An Interpretive Phenomenological Analysis Exploring African American Women's Perceptions of Access to Healthcare in the Midwest

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A Dissertation Presented in Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

School of Behavioral Sciences
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Abstract

The purpose of this interpretive phenomenological study was to explore access to healthcare through the lens and lived experiences of African American Women (AAW) in Midwestern towns throughout the United States. African American women and other people of low socio-economic backgrounds continue to live with poorer health outcomes than many of their counterparts African American Women experience barriers to healthcare from a unique perspective than their White counterparts. Although medical professionals endeavor to attain equal treatment among each of their patients, significant healthcare disparities are prevalent among AAW Commonly recognized ethnic stereotypes are not always intentionally supported, however, their mere existence shapes how information about a person is processed and can result in unintentional prejudices in decision-making. This well-known phenomenon is commonly referred to as implicit bias. Systemic structural obstacles and different methods of marginalization as described above, continue to plague and limit AAW's access to quality healthcare in their neighborhoods. This research considered these factors in addition to the access to culturally competent healthcare providers and their ability to address known mental and physical health disparities among AAW through qualitative interviews.

Keywords: African American Women, cultural competency, minorities, minority stress, access to healthcare, health disparities, discrimination, race matters, health policies.

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Dedication

This labor of love is dedicated to my entire family, including my church family and pastor at the Light Church, sorority sisters of Delta Sigma Theta Sorority, Inc., my close circle of friends that I lovingly call “my village”, and all those who supported me in this educational endeavor. You know who you are. I especially want to thank from the bottom of my heart, my beautiful and loving Mother Joyce, my stunningly beautiful, talented, incredibly smart, and gifted daughter Akeila Monae, and my sweet, precious ball of light and joy, my granddaughter Yunitiee! My village is unquestionably the force behind getting this work done. Thank you for enduring my seemingly endless days of gripping without feeling judged. Thank you for your encouragement to keep going, even when I just knew the light at the end of the tunnel was a freight train. Mommy, Keila, Renee, Felicia, Paula, Virginique, and Chris, each of you played a huge part in my success, and I want you to know I will always love you and appreciate all of what you have sewn into me.

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Dr. Schultz is my true hero. Thank you for saving years of work and helping me realize the worth of my work. Your continued encouragement, feedback, and support undoubtedly got me over the finish line. Your time and commitment to my success never went unnoticed and I will forever be grateful to you and your years of wisdom. I could not have left this page without acknowledging Dr. Juanita White who graciously agreed to edit my research document and didn’t count it against me for everything I didn’t know, and desperately needed her help. Thank you!

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List of Abbreviations

African American Women (AAW) (AAW and Black Women will be used interchangeably.)

Critical Race Theory (CRT)

Interpretive Phenomenological Analysis (IPA)

Minority Stree Theory (MST)

Reflexive Thematic Analysis (RTA)

Social Stress Theory (SST)

Thematic Analysis (TA)

White Women (WW)

Chapter One: Introduction

Overview

Many minorities find their day-to-day lived experiences rife with prejudices, discrimination, and mistreatment leaving them with an overwhelming sense of stress, anxiety, and grief, as well as poorer physical health conditions. African American women (AAW) are no exception and are not immune to minority stress, but often struggle with basic necessities such as access to healthcare. Structural barriers, different forms of discrimination both implicit and explicit, and side-lining continue to constrain AAW from access to quality healthcare benefits (Adebayo et al., 2022). Not unlike the social and economic measures mentioned above, health disparities are in large part another sign of the inequalities experienced by AAW in the United States (Chinn et al., 2021). Although there have been new mandates by the National Institutes of Health (NIH) to boost the inclusion of minority groups that are underrepresented in biomedical studies, the presence of AAW in empirical studies continues to be underrepresented (Chinn et al., 2021).

Background

Historical Background

During the Jim Crow era from 1877 until 1954, the United States federal government sponsored, wrote, legislated, and enacted laws supporting the racially separate and unequal delivery and access to resources including but not limited to, education, housing, employment, and unfortunately healthcare (Yearby, 2018). It was initially thought the trajectory of African Americans in this country was beginning to change starting with Brown v. Board of Education the United States Supreme Court ruling in May of 1954. The court determined the separate and unequal education clause, violated the constitution because separate is inherently unequal (Yearby, 2018). The subsequent federal laws such as the Civil Rights Acts of 1957, 1960, 1964, 1968, and the Voting Rights Act of 1965, sought to abolish the unequal and unfair behavior towards African Americans in this country.

Nearly 55 years later, we observe how inequalities still persist in the twenty-first century. This includes the health disparities of AAW this paper seeks to address. This is in part due to the ruling and the subsequent laws had little to no effect on the structures and systemic barriers in place across the country (Yearby, 2018). In particular, underlying racism thwarts the attempts of AAW and other marginalized communities to obtain equal access to community networks and assets such as wealth, employment, housing, education, and healthcare, which all contribute to health disparities across ethnic populations (Yearby, 2018).

The broad-base gaps in health equity can be best addressed through a cross-sectional approach when investigating the health disparities of AAW in this country. When beginning to understand access to health care in the U.S. researchers must consider a plethora of sociodemographic factors such as race and ethnicity, marital status, education, income, and even gender (Vohra-Gupta et al., 2023). Consequently, there is only a scarce measure of research that has examined access to healthcare disparities unique to AAW (Vohra-Gupta et al., 2023).

Going back to the early 2000s, one can secure a good deal of literature demonstrating how gender is a social determinant of health (Vohra-Gupta et al., 2023). Conversely, only recently the research community has developed a greater insight into how AAW experience significantly more disparate health outcomes than their White counterparts in areas such as maternal mortality, infant mortality, cardiovascular health, diabetes, cancer, high blood pressure as well as mental health concerns (Brown et al., 2023; Brown et al., 2022; Chinn et al., 2021; Pauly et al., 2021; Vohra-Gupta et al., 2023) Equitable access to healthcare is critical because it reduces the risk of poor health outcomes and disparities. To date, relatively few researchers examined the avenues in which race, ethnicity, and other demographics, along with social circumstances affect healthcare disparities in the United States (Vohra-Gupta et al., 2023).

Social Background

Access to healthcare for AAW is a particularly underhanded minority stressor, saturating the social context of racism and discrimination, affects AAW at the macro (legal, policy), meso (local community), and micro (individual, couple, family) levels of the social environment (Rostosky & Riggle, 2011). The shielding health effects of factors contributing to socioeconomic status such as education and employment, as well as psychological resources including self-efficacy, perceived control over life, anger control, and emotions are well-known (Assari, 2018). Psychological attributes as listed above are also essential for maintaining mental health (Assari, 2018).

As far back as the late nineteenth century researchers noted the root causes of health outcomes between AAW and White Women (WW) were social, caused mainly by the "vastly different conditions" in which Blacks and Whites live and work in the United States (Boen, 2016). Reviews of many empirical studies demonstrated through the considerable evidence from both laboratory and community studies the harmful health effects of discrimination across a range of mental health outcomes including psychological distress, depression, anxiety, and overall well-being have a significant impact on minorities such as AAW (Chamik et al., 2018; Pascoe & Smart Richman, 2009) Additionally, the perceived racial and discriminatory behaviors toward AAW from healthcare workers have also been linked to specific types of physical health problems, such as hypertension, self-reported poor health, and breast cancer, