants; and (e) the expected time frame to complete the interview process. After obtaining the participant’s consent, I started to record the conversation and began to administer the interview questions (IQs) outlined in the interview guide (Appendix D). Also, I used other data collection tools, including field notes and memos to record additional data from observing and listening to participant responses throughout the interview. Availability of multiple data sets permit researchers to conduct data triangulation during analysis to enhance the quality of study findings (Montgomery & Bailey, 2007; Tessier, 2012). I used data from field notes and memos to supplement recorded interview transcriptions. After obtaining responses to all IQs and addressing any concerns, I briefed participants on the next steps after data collection and thanked them for participating in the study. Finally, I escorted each participant to the main entrance of the church building and went back to the interview room to take care of the collected data.

Participant Demographics

By filling out demographic checklists (Appendix C), participants provided relevant demographic information used in this study, including age, marital status, participants' African region of origin, current place of residence, level of education, employment status, number of children in the household, household income, and health insurance. Table 1 highlights the key demographic information of participants recruited in this study. The age of participants ranged between 24 years and 41 years. Approximately 73% of participants were married, 18% were single mothers, and 9% lived with boyfriends. Majority of participants (45.5%) emigrated from Western Africa, mainly Nigeria; followed by Eastern Africa (27.3%), Southern Africa (18.2%), and Central Africa (9%), with none from Northern Africa.

All participants (100%) resided in the targeted geographic area of this study – BNMSA. More than 60% reported education of a bachelor's degree or higher, only two participants (18%) had education below high school diploma level. More than half of the participants (55%) were not working at the time of the interview; only 45% had employment. After initial eligibility screening and scheduling interviews, I realized that none of the potential study participants had a first name beginning with letter "J". Hence, I selected 11 female first names that begin with letter "J" (i.e., Jessica, Jennifer, Jasmine, Joyce, Julia, Juliet, Jocelyn, Josephine, Judith, Jackie, and Joan), and I assigned them randomly to the 11 recent African mothers I interviewed in this study.

Table 1

Demographics of Study Participants (N=11)

Participants (pseudonyms)	Age (y)	Marital status	No. of children	City of residence (MA)	African region of origin	Education level	Employment status	Household income
Jessica	33	Married	2	Peabody	WA	Bachelor’s	Employed	Low
Jennifer	29	Married	1	Malden	CA	Bachelor’s	Unemployed	low
Jasmine	24	Married	1	Lowell	WA	HSD	Employed	Low
Joyce	31	Married	3	Waltham	WA	Master’s	Employed	Middle
Julia	27	Single	1	Canton	SA	Bachelor’s	Unemployed	Low
Juliet	41	Married	2	Cambridge	EA	Diploma	Employed	High
Jocelyn	29	Married	3	Waltham	EA	LHS	Unemployed	Low
Josephine	36	LB	2	Everett	SA	Bachelor’s	Unemployed	Low
Judith	29	Single	2	Waltham	EA	Master’s	Unemployed	Low
Jackie	38	Married	2	Newton	WA	LHS	Unemployed	Middle
Joan	28	Married	1	Haverhill	WA	Bachelor’s	Employed	Middle

Note: WA = West Africa, CA = Central Africa, SA = South Africa, EA = East Africa, HSD = High school diploma LHS = Less than high school, PT = Participant, LB = Living with boyfriend

Data Collection

I collected data from 11 recent African immigrant mothers, living in different cities in BNMSA, who generously volunteered their experiences through answering the interview questions listed in Appendix D. Interviews took place between 12/27/2015 and 01/18/2016. Participants were (a) legal African immigrants living in BNMSA, (b) 18 years and older, (c) mothers with a child between 6 and 24 months old, (d) mothers who used MCH care in the past 2 years, and (e) immigrants who had lived in the United States for under 4 years by data collection time. The newest African immigrant mother included in this study had lived in the United States for less than 2 years.

Table 2

Eligibility Characteristics of Study Participants (N=11)

Mother's name	Length of stay in the USA (mo)	Eligible child's age (mo) and sex	Type of health insurance	Received MCH care in the past 2 y?
Jessica	38	14/Girl	Public	Yes
Jennifer	32	09/Girl	Public	Yes
Jasmine	21	8/Boy	Public	Yes
Joyce	26	17/Girl	Private	Yes
Julia	39	10/Girl	Public	Yes
Juliet	42	07/Girl	Private	Yes
Jocelyn	33	14/Boy	Public	Yes
Josephine	37	19/Boy	Public	Yes
Judith	41	11/Girl	Public	Yes
Jackie	46	16/Girl	Private	Yes
Joan	23	10/Boy	Private	Yes

Note: y = years, mo = months

All participants recruited in this study responded to invitation flyers (Appendix A) I distributed at six research cooperating organizations in BNMSA, which included five churches and one grocery store. Recent African immigrant mothers who came into contact with the study invitation flyers and picked interest to participate, contacted me directly through the phone contacts I provided on the flyer. When contacted by prospective participants, I gave them a brief introduction to the study and completed an initial screening process (Appendix B) that lasted 6 to 10 minutes to determine eligibility. After determining eligible prospective participants and affirming their interest to participate, we worked together to schedule a future date of their convenience for a face-to-face interview at VFCI, the interview venue. Prospective participants who failed to meet the initial screening process, I thanked them for showing interest to participated, and regretted that at the moment they did not meet the requirements needed to participate.

During the interviews, I asked study participants several semistructured questions pertaining to the phenomenon of access disparities in MCH care service listed in the interview guide. Both the dissertation committee and Walden University's IRB approved the content of the data collection tool— interview guide. The interviews took place at VFCI in a private room described under study setting, which ensured privacy of the study participants and confidentiality of the information they shared during the interview. Also, as highlighted in the study setting, I emphasized privacy of the participants by not using their real names. Instead, I assigned each participant a pseudo name, that was used during data collection, analysis, and reporting of study findings. Interviews went well for all participants, no unusual concerns arose before, during, or after. Each interview lasted between 30 and 45 minutes, during which study participants voluntarily shared stories of their lived experiences pertaining to the phenomenon of access disparities in MCH care.

After completing the interview process, I immediately transferred all recorded interviews from the recording devices to a single file folder on my computer secured with a strong pass code. It is on this same computer where I personally transcribed all interview recordings into word documents. I stored duplicate copies of the transcribed data in multiple places on my computer and on external storage device also secured with a strong pass code to avoid data loss in case an unplanned technology failure. In addition, I securely kept field notes and memos in a cabinet with a pass coded locker only accessible to me.

Participant Profiles

Below are brief profiles of the 11 recent African immigrant mothers I interviewed in this study identified only by the pseudo names assigned to them. Each profile highlight details of the participant’s demographics, including age, marital status, number of children, city of residence, African region of origin, education level, employment status, and household income. In addition, profiles include information pertaining to ages of eligible child, participants’ length of stay in the United States, types of health insurance participants had during the time of MCH care, as well as the different types of MCH care they used.

Participant 1, Jessica, was a 33-year-old, married, mother of two (a 5-year-old boy and 14-month-old girl) living in Peabody, Massachusetts at the time of the interview. She identified herself as a legal immigrant from Ghana. She moved to the United States with her husband and her firstborn in November of 2012 after winning the Diversity Visa

Lottery. Jessica has a Bachelor's degree in human resource management from Ghana and is currently employed as an employee benefits associate at one of the local NGOs in Boston Metro-North area. Jessica noted that being a recent immigrant in low household income bracket, she qualified for MassHealth a free state-run health insurance program for low-income earners. She used the MassHealth insurance program to access prenatal, childbirth, postnatal, and child care for her children.

Participant 2, Jennifer, was a 29-year-old, married, mother of a 9-month-old girl living in Malden, Massachusetts at the time of the interview. She had lived in the United States for 2 years, 8 months by the time of data collection. She came to the United States from Democratic Republic of Congo (DRC) in May 2013 to live with her husband who is a naturalized U.S. citizen from DRC. Jennifer reported low household income and she has been out of work since she gave birth to her daughter. She had a part-time job in a grocery store near to her home in Malden before the baby. She obtained prenatal, maternity, postnatal, and child care using public insurance (MassHealth) and her health insurance status remained the same at the time of data collection. She is a university graduate with a degree in social sciences from the University of Kinshasa, DRC.

Participant 3, Jasmine, a 24-year-old married mother of an 8-month-old boy was the youngest participant included in this study at the time of the interview. She identified herself as a United States legal immigrant living in Lowell, Massachusetts, but she originally came from Nigeria. She moved to the United States in April, 2014 as a derivative child to her mother who is a naturalized U.S. citizen. Jasmine holds a diploma in accounting from Nigeria, but she has failed to find a job in her profession since moving to the United States. She is currently working part time as a certified nursing assistant (CNA) in an assisted live-in facility in Lowell, near her home. With her husband working as an attendant at a gas station, their household income is below the federal poverty guideline for a family of 3, which qualified her for the state's public health insurance (MassHealth). Jasmine reported that she used MassHealth to obtain care during pregnancy, childbirth, postnatal, and child care at Boston Medical Center and Lowell General Hospital.

Participant 4, Joyce, was a 31-year-old, married, mother of 3 children living in Waltham, Massachusetts at the time of the interview. A legal immigrant from Senegal, Joyce moved to the United States in the fall of 2013 with her husband and their two older children after winning a Diversity Visa Lottery. Her youngest child (a girl), who was born in the United States, was 17 months' old at the time of data collection. Joyce is one of the two participants included in this study with a master's degree, which helped her to find a well-paying research job with RTI International in Waltham soon after she arrived in the United States. She has private insurance through her workplace that covers her entire family and is what she used to access maternal care (i.e., prenatal, childbirth, and postnatal) and child health care for all her children. Joyce is one of the few mothers included in this study who reported middle household income.

Participant 5, Julia, was a 27-year-old, single mother of a 10-month-old girl, living in Canton, Massachusetts at the time of the interview. She identified herself as a legal immigrant from Botswana. She arrived in the United States in October, 2013 on invitation of her U.S. citizen boyfriend, with plans to wed the following year. Unfortunately, they developed misunderstandings when she was just 2 months' pregnant, and they parted ways. Without work, Julia currently survives on state welfare programs, including public housing, state-provided health insurance (MassHealth), and food stamps as well as child support from her ex-boyfriend. Although Julia is a graduate with a Bachelor’s of Science in Agriculture from Botswana College of Agriculture, she has not worked since she moved to the United States. She obtained all her MCH care, such as prenatal, childbirth, postnatal, and baby wellness checkups using MassHealth.

Participant 6, Juliet was a 41-year-old mother of 2 children (a 6-year-old girl and a 7-month-old baby girl), originally from Uganda, but currently living in Cambridge, Massachusetts at the time of the interview. She migrated to the United States to live with her husband who permanently migrated to the United States before her. The husband worked as a project director with an international organization in Boston. Juliet has a diploma in social work from Makerere University in Uganda. With over 16 years of experience in counseling, she was able to find work in one of the big hospitals around Boston where she was working at the time of the study. Juliet reported that her family was in a high income household bracket. She used maternal health care, including prenatal, childbirth, and postnatal services and she sought child care for her 7-month-old daughter. Since she moved to the United States, Juliet and her entire family meet their healthcare needs using private health insurance provided by her husband’s employer.

Participant 7, Jocelyn, was a 29-year-old married, mother of 3 children, a set of 4-year-old (girls) twins and a 14-month-old boy living in Waltham, Massachusetts at the time of the interview. She identified herself as a legal immigrant from Somalia. Joslyn moved to Waltham in June, 2013 to join her husband who was granted political asylum by the United States government. Although she speaks relatively good English, Jocelyn noted that she never completed high school. She has not worked since she moved to the United States. Instead, she was a stay-at-home mom taking care of her 3 children, while her husband was a taxi cab driver. She reported lower household income, adding that her husband's meager check could not sustain their family of 5, which was the reason why they qualified for government housing assistance, food stamps, cash benefit and public health insurance (MassHealth). Jocelyn used MassHealth to meet all MCH care needs for her including prenatal, delivery, postnatal services and child care for her children.

Participant 8, Josephine, was a 36-year-old mother of 2 living with her boyfriend (but not father of her children) in Everett, Massachusetts at the time of the interview. She identified herself as a legal immigrant from Zambia who had moved to the United States in December, 2012 with her husband after winning a Diversity Visa Lottery. At the time she moved to the United States, she was 6 months' pregnant with her first boy. However, she divorced her husband after giving birth to their second child, a 13-month-old boy. She was a graduate with a Bachelor's in public health degree from University of Lusaka, but she had not worked since she moved to the United States. Currently living with her new unemployed boyfriend, Josephine reported lower household income. Public assistance in form of public housing, state provided health insurance (MassHealth), food stamps, cash benefits and the inconsistent child support from her ex-husband was the main sources of livelihood for Josephine's family.

Participant 9, Judith, was a 29-year-old, single mother of two 11-month-old girls (twins) living in Waltham, Massachusetts at the time of the interview. She reported that she left her motherland Uganda to seek political asylum in the United States in May of 2012. She holds a Bachelor's degree in Social Sciences and a Master of Arts in International Relations and Diplomatic Studies from Makerere University. In the process of waiting for her asylum case to be decided, Judith met the father of her twins who moved out of her life and left her with responsibility when she was about to give birth. She noted that it was not an easy experience to be a single immigrant mother of two without the support of immediate family. She quit her administrative assistant part-time job to take care of her children. Judith explained that her household depends on government assistance, which includes housing, food stamps, cash benefits, and health insurance. Unfortunately, she receives no form of support from her unemployed ex-boyfriend. She used MassHealth MCH care services.

Participant 10, Jackie, was a 38-year-old married mother of 2 children (a 10-year-old boy and a 16-month-old girl), living in Newton, Massachusetts at the time of the interview. She identified herself as a legal immigrant from Liberia. Jackie had lived in the United States for 3 years, 10 months at the time of data collection. She moved to the United States in March of 2012 to join her husband who ran away from political persecution and was granted asylum by the United States government. Jackie was the second study participant in this study with less than a high school education. However, she has a good command of the English language, something she attributed to working at a Catholic seminary back home in Liberia. At the time of the study, Jackie was out of work after losing her most recent certified nursing assistant (CNA) job when the client she cared for passed on. Jackie's husband work with a biotech company as a clinical research specialist, and his income places her family in a middle-income household status. Jackie obtained MCH care services using private insurance provided by her husband's employer.

Participant 11, Joan, was a 28-year-old, married, mother of a 10-month-old boy who is living with her husband in Haverhill, Massachusetts at the time of the interview. She identified herself as a legal immigrant from the West African country of Nigeria. By the data collection time, Joan had spent less than 2 years in the United States. She moved to the United States as a derivative to her husband's Diversity Visa Lottery in February of 2014. Joan has a bachelor's degree in law and her husband has a master's in public health. She was enrolled in master's program and working part time as well. She reported a middle household income and her family used private insurance provided by her husband's employer to obtain health care. She sought and used prenatal, deliver, postnatal, and child health care in the past 2 years.

Data Analysis

In this section, I describe the procedures I followed to analyze the data in accordance with Colaizzi’s 7-step descriptive phenomenological data analysis technique as detailed in Sosha (2014). Data analysis started after interviewing the first study participant and progressed side-by-side with data collection. After collecting all the data, I followed Colaizzi’s 7-step descriptive phenomenological data analysis technique, as highlighted in Chapter 3, to analyze my data. I transcribed all recorded interviews, extracted significant statements, interpreted and formulated meanings, aggregated formulated meanings into clusters and themes, synthesized the descriptions of the study phenomenon narrated by study participants, conceptualized fundamental structures, and validated findings with the original collected data. In addition, I used NVivo 11, a qualitative data analysis software to organize, manage, analyze, and reduce transcribed data into nodes (codes). Further, I aggregated nodes into similar clusters and themes to identify emerging patterns pertaining to the phenomenon of access disparities in MCH care as viewed in the lenses of participant narratives.

The consistency I employed in the process of interviewing study participants (i.e., all participants were asked the same questions) allowed me to auto code most of the transcribed data into NVivo 11. The combined use of NVivo 11 and Colaizzi’s seven-step data analysis technique enabled me to deduce meaning out of the narratives and stories participants shared about their lived experience pertaining to the phenomenon of access disparities in MCH care. IQs generated consistent responses that addressed study questions, and I was able to organize and arrange the collected data according to RQs and corresponding IQs.

I analyzed and interpreted the organized data using constructs of ABMHSU, the theoretical framework that guided this study. I created nodes for each interview question, and extracted words and phrases from transcribed data that captured best the study participants' lived experiences with the phenomenon of access disparities in MCH care. Analysis of data in this format allowed me to stay organized, to visualize the data, to capture meaning, and to understand themes as well as emerging patterns.

Evidence of Trustworthiness

Credibility

The first step I took to ensure credibility of this study was to conduct a pilot study to test the quality of the interview guide/protocol. The goal of the pilot study was to ensure that the data collection tool gathered accurate data needed to answer the three research questions The pilot study helped me to ensure that planned data collection procedures were able to generate needed data (Chenail, 2011). In addition, I collected multiple forms of data, including field notes, memos, and audio, which allowed me to carry out data triangulation during analysis to establish data consistency, thus strengthening credibility of study findings (Cleary et al., 2014). Also, as noted by Tufford and Newman (2012), I applied bracketing to limit potential harmful effects of unacknowledged prejudices related to the research, which enabled me to sustain in-depth reflection on my study as it unfolded.

Transferability

To achieve transferability, I used descriptive research context and assumptions to define the scope of this study. Thus, results from this study may be applicable to similar studies conducted by other researchers investigating similar problems, in similar settings, on similar populations. During the entire process of carrying out this study, I maintained objectivity and controlled possible personal/researcher biases from influencing the study process and findings.

Dependability

To enhance dependability, I systematically applied the methodology approved for this study. For instance, I consistently used IRB approved study guide to recruit and interview participants, and during data analysis. I used a research journal and audit trails to keep record of the study process as a means to establish study validity and to demonstrate high-quality research. Audit trails provide a step-by-step overview of each stage of the research process that can be repeated by researchers interested in replicating this study in a similar setting on similar study populations (Miles et al., 2014). The readers interested in learning more about the quality of this study may draw insight from reviewing the research journal of this study, in which I recorded how I maintained objectivity and the steps I took to address possible researcher biases.

Confirmability

I clearly defined and rigorously applied research methodology throughout the entire study process to achieve confirmability. The rationale for ensuring clarity of the study methodology was to enable readers, including those who may not share my interpretation, to discern the means by which I reached my study conclusions. I maintained audit trails to comprehensively track the contextual background of the data and the incentive and rationale for all methodological decisions taken throughout the study. NVivo’s query tools simplified the process of navigating through voluminous qualitative data and auditing findings (Bergin, 2011). In addition, I applied the technique of audit trails as highlighted in Miles et al. (2014) to organize, document and keep track of the data on an ongoing basis. Audit trails allowed me to summarize and synthesize data from time to time as the process of data collection progressed.

Results

Each study participant was interviewed privately on the scheduled date and time at the interview venue, Victory Family Church International (VFCI) in Newton, Massachusetts. When I finished transcribing my first recorded interview and started analyzing the data, I felt it was crucial to include examples of verbatim sentences to express spoken words exactly as narrated by the study participants during interviews. However, as I progressed with my transcription and analysis, I realized that a majority of participants gave similar responses to interview questions. During the transcription process, I paid detailed attention to sound and tone of participants’ voices and focused on capturing all the details relayed during the interview processes.

In addition, I used field notes to capture and keep track of nonverbal communications that transpired during the interviews, including facial expressions, gestures, and pauses. Originally, I planned to present the data according to the ten interview question (IQs) to which study participants responded. However, after seeing the close similarities between participants' responses and themes that emerged as I progressed with my data analysis, I decided to use themes instead. In this study, I sought to present the voices of recent African immigrant mothers as they narrated stories of their lived experiences with MCH access disparities using the five themes and 13 subthemes that emerged from analyzing participant responses to interview questions (see Tables 3, 4, 5, and 6). Themes were selected based on the statement, phrase, and word similarities as they emerged during data analysis in NVivo 11.

Only four and one participants responded to interview questions (IQs) 9 and 10 respectively. All the four responses to IQ9 emerged to be supplements to any of the eight interview questions; thus, I simply integrated them to the main IQ they addressed. The only participant who responded to IQ10 asked a personal question, and I politely explained that I could not answer her question because it was too personal. Hence, there are no separate results for IQs 9 and 10 presented herein.

Research Question 1: MCH Access Disparities Experienced by Recent African Immigrant Mothers

The first research question was: What are the access disparities in MCH care services experienced by recent African immigrant mothers? Desiring to generate quality responses, I made sure that all participants enrolled in this study had (a) sought and used maternal or child health services, (b) a clear understanding of what health access disparities means, and (c) had experienced the phenomenon of access disparities in MCH care. To achieve this goal, I developed four interview questions (IQs) that were answered by study participants:

> IQ1. Tell me about the various forms of maternal and child health services you sought and used in the past 2 years.
>
> IQ2. What do you understand by health access disparities?
>
> IQ3. Can you describe to me an instance(s) when you experienced access disparities or when you felt you were being treated differently in the process of seeking maternal or child health care services?
>
> IQ9. Is there anything else you want to share with me concerning your MCH care service experiences in relation to access disparities?

Data analysis showed that all participant responses to RQ1 had a similar meaning. All participants reported having experienced one or more forms of access disparities in the process of seeking MCH care. Three themes emerged from participant responses to RQ1: (a) types of MCH care services, (b) meaning of health access disparities, and (c) types of MCH access disparities, including access to specialized services and diagnoses disparities, care quality disparities, patient information access disparities, and waiting time disparities. Table 3 summarizes the themes and subthemes that emerged from participant responses to the three research questions.

Table 3

Emergent Themes and Subthemes for Research Question 1

RQs	Themes	Subthemes
RQ1. What are the access disparities in MCH care services experienced by recent African immigrant mothers?	i. Types of MCH care services (i.e., prenatal, postnatal, family planning). ii. Meaning of health access disparities. iii. Types of MCH access disparities.	• Access to specialized services and diagnoses disparities. • Care quality disparities. • Patient information access disparities. • Waiting time disparities.

Abbreviations: RQs, research questions; MCH, maternal and child health.

Theme 1: Types of MCH care services

Although participants confessed difficulties in accessing MCH care services, they at least used or more types of MCH care services in the past 2 years prior to data collection time. When asked to tell me the kinds of MCH services they had used in the past 2 years, some participants could not easily grasp the term “maternal health.” However, after giving a little explanation of what MCH entails, all participants were able to report several types of maternal care they had used, including preconception, prenatal and postnatal services, childbirth, and family planning services. Also, several child care services were reported, such as regular baby wellness checkups, children’s preventive health services (i.e., immunization), health assessments, and diagnostic and treatment services. Jessica shared about MCH care she used and sought for her 14-month-old daughter. She reported:

> . . . I had regular prenatal visits to the hospital during pregnancy to monitor how my baby was growing. During these visits, the nurses took my vital signs, and I filled questionnaires that asked me general wellness questions. On occasions, they did ultrasound scans or blood work. Also, during my prenatal visits the doctor prescribed for me prenatal vitamins . . . well, my daughter is a healthy baby. I have not been at emergency room nor visited her care providers because of sickness. It is children wellness checkup visits with her pediatrician during which they assess her development and give her immunization shots if they are due. On my most recent visit in November is when my daughter had her flu shot.

In a similar narration, Julia shared that even though she had no private transportation, she made sure that she attended all her recommended prenatal and postnatal services. She had learned about the importance of maternal care to child health outcomes, and she did not want to take risks:

> I must confess that it was not easy for me to attend all recommended care because I had no car and had just broken up with my boyfriend at 2 months pregnant . . .. But because I was excited about being pregnant and having a baby I did research about the care I needed to have a healthy baby. This is what motivated me to try

> my best not to miss any recommended maternity services, except what was not covered by my MassHealth insurance. I pretty much had all forms of maternal care, I attended all my prenatal visits, yes, delivery is also maternal care, and visited my maternity doctor a couple of times after giving birth, which I think is postnatal care. After giving birth, I appointed a pediatrician for my daughter whom she has seen until now. She was seen at 1, 2, 4, 6, and 9 months. During these visits, the doctor normally does a complete physical on my daughter; sometimes orders blood samples, and always ask me if I have any concerns about her health and growth. Also, at times he orders shots that are usually given by the nurse . . .. I think those are the routine services my daughter regularly gets.

Although variations were reported in amount (quantity) of MCH care services used by individual participants, data analysis indicated that each had used at least one or more types of MCH care services. For instance, when asked to MCH services she had used in the past 2 years, Josephine only stated that “I used prenatal services in the past 2 years when I was going to have my last child, and I had services at Harvard Vanguard.” Efforts to seek further details, which involved rephrasing the question yielded no additional responses. On the other hand, Juliet, whose daughter had just turned seven by the interview time, gave a detailed response when asked about MCH services she used in the past 2 years. In her words, Juliet stated that “I have used prenatal, postnatal and some family planning, pediatric care and infant care. I went for pregnancy checkups, and good motherhood classes such as breastfeeding sessions.”

Theme 2: Meaning of Health Access Disparities

After asking questions that elicited study participants to share the types of MCH services they had used in the past 2 years, I was interested in knowing their understanding of health access disparities. The rationale was that participants’ perception of what health disparities were informed their views about MCH access disparities they experienced. Although they used varied statements, phrases, and words in their explanations, all participants seemed knowledgeable of what health access disparities are. When asked what health access disparities meant to her, Juliet stated:

It means like having no access to health care that you need or experiencing something that is not worth what you expect, yeah, yes, something like that. Look, there are some specialists you can never see because of access disparities. For example, you may not access certain doctors because of your insurance and there are some hospitals you also cannot access depending on what insurance you have, especially if you have MassHealth some doctors don't take that kind of insurance. Therefore, you can never have access to better health care or better service because of the kind of insurance you have as a patient. That’s one of the disparities I experienced.

Although it seemed like a struggle for her to respond to the question in her words, Joan appeared to have a clear grasp of what health access disparities were:

> . . . okay to me the health care access disparities, I think, to me, I believe it is the inequality in providing services due to, you know, based on race, ethnicity or your background. I mean, that's how I can explain it to you.

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

Responses from other study participants, including Jennifer, Jasmine, Jackie, Joyce, Josephine, and Judith were very similar. They all viewed health access disparities as simply inequalities in care or access to care. In contrast, Julia and Jocelyn explained their understanding of health access disparities in an unconventional manner. When asked what health access disparities mean to them, Jenifer and Jocelyn seemed to have no clear words to use to respond to the question directly; hence, they replied by stating the opposite of health access disparities – equal access to health care services. Jennifer reported:

> Oh my God, yeah . . . to me health access disparities mean . . . . well let me just say that an environment where all patients, all people who need care are treated the same way, in that situation there is no disparity—an environment where there is no discrimination, all patients are given the same quality of care, whether you are Black or White, rich or poor, or whether you are dressed well or bad, then such a hospital is free from disparities. For example, receptionists need to treat all people who go to the hospital the same, not greeting me with a smile because I am Black or because I have free insurance and greet a White person behind me well with a smile and even let them see the doctor before me is disparities. Yeah,

> (aaaaa) to me yes, there is no disparities when all patients are treated equally, and this makes me feel good as a patient.

Similar to Jennifer’s response, Jocelyn reported:

> I cannot deny the fact that health access disparities exist everywhere, not only to us mothers and our children but to other patients too. So in my opinion, to have hospitals where me and you, or any other person whether an immigrant or a native-born American, poor or rich, Black or White have equal access to quality health care, is what we need. Yes, I mean that kind of care without inequalities in all aspects. I know the government is trying to address the issue of health care disparities, but I think it will take a lot to ensure that all people are treated equally. For example, in my opinion, to have doctors and nurses respect and treat patients with MassHealth the same way they treat patients with private insurance will not be that easy. Well, for me I pray that one day all Black woman from Africa will be treated without prejudice and have access to the same respect and care White patients receive in hospitals. I hope I have answered your question? Yes, to me that is health care access disparities. So there should be no discrimination and unfair treatment so we can all receive the same care and services when we go to hospitals. Otherwise, disparities will not end.

Theme 3: Types of MCH access disparities

Statements, phrases, and words supporting that recent African immigrant mothers experienced unequal access to MCH care services compared to other care seekers emerged from the majority of participants. More than 90% (10/11) of the total study participants reported that they experienced one or more types of disparities. Only one participant, Juliet, a 41-year-old, married mother of two who reported a high household income status stated that she was not treated differently in any way compared to similar care seekers. Participants reported several types of access disparities, including access to specialized services and diagnoses disparities, care quality disparities, patient information access disparities, and waiting time disparities.

Access to specialized services and diagnoses disparities: More than half (6/11) of the total study participants reported having failed to obtain some form of necessary specialized care or diagnoses they needed in the process of seeking MCH services. More than any other participant, Judith was eager to share her frustration regarding her failure to access specialty care during pregnancy, which she attributed to disparities. She knew that disparities in access to specialized care and diagnoses contributed to the poor health outcomes of her 11-month-old special needs daughter. Frustration was all over her face, in her voice, and body movements as she opened up how she could not see a specialist for over 7 weeks after ultrasound results indicated a complication with her pregnancy. Judith stated:

> I don't know whether I have enough words and time to share what I experienced when I went to see doctors during my pregnancy. I don't know whether it was because of my skin color, or because of the English proficiency, or because I don't pay doctors for the services since I had public insurance or something else!

> Well, it all doesn’t make sense because we are all human beings, and we all have one life, so we deserve to be treated equally. The results from my monthly ultrasound revealed that my baby was not growing well, that the size of my baby’s head was not proportionate with the rest of her body. After receiving this unpleasant news about my baby, I was told that I needed to see a specialist in Intrauterine Growth Restriction. Unfortunately, the appointment never went through until after 5 weeks had past. With this delayed treatment, I gave birth to a special needs baby girl. Now tell me, do you think if I had private insurance I would have waited for all this much? So do you think I am wrong when I blame the health of my daughter to inequalities in accessing care? Well, prove to me that this could have happened to someone else not to me, a poor foreigner on government assistance . . ..

Jennifer, a 29-year-old mother of a 9-month-old baby girl, reported an incidence of unequal access to specialty MCH care and diagnoses services similar to that of Judith. She narrated that when she visited for one of her prenatal appointments in the second trimester, the doctor indicated that her cervix was already open, meaning the baby could come out any time. She was overwhelmed and became stressed by the information, but frustratingly she could not see a recommended specialist, something she viewed as a disparity in accessing specialized care. During the interview process, Jennifer responded passionately, paused frequently, and at times seemed overwhelmed:

> Well, most of the time when I have gone to seek care in this country I believe I am always treated different, but I don’t pay much attention to it because either way I get better services compare to back home in my country. I have several incidences where I believe I was treated different, but let me share about this particular incident that almost cost both my life and that of my baby. Nearing the end of my second trimester, I went for my regular prenatal visit, but the doctor gave me the scary news that scan results had revealed my baby was way down and that cervix had opened as though I was due for delivery. Overwhelmed with the news, I asked him now what next? He responded that I needed to see a specialist who will determine the appropriate care for me . . .. I was sent home that day to wait for the specialist’s appointment. Unfortunately, it took over a month and when I finally got a chance to see the specialist I was unable to get the diagnostic tests she ordered on time because they required approval from my insurance provider, MassHealth. Before approval of the required tests was secured, I lost conscious, and I was rushed to emergency room. I was admitted that day and held in the hospital for over 2 months on bed rest until I gave birth.

In addition to Judith and Jennifer’s experiences, three other recent African immigrant mothers (i.e., Joan, Jackie, and Josephine) reported some form of unequal access to specialty MCH care and diagnoses services. Notably, Jessica and Josephine related that the primary care providers (PCPs) of their children, who were on public insurance, could not order recommended tests for the children, suggesting that their insurance did not cover those services. Josephine stated that:

> . . . it was frustrating to learn that my son was unable to have a chest MRI simply because his insurance could not pay for such expenses, yet his mates from families with private insurance had access to the very services my son is denied a right to.

Similarly, Jessica shared that her daughter was diagnosed with a medical condition that required urgent surgery, but she had to wait for approval from MassHealth before getting care, which took several days. With frustration, Jessica stated that “If I had private insurance, my baby would have had surgery the same day than waiting for days.” She further added that variations in access to specialized care based on the type of insurance a patient carry is evil because health is a fundamental human right whose access should not be regulated by anything other than “need.”

Care quality disparities: Several participants believed that the quality of care they received from doctors, nurses, and other provider’s varied from person to person, right from the front desk to discharge. Participants are perceived care quality in terms of how they are treated when they go to seek for care at health care facilities, right from the front desk receptionist to nurses, doctors, and other members of the caring team. “Some patients are received with a smiling welcome face, while others are welcomed with an expression of why are you here, or you do not belong here, said one of the participants.

In a frustrated voice that was mixed with anger at times, Jasmine shared an experience she viewed as receiving low-quality care compared to other care seekers:

> . . . yes, when they discover you have MassHealth, which is the state insurance for people who are not able to afford private insurance, there are some appointments you cannot get. The best appointments of the day are reserved for those who have better insurance, and that means that you are given awkward appointments very early in the morning or late in the evening . . .. While other races have a right to walk to and ask desk attendants any question about their appointments, as a pregnant Black woman who has been waiting for hours in the lobby I have no rights to ask. One time I went for my prenatal checkup, but after waiting for over 2 hours past my appointment time, I decided to move to the appointment desk to ask what was going on. To my surprise, the young White lady at the desk just shouted at me that she knew I was waiting, but the doctor was still busy. In humiliation, I walked back to my seat and waited. A few minutes later a White pregnant woman who had sat adjacent to me for about 15 minutes walked to the same appointment desk attendant; because she had yelled at me, I was observant to see how she was going to treat her. To my surprised, she got out of her chair and talked to her nicely explaining that the doctor had a long line of patients that day. I have witnessed many of such incidences happening, where I am treated as a nobody or someone seeking for favor . . . . yes, I am a Black woman with public insurance, but you are not giving me free care, the government pays you for the

> services you provide to me, so treat me the same way you treat your skin color patients.

Related to the experience of disparities in quality of care received by different patients as narrated by Jasmine, several other participants reported scenarios of receiving less quality care compared to other care seekers. Julia said that the first doctor she saw during pregnancy always examined her hurriedly, and she never listened to her concerns. To her this was a disparity in quality of care:

> . . . I must confess that it always bothered me to see how other patients (fellow pregnant women) with appointments before mine would spend 30 or more minutes with the doctor and mine was always between 5 to 8 minutes. Whenever she entered the room after nurses had finished taking my vital signs, she would quickly go through the records on the computer and then double-glove herself before hurriedly doing a physical check on my belly. My effort to ask her questions about how I was doing always got me a plain consistent answer that everything was ok and that she would see me on my next visit . . . . Attempts to address my concern with my doctor, including reporting how she treated me to her bosses, never worked. So, at 6 months I changed the doctor and the hospital because I could not stand her attitude towards me anymore. We all need to be given equal time; we need to be listened to and to be treated well. . . . of course, the more time you give a patient, the more you can listen to her concerns, and the better the care.

For Josephine, it was her son’s experience of always missing out on stickers that were given to other children on their medical appointment visits she viewed as disparities in quality of care.

> . . . it may not mean a lot to others, but to me, it did to me. I could not believe that for some reasons my son missed out on stickers given to children at his pediatrics hospital. Seeing other children given stickers always upset my son and he always cried all the way to our home. To me it is simple, if you cannot do it for all children, then don’t do it at all. Having to see my son cry all the time because his peers are given stickers and he is not, I view it a disparity in quality of care given.

Patient information access disparities: Three participants (i.e., Judith, Julia, and Jocelyn), about 27%, believed that their process of seeking maternal or child care involved disparities about access to information. These recent African immigrant mothers reported that doctors and nurses were never willing to share critical health information about their health and that of their children as they did with other patients. Judith, a 29-year-old single mother of a special need daughter who admitted to being a regular guest at doctor's offices, had this say about patient information access disparities:

> …when you go to see the doctor, for example in the case of my daughter who is a special need child; I rely on the quantity and quality of information the information given by doctors and nurses. Hence, it is disappointing to notice that the doctors are not taking it serious to share with you the full information about your child. For example, when my daughter was admitted, the doctor ordered an

> MRI for her in the night, but when they came in the morning, they never thought I needed to know the results . . .. They didn't explain to me what was going on, how the MRI went. Instead, they simply told me everything is fine, that my daughter is okay. I was disappointed because I had just seen a group of doctors who came in and spent time explaining results to a White mother with a special need child with whom I shared the room. It bothers me why people of other skin colors get what they want and me, a Black woman, I cannot. Do doctors think they understand better than we do or what? It is frustrating to combine the burden of caring for a special need child with being treated like a half human being because of racial differences.

Jocelyn, a 29-year-old mother of three without a high school education, explained that emphasis on accessing patient information (i.e., test-results) online limited her full access to patient information:

> I have a problem with my hospital, yes, doctors too. They think every patient is good in “IT,” that every patient can access, read, and interpret important patient information online. This is bad because it makes some of us who don’t have good knowledge of the computers to have no access to our information compared to others who know well computers. Whenever I visited the doctors for prenatal services or my child’s pediatrics regular wellbeing check-ups, I asked the doctors to share with me my test results, but they simply told me to check them out online. Because I feel ashamed to say them I have a problem with computers, I

> just keep quiet and forego knowing the results. I think the hospitals need to solve this problem to let all patients, both who know computers and us who don't know to have equal access to our patient information.

Waiting time disparities: During interviews, I asked participants to share incidences where they felt that they experienced access disparities in the process of seeking MCH care services. In their responses, four participants viewed differences in waiting times as a type of access disparities. These participants reported their waiting time to be unnecessarily longer than that of other similar care seekers during their doctor's appointment visits. They felt it was unfair for patients with appointments to wait for more than an hour, and worse still see those who come in after receiving care first. These four recent African immigrant mothers knew that imbalances in waiting times were a type of access disparity they faced in the process of seeking MCH care services. Josephine stated that:

> . . . they make you sit and wait for long hours--that puts me off, and it hurts my feelings. Sometimes you go there with the sick child, and they make you sit and wait for over 1 hour or more, yet you had an appointment. Waiting for the same doctor and you see people who come in after you being seen by the same doctor and you are there waiting. Worse still the receptionists are arrogant on you. They turn you down when you try to express your concern; they are not ready to listen or give you an answer . . . . that is so unfair because they need to communicate with us, they need to tell us what is going on, if someone with a sick child and has

> an appointment sit and wait for over an hour and the nurses cannot communicate well to you yet you see others coming after you and they go in before you, it is a big disappointment and a pain to see that you are treated differently. I mean. Why should I wait, wait, and wait, yet others just come in, see doctors, and leave when I am still waiting? It would be different if I had no appointment, then what is the essence of making an appointment. I don’t know if I am sounding bad on this . . . . but it is like some people are given priority over me–they simply come, check in and in a few minutes are taken to see the very doctor I am waiting to see. Honestly, this is not right, and it need to change. We should all be treated the same way. Otherwise, it makes me think that I am treated differently because of who I am . . . . like because I am Black or something like that.

Similar to Josephine’s response, Joan referenced incidences during her prenatal appointment visits when she waited longer to see her provider and other pregnant White women who came in later did not have to wait:

> . . . I don’t know even how to start because I have a lot to share about the inequalities I faced when I went to see doctors during my pregnancy. But let me start with the issue of waiting for so long to see the doctor when you have a preapproved appointment because I am not the only victim, many other people I know have complained about it . . .. There was no single time for whatever reason I went to see my doctor that I was seen at the time of my appointment. However, it was unbearable those days when I was in my third trimester (those moments

> when even a small thing could disgust me) that I had to wait for hours. Well, I wouldn’t mind waiting if everyone had to, but the fact that other patients who came after me would see the very doctor I am waiting for before me is what made the whole experience difference. It is unfair to treat patients differently for whatever reason. Why should I wait for hours and others simply marched in to see the same doctor I am waiting for? When to believe me at times I wept like a baby asking God why people would still discriminate others in this generation . . . I was always convinced in my heart that I was left to wait on purpose for reasons I can’t explain right now.

Summary of Results for Research Question 1

The first research question addressed (a) the types of MCH care services recent African immigrant mothers had used in the period of 2 years prior to the data collection time, (b) what health care access disparities meant to recent African immigrant mothers who participated in this study, and (c) the types of access disparities recently experienced. All participants reported that they had sought and used either maternal care, child care, or both in the past 2 years, including, prenatal, childbirth/delivery, postnatal, family planning, and regular children wellness checkup or illness initiated visits.

Although participants used differing sentences, phrases, or words to describe health care access disparities, there was no significant variation in their responses. All participants seemed to have a clear common understanding of what health care access disparities are. Although, some participants responded precisely, others gave detailed explanations of about a full paragraph. And other participants who appeared to have no precise words to use directly talked about situations in which they believe they experienced disparities to express what health care access meant to them.

The majority of recent African immigrant mothers I enrolled in this study perceived their process of seeking MCH care services to have involved one or more access disparities. More than 90% (10/11) of the participants reported incidents in which they believed they were treated differently compared to other similar care seekers. Only one participant, Juliet, a 41yearold married mother of 2 stated that she was not treated differently in any way compared to similar care seekers.

Access to specialized services and diagnoses disparities, care quality disparities, patient information access disparities, and waiting time disparities were the types of access disparities reported by recent African immigrant mothers recruited in this study. More than half (6/11) of the total study participants reported having failed to obtain some form of necessary specialized care or diagnoses they needed in the process of seeking MCH services. Likewise, several participants believed that the quality of care they received from doctors, nurses, and other provider’s varied from person to person, right from the front desk to discharge.

In addition, three participants (about 27%) believed that their process of seeking maternal or child care involved disparities pertaining to access to information. These recent African immigrant mothers reported that doctors and nurses were never willing to share critical health information about their health and that of their children as they did with other patients. Finally, four participants viewed differences in waiting times as a type of access disparities. These participants reported their waiting time to be unnecessarily longer than that of other similar care seekers during their doctor's appointment visits. They felt it was unfair for patients with appointments to wait for more than an hour, and worse still see those who come in after receiving care first.

Research Question 2: Circumstances Leading to MCH Access Disparities among Recent African Mothers.

Research question 2 (RQ2) focused on eliciting participants to share their views on the factors that led to MCH access disparities they reported in their responses to research question 1 (RQ1). To elicit the responses needed to address RQ2, I asked all participants the following three interview questions (IQs).

> **IQ4**. In your opinion, what led to a difference in treatment or the disparities you experienced in the process of seeking maternal and child health services?
>
> **IQ5**. How if at all did your status of being a recent African immigrant contribute to the different forms of maternal and child access disparities you experienced?
>
> **IQ6**. How, if at all, did your SES contribute to the different forms of maternal and child health access disparities you experienced?

Analysis of responses to RQ2 shed light on what participants perceived to be the primary causes of the access disparities they experienced in the process of seeking and using MCH care services. Table 4 summarizes the themes and subthemes that emerged from participant responses to the three IQs that addressed RQ2

Table 4

Emergent Themes and Subthemes for Research Question 2

RQs	Themes	Subthemes
RQ2. What are the circumstances leading to MCH access disparities experienced by recent African immigrant mothers?	Causes of MCH access disparities.	• Racial/ethnic discrimination. • Health insurance types. • Immigration status. • Socioeconomic status.

Abbreviations: RQs, research questions; MCH, maternal and child health.

Theme 4: Causes of MCH access disparities

Several subthemes emerged out of participant responses to RQ2, including racial/ethnic discrimination, health insurance types, immigration status, and SES. But for better analysis and presentation of results, I grouped all subthemes under one theme: causes of MCH access disparities. Over 90% (10/11) of the total study participants attributed MCH access disparities they experience to at least one cause. Only one participant who said she had no maternal or child health access disparities experience had nothing to report.

Racial/ethnic discrimination: A majority of the participants perceived racial/ethnic discrimination as the primary cause of access disparities they reported. Phrases and words reflecting racial/ethnic discrimination were the most referenced in participant responses to IQ4. About 73% (8/11) of the total participants attributed the access disparities they reported to racial/ethnic discrimination. Participants who were shy to mention openly that racial/ethnic discrimination contributed significantly to disparities used other ways to express their views. Josephine considered the unequal treatment she experienced at the front desk of her doctor's office as caused by nothing but racial/ethnic discrimination. She responded that:

> . . . you see, when you arrive at the reception, the first thing you observe is that some people are received and welcomed with wide smiles and others are given cold faces . . . . for example, let me say, if White patients came in, front desk officers would receive them with a wide smile and greet them. But whenever I showed up, or any other person of my race, the front desk officers would simply behave like they did not have time for us, in fact, I would even be lucky to get a reasonable response in case I had a question.

In a similar response, Judith a 29-year old mother of 2 attributed the information access disparities she experienced while caring for her 11-month-old special needs daughter to racial/ethnic discrimination. She responded:

> It is frustrating to combine the burden of caring for a special need child with being treated like a half human being because of racial differences . . . . in the case of my daughter who is a special need child, I rely on the information given by doctors and nurses to learn about her health. But the doctors don't think it is important to share patient information with Black mothers as they do it with

> White mothers. For example, when my daughter was admitted, the doctor ordered an MRI for her in the night, but when they came in the morning, they never thought I needed to know the results . . . . they didn't explain to me what was going on, how the MRI went. Instead, they simply told me everything is fine, that my daughter is okay. I was disappointed because that very morning I had watched a group of doctors who came in and spent time explaining results to a White mother with a special need child with whom I shared the room. It bothered me always that people of white skin color could get all the information about their children they need, but me, a Black woman I couldn’t.

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

> As I already told you, during my pregnancy I saw two doctors because I could not stand the character of the first doctor, so I had to change. So it is the first doctor I refer to in this interview. Although I booked my appointments 30 minutes, just like for all other patients, in the real sense they lasted less than 10 minutes and immediately after she would ask me to leave her room . . . . it always bothered me to see how other pregnant women whose appointments were before mine would spend 30 or more minutes with the doctor and mine was always below 10 minutes . . . . I believe that this doctor was a racist who never wanted to attend provide care to Black people like me

Although at first Jocelyn sounded unclear about what contributed to the access disparities she experienced, her response inferred that racial/ethnic discrimination played a crucial role:

> I think maybe it's just because of my background, my culture, my color . . . . these people despise us as people who don't know anything, you know, we are not treated as they treat people of their skin color, we are not considered. So according to how I think, it's maybe because of my origin as a black African immigrant woman that led to disparities.

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

Health insurance types: In their responses, the majority of the participants believed that the type of insurance they had at the time of seeking MCH care significantly contributed to the access disparities they reported. Participants said that the quality of care, access to specialized diagnoses, and waiting times varied considerably depending on whether one had public (MassHealth) or private insurance. Jessica stated that:

> The type of insurance, when you have MassHealth, they look at you as a person who cannot afford to take care of yourself. The state has to take care of you using taxpayer's money and maybe they feel you do not deserve to use the taxpayers' money much as you may be a taxpayer as well. …I think it shouldn't be a

> problem or be treated differently because I have MassHealth, after all, you have no ideas how I qualified for it.

Julia another participant who attributed the disparities she encountered in the process of seeking MCH care to health insurance type had this to say:

> Well, I think a lot contributed to the quality of care I was given, but it was very clear to me that having MassHealth started it all. You know, at the moment you mention the insurance you carry, their attitude changes, if it was relatively fair, it becomes bad, and if it was already bad, then it becomes worse. Even when you are making appointments, the good ones are reserved for those with better insurance, us with MassHealth; we get awkward hours. For example, so early in the morning, so late in the evening, or during lunch hours when all nurses and doctors are out on lunch, so you wait for hours.

Jennifer, a 29-year-old mother of 1 who referenced insurance her insurance type (MassHealth) as the primary cause of the disparities in access to specialized care and diagnostic services she experienced. Judith responded:

> Yeah, the type of insurance you have means a lot because it determines which services you have access to or not. Depending on the health insurance you have, there are some specialists you can never see. You cannot simply access certain doctors when you have state insurance, and there are some hospitals you also cannot access depending on what insurance you have. For example, if you have MassHealth some doctors don't take that kind of insurance. Therefore, you can

> never have access to better health care or better service because of the kind of insurance you have as a patient . . .. As a MassHealth patient, you need to seek authorization first, before gaining access to specialized care. This is not the case for people with private insurance. They choose the doctor and the hospital they want.

Jocelyn was disappointed that she could not access some of her son's prescriptions because she had no money to pay out of pocket and the state provided health insurance (MassHealth) did not cover that particular prescription. She responded:

> . . . the type of health insurance one has also contributed to health access disparities. Health insurance can limit the types of services you can get when you visit the hospital. I had a painful experience when I had no money to pay for my son's medication, yet MassHealth did not cover that particular prescription. You know that moment when you see your son in pain, and you cannot help other than wishing for an ideal world where all people were equal, with equal insurance, and with equal access to prescriptions.

Immigration status: Nearly all study participants felt that their status of being recent immigrants had much to play in what they viewed as inequalities in the process of seeking MCH care services. Some participants reported that sometimes it felt as though immigrants are taken to be less important than other people. Other participants felt that being recent immigrant added to access disparities in some other indirect ways. For instance, immigration status contributed to communication challenges (language barrier), determined the type of insurance available to you, and your socioeconomic position all of which had directly contributed to disparities in the process of accessing MCH care services among this population.

Jocelyn responded with a hint of frustration in her voice and facial expressions that as a recent Black African immigrant she only had access to less experienced doctors and nurses:

> So, you cannot access a specialist, easily like if you are an immigrant, and that was a major problem to me. And also they don't care the kind of doctors they give you, most of the time if you go for the prenatal visit you will see the nurse practitioner and not the gynecologist himself or herself, why because they don't consider you that important a patient. So that disparity bothered me because I believe that when it comes to health care the rich the poor the immigrants, the Black the White or the Yellow they should have the same access to health care services, but unfortunately it's different.

Jackie a 38-year-old mother of two who obtained care using private health insurance attributed the inequalities she encountered in accessing MCH care services to her immigration status. She responded:

> . . . being new in the United States, I wasn’t conversant with what was going on in the hospital system. It took the time to start understanding how doctors and nurses pronounced words, so language barrier was a big problem as well, which contributed to access disparities . . . . the communication was poor; my accent was

> very hard for them to understand as well. Also, being a new immigrant with no experience of seeking care in the United States, I myself did not even honestly know my rights. That is why even though I felt bad about the way I was treated as a patient, I never voiced my complaints or do anything because I didn't know my rights

In an emotional response, Jessica said that as an immigrant, she was always treated with prejudice, something she perceived to have caused the disparities she experienced in accessing MCH care services. She stated that:

> . . . well, I think our status, the fact that we are immigrants, the fact that maybe I am an immigrant these people know a lot about us, they know we are here running from the even worse situation, so they can offer us anything. They believe we come here to consume their services and moreover for free; we have nothing to add on; we are just a public charge and that we burden their economy.

Also as a recent immigrant, I didn’t have relatives around me when I was in my labor pain. At a point, the drip for pain medicine stopped working, and I went through much pain because the alarm system for calling for help was not working. So if I had relatives around, someone would go in person and call the nurse and call someone responsible, but I had no help. So again I see my status of being a recent immigrant causing care disparities in this case.

Socioeconomic status: In the process of analyzing responses to RQ2, it was evident that some participants felt that their poor SES contributed to MCH access disparities they experienced. The poor SES of participants arose from several factors, including immigration status and employment status, which determined their household income levels. More than half of the recent African immigrant mothers (6/11 or about 55%) were unemployed and about 64% of the total study participants (7/11) reported low household income levels. Participants noted that household income and employment status are determined the insurance type (public or private) one carries, the ease of transportation to and from the provider's office, and access to prescriptions.

Jennifer felt that if she had a better income, she would probably have an option of not using state provided insurance (MassHealth), usually viewed as insurance for the poor, the needy, or the lazy ones who cannot work. She responded:

> Well, I think, I have a feeling like if I had like, you know…better income, I would not use MassHealth. I would probably get my own private insurance that could enable me go to a very super, very well caring hospital like maybe private ones where I could get extra care and maybe a better treatment or something like that. But being an immigrant, it is to find a job, later on, a well-paying job that provides employees health insurance. If you are on MassHealth, you will definitely receive less quality of care compared to private insurance holders.

Josephine noted that recent immigrants live under low SES conditions, which influence the type of health care and insurance available to them. Immigrants' health care needs are met largely through state provisions (public insurance), which quite often covers basic minimum care. She stated:

> Because I had no job, the only insurance I had was the MassHealth, so a lot of things were not covered including valuable prescriptions. So my low household income denied me access to quality care enjoyed with those from better household incomes who could afford their private insurance, which probably covers everything.

Jessica was another participant who perceived the poor SES of recent African immigrant mothers as a critical cause for access disparities in MCH care services. She responded:

> It contributed a lot because actually it played a big role in what kind of insurance you have and the doctor you can, or you cannot see. My family income dictated the hospitals I used to get care; you cannot just go anywhere you want with MassHealth. As a matter of fact, not all doctors accept MassHealth. For example, as a MassHealth holder, I could not get good prenatal vitamins during. The doctors used to prescribe for me the cheapest brands covered by MassHealth, which I believe were of poor quality too. Access disparities also continue even after birth, . . . as a low-income household, my child was enrolled in MassHealth as well before I left the hospital. Sadly, whereas parents from high SES have access to a wide choice of Pediatrics for their children, I could not choose a pediatric outside of MassHealth-approved providers.

Summary of Results for Research Question 2

The second research question (RQ2) was designed to explore perceptions of recent African immigrant mothers on what led to access disparities in MCH care services experienced by this population. The aim was to elicit participants to share their views on the factors that resulted in MCH access disparities they reported in their responses to RQ1. Ten out of 11 participants responded referred to one or more causes of access disparities. Only one participant who felt that her MCH care services were free from access disparities never responded to RQ2. While many subthemes emerged from analysis of participant responses to RQ2, including racial/ethnic discrimination, health insurance types, immigration status, and SES, I was able to group them all under one major theme – causes of MCH access disparities.

A majority of participants perceived racial/ethnic discrimination as the major cause of access disparities they reported. Phrases and words reflecting racial/ethnic discrimination were the most referenced in participant responses to IQ4. About 73% (8/11) of the total participants attributed the access disparities they reported to racial/ethnic discrimination. Whereas some of the participants seemed shy to mention openly that racial/ethnic discrimination played a significant role in the disparities they experienced, they used other ways to express their views, such as referring to skin color. In addition to racial/ethnic discrimination, several participants believed that the type of insurance they had at the time of seeking MCH care significantly contributed to the access disparities they reported. Participants said that the quality of care, access to specialized diagnoses, and waiting times varied considerably depending on whether one had public (MassHealth) or private insurance.

Data analysis also showed that nearly all study participants felt that their status of being recent immigrants had much to play in what they viewed as inequalities in the process of seeking MCH care services. Some participants reported that sometimes it felt as though immigrants are taken to be less important than other people. Other participants felt that being recent immigrant added to access disparities in some other indirect ways. For instance, immigration status contributed to communication challenges (language barrier), determined the type of insurance available to you, and your socioeconomic position all of which had directly contributed to disparities in the process of accessing MCH care services among this population

Finally, the process of analyzing responses to RQ2 revealed that it was some participant’s perception that their poor SES contributed to MCH access disparities they experienced. The poor SES of participants arose from several factors, including immigration status and employment status, which determined their household income levels. More than half of the recent African immigrant mothers (6/11 or about 55%) were unemployed and about 64% of the total study participants (7/11) reported low household income levels. Participants noted that household income and employment status determined the insurance type (public or private) one carries and the treatment received from the providers thereof.

Analysis of responses to RQ2 showed that the four top subthemes (i.e., racial/ethnic discrimination, health insurance types, immigration status, and SES) that emerged from participant responses were not exclusive. For instance, immigration status influenced the poor SES reported by African immigrant mothers, which also determined the kind of insurance available to this population. Similarly, immigration status contributed to communication issues (i.e., language barrier) that let to access disparities in MCH care services among the population focus of this study.

Research Question 3: Effects of Access Disparities on the Experience of Seeking MCH Services among Recent African Immigrant Mothers

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

IQ7. How, if at all did the access disparities you experienced affect your feeling and decision towards seeking subsequent maternal and child care?

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

IQ9. Is there anything else you want to share with me concerning your maternal and child health care service experiences in relation to access disparities?

Analysis of responses to RQ3 revealed that recent African immigrant mothers who participated in this study felt that overall access disparities had a negative effect on their experience of seeking MCH care services. All participants shared at least one negative aspect in which access disparities affected their MCH care-seeking process. Table 5 summarizes the themes and subthemes that emerged from participant responses to the three research questions.

Table 5

Emergent Themes and SubThemes for Research Question 3

RQs	Themes	SubThemes
RQ3. How do access disparities affect the overall experience and perceptions of recent African immigrant mothers towards seeking MCH services?	Causes of MCH access disparities.	• Feeling unworthy, • Emotional distress, • Changing providers, • Skipping or missing care, • Loss of trust in the system.

Abbreviations: RQs, research questions; MCH, maternal and child health.

Theme 5: Effects of access disparities

Five subthemes (i.e., feeling unworthy, emotional distress, changing providers, skipping or missing care, and loss of trust in the system) emerged out participant responses to RQ3. For better analysis and presentation of results, I grouped the five subthemes under one major theme--effects of access disparities on the experience of seeking MCH services.

Feeling unworthy: Participants viewed disparities in accessing MCH care services as unfair treatment that make victims to feel unworthy or less human. In their responses to RQ3, four participants referenced that the access disparities they experienced diminished their sense of being and felt disregarded, unworthy, and unwelcome to the providers. Notably, Josephine responded:

> . . . I felt disregarded whenever I walked to the reception at the hospital where I had my prenatal services and gave birth to my child. The people at the reception would receive with a mean face that suggested that you were not welcome at all . . . . I used to feel so bad that sometimes I cried. As time went on, I developed this sense of feeling like I am insignificant, just a foreigner who didn't deserve to be treated better like others.

In a miserable tone and voice, Julia shared that she was shocked by the unfair treatment she experienced, and she felt less worthy to deserve better treatment:

> . . . no one wants to be treated different or with disrespect. You know, when someone looks down on you like you are nothing, it can affect your confidence, and you start feeling unworthy. This is how I exactly felt whenever the nurses and doctors treated me differently. Well, just like any other person, you cannot feel good if you are treated differently or with plain disrespect . . . . honestly, I felt rejected and bad about the whole experienced. I never wished to go back to the hospital.

Emotional distress: Other participants reported that access disparities caused them emotional and they hated their regular prenatal visits during pregnancy and the doctor's appointments for their children. When asked to share her overall experience with the challenging of seeking care in presence of access disparities, Jessica became emotional. She responded:

> . . . time came and I felt hesitant to even attend doctor's appointments. I was worried of going to the hospital and sitting there the whole day in front of people who didn't seem to care about me being pregnant and sick. …it used to affect my heart; it really hurt me so much. You go to a hospital and greet someone politely with a smile and that someone doesn't greet you back, but instead look at you like you are a nobody. Do you know how it feels that after being disregarded; a White person shows up and is received with a warm welcome with an ear-to-ear smile? Of course you feel emotionally tortured and horrible like you are a nobody whose presence is insignificant.

Jennifer a 29-year-old mother who had lived in the United States for less than 3 years shared a perception similar to that of Jessica regarding the effect access disparities had on her experience of seeking MCH care services. She responded:

> . . . but it's like you've gone there and they are treating you like you don't deserve anything, maybe you should go and die, to me that was their implied attitude to me. I don't go to hospitals by choice or to look for pleasure, but because I am unwell, and I need treatment. So the least I would expect is to be treated

> differently, discriminated, undermined, or being treated with disrespect. Unfortunately, this was the norm whenever I went to my doctor's appointments. I used to feel bad that sometimes I would feel depressed whenever I had an upcoming appointment to extent of falling sick.

Changing providers: Several participants highlighted in their responses that the access disparities they encountered in the process of seeking MCH care services forced them to change providers involuntarily. Participants reported that the decision to switch providers was painful because they understand very well the benefits of having a stable relationship with providers, but they had to anyway. Although it is not what they wanted to happen, the participants who changed providers believed that it was in their best interest to avoid what they viewed as unfair treatment. Julia who reported that her prenatal care involved quality disparities, which she attributed to the doctor's attitude towards her she had to change providers at 6 months. She responded:

> . . . attempts to address my concern with my doctor, including reporting how she treated me to her bosses never worked. So, at 6 months I changed the doctor and the hospital because I could not stand her attitude towards me anymore. It wasn't easy to find someone to trust fully; I must confess that I still felt like a stranger to my second doctor until the time I gave birth. If I had a choice, I should have stayed with my first doctor r. I am a very patient person, who can't just make abrupt decisions, believe me, by the time I decided to move on, it was overdue.

Jessica and Joyce were the other study participants who reported that their experience of access disparities in the process of seeking child health care for their children forced them to change providers. Jessica stated:

> . . . It is true; I can't sit back and simply watch when someone is treating my daughter as though she is less valuable compared to her peers. …this is the reason why at just over one year, I have had to change her pediatricians two times. …. yes, I know that it would be useful if the same pediatrician sees her for a long time, but at the same time, I can't allow anyone to treat my baby unfairly. Joyce echoed Jessica's response when she replied that, ". . . I transferred my daughter to another doctor because I was not happy with how the staff at her former pediatrician's office treated her."

Skipping or missing care: Participants also reported that the difference in treatment by the caring teams in hospitals influenced their decisions to miss recommended care because their previous experience with the same providers. Two study participants referenced in their responses that they missed one or more of their doctor's appointments intentionally because they were mistreated in their previous visits and were afraid of experiencing the same. Julia indicated that if it is not a life-threatening emergency, then it is not worth it to go for appointments where providers treat you as though you are less human. She responded:

> . . . to me if it is not a life-threatening emergency I feel there is no need to go to the hospital where I know they will undervalue me or treat me different because it

> affects my self-esteem and my wellbeing as well. My reasoning may sound stupid, but I look at it this way, if you can't do it from the heart, then don't do it at all. The problem is that, when people think you are nothing and that you don't deserve anything good, they may as well think that you deserve to die. So, if I am not in pain, I am better off not going there at all.

In a similar response, Jocelyn admitted that she missed care not because she does not value health, but because of what she perceived as unfair treatment by her providers. She responded:

> . . . it is not something I am proud of but, I have missed doctors' appointments because I hated the way I was treated at that particular hospital. To be honest, I value health, and I am aware of all the benefits associated with preventive treatment, but the manner in which these people treated my child, and I made me hate going to doctors' appointments. It is hard to keep visiting a place where they plainly show it to you that you are not regarded or valued.

Loss of trust in the system: Some study participants felt that the major effect access disparities had on their experience of seeking MCH care services was the loss of trust in providers and the United States' health care delivery system as a whole. Participants indicated that they had a lot of confidence and respect for providers when they had just arrived in the United States. In her response, Judith admitted that she had different expectations about health care delivery in the United States, until when she became pregnant and started seeking maternal care using public insurance:

> The disparities I experienced in prenatal care breaded a lot of mistrust within me. When I had just arrived in the United States, I had a lot of trust and respect for doctors and nurses, but after becoming a patient and experiencing the access disparities earlier reported I developed mistrust . . . . I am convinced that disparities in access to specialized care contributed to my daughter's health outcomes something that always make me think negatively about doctors and nurses in this country. Whenever I look into the eyes of my special needs daughter and remember how I was treated during pregnancy, I cannot think of having another baby. I felt like the doctors, and the nurses have no compassion and don't care about the health outcomes of some patients. When it comes to us, they simply do their job as an obligation. They treat us as though our lives don't matter.

In a similar response, Josephine indicated that access disparities left a negative effect on her perception towards caring teams in the United States' health care facilities. She reported:

> Well, the inequalities in accessing care gave me a very negative impression of this country's hospital system, the doctors, nurses, and the nonmedical staff. You know there is a lack of promoting equality and not treating people the same way. Let's say if you don't have some type of insurance they disrespect you and treat you like you are less human compare to others with another type of insurance . . . . the idea of being treated according to how you look, your race, your ethnicity, or

> the way you speak your English is not what I expected to encounter in this country. Yes, I was really disappointed, and I can't trust them with my life anymore. I feel they are not there for me, they are there for their "people" not mean outsider, because to them race supersedes need for care.

Summary of Results for Research Question 3

The third research question (RQ3) addressed the effects of access disparities on the process and experience of seeking MCH services among recent African immigrant mothers living in the BNMSA. In response to RQ3, participants shared their perceptions about the effects access disparities had on their experience of seeking MCH care services. Overall, recent African immigrant mothers who participated in this study felt that access disparities had a negative effect on their experience of seeking MCH care services. Five subthemes (i.e., feeling unworthy, emotional distress, changing providers, skipping or missing care, and loss of trust in the system) emerged out participant responses to RQ3. For better analysis and presentation of results, I grouped the five subthemes under one major theme – effects of access disparities on the experience of seeking MCH services.

All participants who reported disparities in accessing MCH care services viewed them as an unfair treatment that makes the victim feel unworthy or less human. In their responses to RQ3, four participants referenced that the access disparities they experienced diminished their sense of being and felt disregarded, unworthy, and unwelcome to the providers. To echo this negative perception, other participants reported that access disparities made them emotional, and they hated their regular prenatal visits during pregnancy and the doctor's appointments for their children.

Similarly, some study participants felt that the major effect access disparities had on their experience of seeking MCH care services was a loss of trust in providers and the United States' health care delivery system as a whole. Participants indicated that they had a lot of confidence and respect for providers when they had just arrived in the United States. Also, several participants highlighted in their responses that the access disparities they encountered in the process of seeking MCH care services forced them to change providers involuntarily. Participants reported that the decision to switch providers was painful because they understand very well the benefits of having a stable relationship with providers, but they had to anyway. Although it is not what they wanted to happen, the participants who changed providers believed that it was in their best interest to avoid what they viewed as unfair treatment.

Also, some participants reported that the difference in treatment by the caring teams in hospitals influenced their decisions to miss recommended care because their previous experience with the same providers. Two study participants referenced in their responses that they missed one or more of their doctor's appointments intentionally because they were mistreated in their previous visits and were afraid of experiencing the same.

Summary

The purpose of this chapter was to present an analysis of the lived experience of recent African immigrant mothers in relation to the phenomenon of access disparities in MCH care as narrated in response to research questions that guided this study. To gain a deeper understanding of the study phenomenon (i.e., access disparities in MCH care among recent African immigrants), I designed three research questions that guided this study. I recruited 11 study participants who met all aspects of the eligibility criteria listed in Appendix B. The 11 participants provided responses that formed all the data used in this study. Table 6 summarizes subthemes, themes, and key findings that emerged from analysis of participant responses to research questions.

Table 6

SubThemes, Themes, and Key Findings

SubThemes	Themes	Key Findings
• Access to specialized services and diagnoses disparities, • Care quality disparities, • Patient information access disparities, • Waiting time disparities • Racial/ethnic discrimination, • Health insurance types, • Immigration status, • Socioeconomic status. • Feeling unworthy, • Emotional distress, • Changing providers, • Skipping or missing care, • Loss of trust in the system	• Types of MCH care services (i.e. prenatal, postnatal, family planning). • Meaning of health access disparities. • Types of MCH access disparities • Causes of MCH access disparities. • Effects of access disparities.	• All (100%) participants used one or more forms of MCH care services, • All participants understood what health care access disparities were, • 91% reported access disparities in MCH care services • 55% failed to access needed specialized care or diagnostic services • Over 90% attributed access disparities to SES, 73% to racial/ethnic discrimination, 64% to immigration status, and 45% to insurance type. • All (100%) participants admitted that access disparities negatively affected their MCH care experience

Abbreviations: MCH, maternal and child health.

RQ1 was designed to elicit detailed participant responses about access disparities recent African immigrant mothers experienced in the process of seeking MCH care services. All participants reported that they had sought and used either maternal care, child care, or both in the past 2 years and had experienced access disparities in the process. Also, all participants seemed to understand what health access disparities mean. Themes that emerged from participant responses to RQ1 were, (1) types of MCH care services, (2) meaning of health access disparities, and (3) types of MCH access disparities, including access to specialized services and diagnoses disparities, care quality disparities, patient information access disparities, and waiting time disparities. All recent African immigrant mothers who participated in this study reported having experienced at least one types of access disparities in the process of seeking MCH care. Although interviews were conducted one-on-one in a private setting, analysis of participant responses to this RQ1 showed that several participants reported having experienced similar access disparities.

RQ2 was designed to explore perceptions of recent African immigrant mothers on what led to access disparities in MCH care services experienced by this population. Analysis of responses to RQ2 shed light on what study participants perceived to be the primary causes of the access disparities they encountered in the process of seeking and using MCH care services. Ten out of 11 participants responded referenced one or more causes of access disparities. Only one participant who felt that her MCH care services were free from access disparities was the only one who never responded to RQ2.

Racial/ethnic discrimination, health insurance types, immigration status, and SES were the subthemes emerged from analysis of participant responses to RQ2. For better analysis and presentation of study results, I group the four subthemes under one major theme – causes of MCH access disparities.

RQ3 was designed to explore how access disparities affected study participants' overall experience in the process of seeking MCH care services. In response to RQ3, participants shared their perceptions about the effects access disparities had on their experience of seeking MCH care services. Overall, recent African immigrant mothers who participated in this study felt that access disparities had an adverse effect on their experience of seeking MCH care services. Five subthemes (i.e., feeling unworthy, emotional distress, changing providers, skipping or missing care, and loss of trust in the system) emerged out participant responses to RQ3. For better analysis and presentation of results, I grouped the five subthemes under one major theme – effects of access disparities on the experience of seeking MCH services.

Chapter 4 presented an analysis of participant responses to the three research questions that guided this study and a summary of study results pertaining to the phenomenon of access disparities in MCH care as narrated by recent African immigrant mothers. Also, this chapter provided an overview of data collection and data analysis procedures and explanation about evidence of quality in this research. Chapter 5 will involve a brief overview of the study purpose, an interpretation of the study results, limitations of the study, recommendations, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this inquiry was to (a) understand the disparities in access to MCH services experienced by recent African immigrant mothers in the United States, (b) explore circumstances that led to MCH access disparities experienced by this population, and (c) understand how access disparities affected participants' overall experience of seeking MCH care services. Earlier studies on immigrants' health focused on larger immigrant populations, such as the Latinos, the Asians, and the Europeans, which left health needs and challenges of minority immigrants less known (Filippi et al., 2014). Thus, the information generated in this study potentially filled a gap in the literature on access disparities in MCH of minority immigrants.

Besides, findings from this study may lead to increased understanding of health needs of minority immigrant populations in the United States. Such understanding may, in turn, lead to design and development of evidence-based policy interventions tailored to the needs of this population. Thus, findings from this study may potentially lead to improved health services and population health outcomes for African immigrant mothers and their children or the entire immigrant population at large.

Study findings emerged from analyzing participant responses I generated through conducting in-depth, face-to-face interviews with 11 recent African immigrant mothers who voluntarily accepted to participate in this study. I used semistructured phenomenological questions (Appendix D) designed to elicit detailed responses from participants to answer the three research questions that guided this study. I compare results to findings in the literature I reviewed in Chapter 2 to establish whether this study added new knowledge on the phenomenon of access disparities in MCH of minority immigrants or not. ABMHSU (Aday & Andersen, 1974; Andersen 1968, 1995; Andersen & Newman, 1973, 2005) provided the theoretical lens I used to analyze and interpret findings from this phenomenological study.

The main findings that emerged from analysis of all participant responses were that participants felt they were treated different or unfairly in the process of seeking MCH care services compared to care seekers of other races. Participants perceived the differences in treatment as types of access disparities caused mainly by racial/ethnic discrimination, health insurance types, immigration and SES. The recent African immigrant mothers who participated in this study unanimously believed that the access disparities adversely affected their experience of seeking necessary MCH health services. This chapter presents an interpretation of the findings from this research project, limitations of this study, recommendations, and suggestions for future research, and implications for social change. The chapter ends with final conclusions and remakes about personal researcher experiences.

Interpretation of Findings

This section presents my interpretation of study findings on the topic of experiences of MCH access disparities experienced by recent African immigrant mothers. When I reviewed the literature, it was clear that earlier studies of immigrants' health focused on larger immigrant populations, while the health needs and challenges of minority immigrants remained less known (Filippi et al., 2014). Findings from this study potentially filled a gap in the literature on access disparities in MCH of minority immigrants. The three research questions (RQs) that guided this entire study were: What are the access disparities in MCH care services experienced by recent African immigrant mothers? What are the circumstances leading to MCH access disparities experienced by recent African mothers? And how do access disparities affect the overall experience and perceptions of recent African immigrant mothers towards seeking MCH services? Given that majority of participants provided similar responses to the three RQs, I interpreted results according to themes that emerged from each RQ in the lens of ABMHSU and the context of relevant literature reviewed in Chapter 2.

Research Question 1 Findings and Reviewed Relevant Literature

Research Question 1: What are the access disparities in MCH care service experienced by recent African immigrant mothers? Three themes emerged from participant responses to interview questions (IQs) that were asked to generate data needed to address RQ1:

1. Types of MCH care services.
2. Meaning of health access disparities.
3. Types of MCH access disparities.

Participants used several types of maternal care in the period of 2 years before data collection including, preconception, prenatal and postnatal services, childbirth, and family planning services. Also, several child care services were referenced, such as regular baby wellness checkups, children’s preventive health services, (i.e., immunization), health assessments, diagnostic, and treatment services. Although some reported more and others less, none of the 11 study participants included in this study reported complete nonuse of needed maternal or child care services. These results support the findings of Bellis et al. (2012), Tylor and Nies (2013) and Teitler et al. (2012) that there is growing awareness of the importance early life development to adult health outcomes. The commitment of the mothers included in this study to seeking and using MCH care may partly be due to their increased understanding of the benefits associated with using recommended MCH on their future health and that of their children.

A majority of the participants obtained MCH care services using public insurance, which is in line with the findings of Bekemeier et al. (2012) that there is evidence of commitment from local, state, and federal governments to improve MCH outcomes through women, infant, and child health promoting programs. Programs such as CHIP, Medicaid and Medicare, and other services delivered at LHD help vulnerable populations to gain access to MCH care services (Bekemeier et al., 2012; Taylor & Nies, 2013). About 64% (7 of 11) of the total participants they had MassHealth, a state health insurance program provided to residents of Massachusetts who meet specific criteria, including house-hold incomes.

Although there is no consensus on the exact definition of health disparities, NIH (2015, para. 4), defines health disparities as gaps in the quality of health and health care that mirror differences in SES, racial and ethnic background, and education level. Whereas participants used varied sentences, phrases, or words to explain what health care access disparities meant to them, there were no major discrepancies between NIH's definition of health disparities and the explanations given by study participants. For instance, to one of the participants, Joan, health disparities meant inequality in provision of care based on one's race or ethnic background. Likewise, Jessica started that, "…to me this is the unfair treatment or the differences in access or availability of care, services, or facilities in a certain setting." Participants commonly referenced inequalities in care or access to care in their explanation of what health disparities meant to them.

Further, participants' perceptions of what health access disparities means were in line with the four major indicators of measuring health access (i.e., coverage, services, timeliness, and workforce) highlighted by Healthy People 2020 (2015). Notably, Julia echoed the importance of the element of coverage and quality service in measuring access to care when she stated that,

> . . . an environment where there is no discrimination, all patients are given the same quality of care, whether you are Black or White, rich or poor, or whether you are dressed well or bad, then such a hospital is free from disparities.

Likewise, in her explanation of what healthcare access mean to her, Jocelyn emphasized the need to for providers to eliminate all forms of inequality in care to ensure that all people, the rich and the poor, immigrants and native born, White and Black have equal access to care.

Several researchers indicated the prevalence of worse health care disparities among the minority populations, such as African Americans, Latinos, Indian Americans, and immigrants compared to their White counterparts (Derose et al., 2011; Morrison et al., 2012; Wilson et al., 2012). Study results indicated that over 90% recent African immigrant mothers who voluntarily participated in this study had experienced access disparities in the process of seeking MCH care services. Several participants referenced incidences of receiving different or unfair treatment compared to other care seekers, which in their views contributed to access disparities that negatively affected their care experience. These results are supported by findings of Belue et al. (2012), Blair et al. (2011), and Edberg et al. (2011) who argued that minority populations such as African Americans, Latino Americans, and immigrants face disparities in access to health care services in the United States that contribute to their adverse health outcomes. Results from this study are also supported by Bloom (2011), and Taylor and Nies (2013)'s findings suggested that mothers and children of color, or low-income families, and or those from immigrant families experience disparities in access to care in the United States.

More than 90% (i.e., 10/11) of the participants reported incidences of access disparities including, variations in access to specialized services and diagnoses disparities, care quality disparities, variations in access to patient information, and waiting time disparities. Remarkably, more than half (6/10) of the study participants failed to access recommended specialized maternal or child care or diagnoses, which echoes findings of Belue et al. (2012) that despite policy and program interventions at local, state, federal, and international levels to enhance access to healthcare, some population subgroups in the United States continue to experience disparities in access to MCH care services. Taylor and Nies (2013) noted that improving national MCH outcomes requires a rounded intervention approach that addresses both clinical and socioeconomic determinants. Thus, Taylor and Nies' findings explain why recent African immigrant mothers experienced disparities in MCH care services despite having access to insurance and providers.

This study unveiled that quality of care provided varied from one patient to another. Participants felt that they were treated differently right from the time they arrived at the front desk through discharge. Several researchers indicated (Edberg et al., 2011; Miller et al., 2014) suggested that foreign-born individuals were victims of prejudice that made them vulnerable to being treated differently in the process of seeking care. This study conducted by Jarlenski, Baller, Borrero, and Bennett (2015) showed that children of immigrant parents who had public health insurance experienced poorer reception and often poor treatment from care providers, another confirmation of findings of this study.

In addition, approximately 27% of the participants experienced disparities in access to patient information in the process of seeking MCH care services. Jocelyn a 29-year-old mother, three children with less than a high school education, explained that high emphasis of accessing patient information (i.e., test-results) online limited her full access to patient information. These results were in line with the findings of Selsky et al. (2013) that revealed variations in access to cancer information among Latino immigrants. Whereas educated younger Latino immigrants had higher odds of using the internet to seek cancer information, older less well-educated Latino immigrants, who had no computer had less access to cancer information. Participants experienced other cases of information-access disparities in this study, which amplified findings of several. Also, the findings of disparities in access to patient information support results of Tarraf, Vega, & González (2014) that immigrant patients who used emergency department services in the United States had less access to their patient information when compared to their nonimmigrant counterparts.

Approximately 36% experienced variations in waiting times for their medical appointments at the provider's office. Even with preapproved appointments prior to their visits, participants indicated that they waited unnecessarily longer than other care seekers during their doctor's office visits. Participants were in agreement with Tak, Hougham, Ruhnke, and Ruhnke (2014) study that indicated the existence of inequalities in in-office waiting time on physician visits. In relation to findings of this study, Tak et al. (2014) noted that adult-aged adults reported waiting time varied from one patient to another, something they viewed as disparities in care. Similarly, Cayirli and Gunes (2013) found out that lack of consistency in waiting time may have a substantial negative influence on patients' desire to seek medical care. Likewise, findings of Zhu, Heng, and Teow (2012) showed that the common belief that increasing health insurance coverage enhances health care use but may prove to be ineffective if in-office waiting time increases as well.

Overall, results from participant responses to RQ1 agrees with the literature reviewed in this study supports that MCH access disparities are major health challenges experienced by minority populations such as African-Americans, Latino Americans, and immigrants. These studies indicated that access disparities led to adverse health outcomes among these population Subgroups. More than 90% (10 of 11) of the study participants admitted that they sought and used different types of MCH care services during which they encountered several access disparities.

Research Question 2 Findings and Reviewed Relevant Literature

Research Question 2 (RQ2): What are the circumstances leading to MCH access disparities experienced by recent African immigrant mothers?

Study participants had varied perceptions and opinions about what led to access disparities they encountered in the process of seeking and using MCH care services. More than 90% of the recent African immigrant mothers who participated in this study attributed access disparities in MCH to one or more causes. Only one participant felt her care involved no access disparities. The subthemes that emerged from RQ2 include racial/ethnic discrimination, health insurance types, immigration status, and SES. But for better analysis and presentation of results, I grouped all subthemes under one theme: causes of MCH access disparities.

While participants highlighted several factors that led to inequalities in access to MCH care services, the majority (i.e., 8/11 or approximately 73%) perceived racial/ethnic discrimination as the primary cause of access disparities they reported. Participants felt that they were treated differently or unfairly during their medical appointments when compared to people of other skin color or ethnic origin. These findings expand upon investigations of several researchers (Bekemeier et al., 2012; Belue et al, 2014; Bromley et al., 2012; El-Sayed et al. 2015; Garbarski, 2015; Mehta et al., 2013) that attributed the challenge of persistent health care disparities in the United States' health care system to discriminations on racial/ethnic lines.

Previous studies have found substantial racial/ethnic disparities in nearly all health indicators, including access (Frieden, 2014; Hossain et al., 2013; Garbarski, 2015; Mehta et al., 2013). For instance, studies have shown negligible evidence that racial/ethnic disparities in child health have changed over time, in fact for Black-White disparities for some diseases such as asthma have grown even larger over time (Mehta et al., 2013). Participants felt discriminated upon right from the time they arrived at the reception all through to discharge. They stated that patients received varied treated depending on one's skin color or on the place of origin. These results agree with findings of Blair et al. (2011), Derose et al. (2011), and Frieden (2014) that ethnic and racial backgrounds significantly contribute to health care disparities. Also, other studies (Derose et al., 2011; Morrison et al., 2012; Wilson et al., 2012) have shown that minority immigrant populations are more prone to disparities compared to mon-minority populations, which directly supports the existence of racial/ethnic discrimination identified by participants in this study.

The majority of participants attributed disparities in accessing MCH care services in part to the type of insurances they had at the time of seeking care. Participants argued that the kind of insurance coverage they had restricted the level of care or services they could access and use. For instance, unlike participants with private insurance who had no restriction on which provider or service to use, the state provided insurance (MassHealth) holders could only get care from MassHealth-approved providers. The perception of participants that health insurance restrictions caused disparities in their access to MCH care agree with the findings of Tan, Chuang, Shirk, Laviana, and Hu (2016) that public insured patients suffer disproportionately from health disparities compared to their counterparts with private insurance. In their study, Tan et al. found that even as insurance coverage expands differences in outcomes continue to persist between Medicaid patients and private insurance patients, underscoring the finding that differences in insurance type contributed to access disparities in MCH care services reported by participants in this study. Thus, there is need of additional interventions that address heath disparities beyond expanding insurance coverage

Also, results indicated that nearly all participants attributed access disparities in MCH care services to their status of being recent immigrants. Participants argued that as recent immigrants they lacked complete knowledge of the healthcare delivery system, and they faced other obstacles including language barriers that exacerbated the disparities in access to the care they encountered. These results expand upon findings reported by AHRQ (2015) and Avila and Bramlett (2013) that some population subgroups in the United States experience more barriers to care, receive poorer quality of care, and report poor health outcomes compared with other groups. In addition, disparities in access to care based on immigration status as reported in this study informs results of a pilot study conducted by Filippi et al. (2014), which indicated that African immigrants are one of the medically underserved population Subgroups in the United States.

Findings on immigration status as a cause for disparities in access to MCH care services amplifies the results that were identified by the WHO in 2008. This report indicated that immigrants dealt with challenging conditions including poverty, marginality, and limited access to social benefits and health services, especially during the early stages of settling in host countries (WHO, 2008). In addition, this report highlighted that health disparities faced by immigrants arise from factors such as discrimination, income inequalities, unequal access to education and employment, and lack of social support networks (WHO, 2008).

In addition, some participants felt that their SES was the single most factor responsible for the challenges of MCH access disparities they faced. Approximately 55% of the participants were unemployed, and about 64% were low household income earners. These participants argued that their poor SES limited their choice of health insurance to MassHealth, their choice of transportation to public means, and at times they had no money for co-pay on prescriptions. These findings agree with results from several studies

(Belue et al., 2012; Blair et al., 2011; Taylor & Nies, 2013) that found out that higher disparities in health care access and the poor health outcomes among immigrant populations are due in a major way to high prevalence of socioeconomic inequalities in the United States. With no employment and in most cases totally depending on government welfare programs, new immigrant populations tend to experience low SES.

Researchers contended that some factors, including race/ethnicity, SES, insurance status, geographical location, and immigration status significantly contribute to MCH access disparities. In overall, findings from RQ2 supported results from several studies (Bloom, 2011; El-Sayed et al, 2015; Garbarski, 2015; Jarlenski et al., 2015) that found out that health disparities stem from varied factors, including SES, geography and environment, education levels, insurance status, discrimination, biology and genetics, immigration status, and social support. However, none of my participants attributed access disparities to cultural differences, an aspect referenced as a major cause for health access disparities among immigrant populations.

Research Question 3 Findings and Reviewed Relevant Literature

Research Question 3 (RQ3): How do access disparities affect the overall experience and perceptions of recent African immigrant mothers towards seeking MCH care services?

Several subthemes, including feeling unworthy, emotional distress, changing providers, skipping or missing care, and loss of trust in the system emerged from RQ3. For better analysis and presentation of results, I grouped these subthemes under one major theme – effects of access disparities on the experience of seeking MCH services. Overall participants felt that access disparities had a negative effect on their experience of seeking care and MCH outcomes. This is in line with findings of several investigators (Derose et al., 2011; Morrison et al., 2012; Wilson et al., 2012) who found that poor health outcomes of minority population groups are due in part to high socioeconomic and health care disparities in the United States.

Findings from RQ3 indicated that some patients who experienced access disparities felt unworthy, disregarded, and unwelcome to the providers, while others suffered emotional distress, which affected their care-seeking behaviors. According to Major, Mendes, and Dovidio (2013), socially disadvantaged patients suffered from physiological resentment and reported poorer health outcomes on average than people who belong to more advantaged social groups. Similarly, access disparities caused a loss of trust in providers and the United States' health care delivery system as a whole among some participants. Findings from Martin et al. (2013) indicated increase in evidence of lower patient-trust levels in health care providers, which resulted into lower patient satisfaction among minority populations, particularly African Americans.

Other participants suggested that access disparities forced them to change providers regularly, which ruined their opportunities to enjoy benefits of stabling stable relationship with providers. Findings also showed that participants intentionally missed recommended care due to fear of continuing to suffer mistreatment associated to access disparities. These findings were supported by results from Lum and Vanderaa (2010), which suggested that healthcare disparities contributed to less use of preventive health care services among elder immigrants compared to nonimmigrant populations. Edberg et al. (2011)'s study on understanding and assessing health disparities in immigrant or refugee communities found out that there was little evidence to show immigrants' commitment to using recommended routine preventive health services, which further supports the findings of this study.

Theoretical Lens

ABMHSU was developed by Ron Anderson in the late 1960s to facilitate the process of understanding why families use health services, define and measure equitable access to health care, and assist in the development of policy interventions for enhancing equal access to health care (Andersen, 1968, 1995). ABMHSU suggested existence of factors that enable or impede an individual's use of health care services and grouped them into three categories: predisposing characteristics, enabling resources, and need factors (Andersen, 1968). ABMHSU was used as a lens of analysis to explore access disparities in MCH care services experienced by recent African immigrant mothers living in BNMSA. More than 90% (10/ 11) of the participants who sought MCH care services admitted that they encountered at least one form of access disparities in the process of seeking MCH care services. Only one participant felt that her care was free from access disparities.

Study findings showed existence of several access disparities faced by the study population in the process of seeking MCH care services, which were attributed to a number of factors including, racial/ethnic discrimination, health insurance types, immigration status, and SES. The three categories of factors (i.e., predisposing characteristics, enabling resources, and perceived and evaluated need) ABMHSU presume to enable or impede use of health care services provided insight on the access disparities faced by recent African immigrant mothers in the process of seeking MCH care services. Andersen stated that inequitable access to care occurs when elements of predisposing factors (i.e., social structures – ethnicity), enabling resources (i.e., income), and health beliefs determine who gets medical care.

From ABMHSU's perspective of enabling and impeding factors/conditions, racial/ethnic discrimination and immigration status are predisposing factor that contributed to inequitable access to MCH care services among recent African immigrant mothers. Participants argued that the predisposing factor of being recent immigrants significantly interfered with their process of seeking and using care in form of racial/ethnic discrimination, which contributed to access disparities they faced. Nearly all participants believed that they were treated differently or unfairly at the provider's office, from the reception all the way through discharge.

Likewise, health insurance types and SES, which participants viewed as major causes of the access disparities they experienced, constitutes the ABMHSU's enabling resources. The element of enabling resources explained why participants felt that their poor social economic status that was characterized by unemployment, low household income contributed a lot to access disparities in MCH care services they faced. For instance, SES dictated the type of insurance the recent African immigrant mothers had access to, ease of getting prescriptions, and the available means of transport for them to get to providers. In addition, the element of health beliefs as used in the ABMHSU provided insight on why out of the 10 study participants who experienced MCH access disparities, only 2 reported that they missed recommended due to access inequalities. The commitment to continue seeking MCH amidst access disparities was a reflection of the value recent African immigrant mothers attach to their health and that of their children.

Generally, ABMHSU not only provided lenses for analysis, but its conceptualization covered all aspects of this study. For instance, the model's assumption of existence of enablers and impediments (i.e., predisposing characteristics, enabling resources and need factors) that influence an individual's access to and use of health care services clearly explained the disparities in access to MCH care, their causes, and the effect these disparities had on participants.

Limitations of the Study

Study design, time, resources, and personal bias were the major limitations of this phenomenological study. Responses from the 11 study participants, purposively selected to participate in this study, may not represent the global experience of MCH access disparities among all recent African immigrants in the United States. As any other qualitative study, this phenomenological study generated varied forms of unstructured, voluminous data, which made the process of managing, organizing, storing, analyzing, interpreting, and presenting final study findings a time-consuming exercise.

Although I was knowledgeable about the different health challenges my study population face, I used reflexivity to step back and critically examine to ensure that my assumptions, perceptions, preexisting understanding and the new understanding of the phenomenon of the study did not influence the overall research process and findings. However, I conducted this study single handily; I was responsible for collecting, analyzing, interpreting, and reporting findings. Critics may argue that this study is a product of a single researcher's lenses.

The design of this study poses a generalization limitation to findings of this study. Given the characteristics of the sample (i.e. size and sampling criteria) used in this phenomenological study, it might be hard to generalize findings to other similar populations outside the scope of this study. Notably, participants in this study live in Massachusetts, a state that offers health insurance to all its residents and is implementing the new Affordable Care Act (ACA) of 2010. Hence, findings from this study may not be generalizable to recent African immigrants in states with different health insurance policies, including states, which opted out of ACA. Also, due to the influence of culture on health seeking behaviors, findings from this study that focused on African immigrants may not inform the overall MCH access disparities across the entire immigrant community in the United.

Recommendations

The field of health for minority immigrants, particularly from the African region is ripe for both qualitative and quantitative investigations. Studies indicated that the population of African immigrants is growing rapidly in the United States (Venters & Gany, 2011), but there are no corresponding research efforts focused on understanding health needs of this population. In the process of conducting this research, some researchable areas emerged that were beyond the scope and purpose of this study. First, I would recommend similar studies to be carried out in other regions of the United States and other traditional immigrant destination countries in the West, such as Canada, Australia, and particular Europeans countries with high immigrant populations.

This study focused on access disparities in MCH care services; hence, there is need for research on the disparities this population faces in accessing other specialized care, such as, organ transplants (i.e., kidney, heart, etc.), HIV/AIDS treatment, and treatment of chronic diseases such as diabetes or cardiac illnesses. Due to the phenomenological design of this study and the desire to limit participant responses within the defined scope of this study, I refrained from making a follow-up on interesting aspects that came up during interviews but outside the scope of this study. For instance, there was significant variance in health beliefs and knowledge of the value for seeking preventive care such as MCH preventive care among participants depending on their African region of origin. It would be beneficial to establish whether health beliefs of different African nationalities had an influence on the access disparities this population experienced in MCH care services.

The scope of this study was limited to recent immigrant mothers, but it would be important to explore the experience and perceptions of fathers who are involved in the care for their pregnant wives and children. Also, I would recommend studies that might expand the scope of this study to include all those involved in seeking MCH care including guardians, siblings or any other family member. Further, I certainly recommend time-series investigations that can monitor health outcomes of immigrant mothers and their children who experienced access disparities over a period to establish long-term effects of access disparities on health outcomes of the population. Overall, I recommend that the field of health of minority immigrants should be given equal attention as is for other population subgroups in the United States.

Implications

This study gave recent African immigrant mothers an opportunity to voice their views and experiences on access disparities in the domain of MCH care. This study added new knowledge to the field of MCH care services of minority immigrant populations in the United States. Dissemination of the detailed data generated in this study and the findings thereof could contribute to the gap in the literature on African immigrant health, specifically the domain of MCH care services.

Potential Positive Social Change Implications

The possible social change contributions of this study may involve increased awareness of the challenge in MCH care services (i.e., access disparities) minority immigrant populations face in the United States. Findings of this study will be published and made available to the study population, to health officials, providers, health training institution, community leaders, advocacy groups, and the general public that they can be aware of the access challenges in MCH among minority immigrant populations, particularly those from Africa. To further awareness of the findings of this study, I will avail to discuss or interpret the significant results of this study in academic and research forums (i.e. workshops, symposiums, and conferences) at local, national, and international levels.

Also, I am willing to work with academia, research, and private or public organizations committed to addressing disparities and promoting equality in the provision of care to devise strategies for addressing the persistent access disparities experienced by minority immigrants. Hopefully, the findings of this study will be used by policymakers to design, develop, and implement tailored, evidence-based policy and program interventions to address health needs of minority African immigrants. In turn, these policy and program interventions will result in improved MCH outcomes for recent African immigrants in the United States.

A surge in the population size of immigrants worldwide, especially due to reigning armed conflicts in different parts of the world. I hope that dissemination of the results of this study will awaken the interest of other researchers to carry out similar investigations on minority immigrants in the United States, but also in other traditional immigrant destination countries, such as Canada, Australia, and some European countries. The growth of researchers’ interest in investigating health needs and challenges of minority immigrants will help to bridge the current literature gap about health outcomes of this vulnerable population. Lastly, I genuinely hope that the findings and insights generated by this phenomenological research on access disparities in MCH care services experienced by minority immigrant populations will elicit action that will result in sustainable positive social change in the form of improved health care outcomes for the study population.

Recommendations for Action

The results of this study agree with previously published literature (Derose et al., 2011; Filippi et al., 2014; Frieden 2014; Hossain et al., 2013; Garbarski 2015; Mehta et al., 2013; Morrison et al., 2012; Wilson et al., 2012) that minority immigrants are medically underserved and disproportionately suffer from health care disparities in the United States. Given the increasing awareness of the significance of early life development (i.e., MCH) to overall health outcomes in adult populations, urgent policy and program intervention to address MCH care needs of minority immigrant populations in the United States is strongly recommended. For this to occur, however, there is a need to create awareness among the general public about the health challenges faced by minority immigrant populations through conducting evidence-based research on health outcomes of this population. I propose that it would be useful to for the Department of Health and Human services through agencies such as NIH and AHQR to establish incentives that attract researchers to investigate in the area of health of minority immigrants.

There is a need to strengthen existing and introduce a new policy and program interventions for addressing access disparities in health care facilities. Providers should be trained and sensitized to make them aware of the negative health outcomes associated with health disparities. Management of health care services should implement strict monitoring systems (i.e., patient reported outcomes) to track down root causes of access disparities and offer effective solutions to address them. Also, the management team should establish incentives, such as rewards for recognizing staff who exhibit a commendable commitment to promoting equity in the provision of care.

Conclusion

Although this study focused on investigating experiences of access disparities in MCH care services among recent African immigrants, its findings went deeper to allow participants to share their opinions about the root causes of these disparities and their effect on the overall experience of seeking care. The findings of this study contributed to the gap in knowledge in the area of minority immigrant health. Results of this study indicated that participants disproportionately experienced disparities in access to specialized services and diagnoses, in care quality, in access to patient information, and waiting time during their MCH care appointments compared to other care seekers. Further, this study found out that racial/ethnic discrimination, differences in health insurance types, immigration status as well as SES were the primary causes of access disparities in MCH experienced by minority African immigrants in the United States.

The findings of this study are timely given the ever-growing numbers of immigrants in Western countries mainly due to persistent conflicts in different parts of the world that are not likely to end soon. The key findings in this study will help to increase awareness of the challenges in MCH care services faced by minority immigrant populations in the United States and hopefully be used by policymakers to develop and implement evidence-based policy program interventions to address identified access disparities. The findings and insights generated by this phenomenological research have the potential to elicit action that will result in sustainable positive social change in the form of improved health care outcomes for the study population and other minority immigrants in the United States and beyond.

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Appendix A: Study Invitation Flyer

STUDY INVITATION FLYER

Invitation to Participate in a Study on **Experiences of Maternal and Child Health Access Disparities among Recent African Immigrants** – ***IRB Approval # 12-23-15-0406456***

This research study is for African immigrant mothers who recently moved to the United States and have interacted with the health care delivery system in the process of seeking maternal and child health services for their children. The researcher, **Mr. Bakali Mukasa** is a doctoral candidate at Walden University's College of Health Sciences, and he is interested in gaining detailed understanding of the maternal and child health access disparities experienced by recent African immigrant mothers in the United States.

Note: Your participation would be entirely on a voluntary basis, and you may opt to withdraw at* any *time.

Study Eligibility:

You may qualify for this study if:

a) You identify yourself as a legal female immigrant aged 18 years and older – you possess a valid state issued identification card, such as a driver's license;
b) You are an African immigrant mother of a child aged between 6 and 24 months, who moved to the United States within the past four years;
c) You live in Boston-Cambridge-Newton, MA-NH Metropolitan Statistical Area;
d) You are willing to complete a short demographic survey, and short debrief of the study;
e) You are willing to share freely with the researcher how your experience of seeking maternal and child health services in a recorded, private face-to-face interview that will last between 45 to 60 minutes;
f) And, you can read, write and understand instructions in basic English language;

Benefits to Participants:

Although there may not be any direct benefit for your participation in this study, sharing your experience pertaining to the process of accessing maternal and child health services will provide you an opportunity to contribute to availability of knowledge and scholarly information about health care challenges experienced by immigrant populations in the United States. You will be compensated $10 for taking part in this study. Also, soft drinks and snacks will be served at the interview venue.

To learn more about this study and how you can take part, please contact Bakali Mukasa at [redacted] or by email at [redacted]

Appendix B: Initial Eligibility Screening Questionnaire

Participant Recruiting goals:

Participants must:

- Be legal African immigrant females aged 18 years and older and have lived in the United States for less than 4 years.
- Be mothers with child(ren) aged between 6 and 24 months and have sought either maternal or child health care in the past one year.
- Live in BNMSA and able to write, read and speak at least Basic English.
- Be willing to travel to interview venue, sign the participant consent form and complete a recorded face-to-face interview that will last between 45 to 60 minutes.
- Commit to a date and time they will be available for the interview

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

1. Obtain caller's name, sex, and age.
2. Are you a legal African immigrant?
3. How long have you lived in the United States?
4. Are you a resident of the BNMSA?
5. Do you have a child(ren) aged between 6 and 24 months?
6. Have you sought maternal or child health care in the past 12 months?
7. Are you willing to complete a short demographic survey and short debrief of the study?
8. Are you willing to freely participate and share with the researcher about your experience of seeking maternal and child health services in a face-to-face interview that will last between 45 to 60 minutes?
9. The face-to-face interviews will be audio recorded. Do you have a problem with this?

10. Are you willing to travel to the interview venue, Victory Family Church International, at 161 North St, Newtonville, MA 02460?
11. Are you willing to sign an informed consent, which says that you voluntarily agree to participate fully in the study?
12. When is the best time and date to schedule your interview?
13. How soon are you available to meet with me?

Closing Remarks for Potential Ineligible Participants:

Thank you for your interest in participating in the study and answering the screening questions. However, presently, I am looking for individuals who fit specific criteria, and according to the information you have provided, you do not meet the study eligibility requirements at this time. Thank you very much for your time.

Closing Remarks for Eligible Potential Participants:

Thank you for your interest in participating in the study and answering the screening questions. Based on your answers, I am delighted to inform you that you are eligible to take part in this study, and I would like to go ahead and book an interview time and date convenient to you.

- Do you have any questions for me at this moment?
- So, would you like to participate in this study?
- Can we set your interview? What time and day works best for you?

DATE of INTERVIEW ________________ TIME OF INTERVIEW ______________

Thank you for agreeing to take part in this study. I look forward to meeting you at the church in MA on (the agreed interview data) at (agreed interview time).

Appendix C: Demographic Checklist

Ethnicity: ☐Central Africa ☐Eastern Africa ☐Northern Africa ☐Southern Africa ☐Western Africa

Education level: ☐Less than high school ☐High school ☐Associate degree ☐ University degree ☐ Advanced degree

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

Annual household income: ☐Low ☐Middle ☐High

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

Current employment status: ☐Full-time ☐Part-time ☐Unemployed

Type of health insurance: ☐Private ☐Public ☐None

No. of children in a family: ☐1 – 2 ☐3 – 4 ☐5 or more

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

Health care sought in the last year: ☐Maternal ☐Child

Nature of care sought: ☐Inpatient ☐Outpatient

Do you have a PCP? ☐Yes ☐No

Do you have health insurance? ☐Yes ☐No

Appendix D: Interview Guide/Protocol

Experiences of Maternal and Child Health Access Disparities among Recent African Immigrants

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

Obtain demographic information of the study participant: I asked participants to briefly tell me about herself, her name, age, highest education level reached, marital status, employment status, where she lives, her nationality, the number of children she has, and age of her youngest child. Next, I will go forth to inform the participant that the interview may last between 45-60 minutes. At this moment, I will ask the participant if she has any questions or clarifications before we commence with the interview. In case there are none, I will go ahead and start administering the interview questions.

IQ1. Tell me about the various forms of maternal and child health services you sought and used in the past 2 years.

IQ2. What do you understand by health access disparities?

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

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

IQ5. How, if at all, did your status of being a recent African immigrant contribute to the different forms of maternal and child access disparities you experienced?

IQ6. How, if at all, did your SES contribute to the different forms of maternal and child health access disparities you experienced?

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

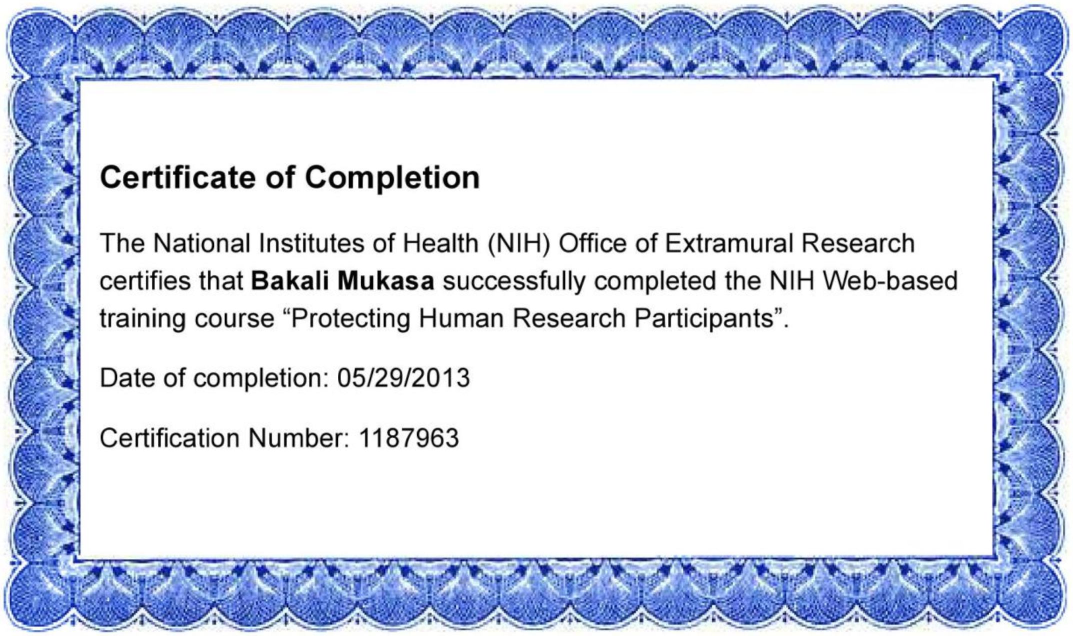
IQ8. How, if at all, did access disparities affect your overall experience of seeking MCH care series?

IQ9. Is there anything else you want to share with me concerning your maternal and child health care service experiences in relation to access disparities?

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

Conclusion: Thank the participant for taking their time to participate in the study and then provide the participants with a description of what will happen next after data collection. Also, at this moment, I will explain and assure the participant that the privacy of their collected data is guaranteed.

Appendix E: NIH Certification



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Bakali Mukasa** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 05/29/2013

Certification Number: 1187963

Appendix F: List if Free or Low Cost Counseling Services

Thrive Boston Counseling and Psychotherapy
872 Massachusetts Ave Suite 2-2
Cambridge, MA 02139
Phone: (617) 395-5806
Email: info@thriveboston.com
Website: http://www.thriveboston.com
Opening Hours:

- Monday - Friday – 8am to 9pm
- Saturday – 8am to 5pm
- Sunday - Closed

Families for Depression Awareness
395 Totten Pond Road, Suite 404
Waltham, MA 02451
Telephone (781) 890-0220 main office
Fax (781) 890-2411
Email: info@familyaware.org
Website: http://familyaware.org
Opening Hours:

- Monday - Friday - 9am to 5pm
- Saturday and Sunday – Closed

Community Legal Services and Counseling Center
1 West Street
Cambridge, MA, 02139
Phone: (617) 661-1010
Fax: (617) 661-3289
Email: info@clsacc.org
Website: http://www.clsacc.org
Opening Hours:

- Monday - Friday – 9am to 5pm
- Saturday and Sunday – Closed

Family Counseling Associates of Andover, LLC
12 Essex Street
Andover MA, 01810
Phone: (978) 222-3121
Fax: (978) 296-3460
Email: info@fca-andover.com

Website: http://www.fca-andover.com
Opening Hours:
- Monday - Friday – 9am to 8:30pm
- Saturday – 9:am to 5pm
- Sunday – 12pm-5pm

Center for Counseling and Psychological Health (CCPH)
127 Hills North
111 Thatcher Road
Amherst, MA 01003
Phone: (413) 545-2337 or the 24/7 crisis hotline (413) 545-0800
Fax: (978) 296-3460
Website: https://www.umass.edu/counseling
Opening Hours:
- Monday - Friday – 8:30am to 5pm
- Saturday and Sunday – Closed

Cambrdge Health Alliance – Central Street Care Center
26 Central Street
Somerville, MA 02143
Phone: (617) 591-6033 or (617) 665-1000 for after working hours and weekends
Fax: (617) 591-6452
Website: http://www.challiance.org
Opening Hours:
- Monday - Friday – 8:30am to 5pm
- Saturday and Sunday – Closed

Crisis Call Center
P.O. Box 8016
Reno, NV 89507
Phone: 775-784-8085
Fax: 775-784-8083
Email: info@crisiscallcenter.org
Website: http://www.crisiscallcenter.org
Opening Hours:
- Monday - Sunday – 24-hour crisis hotline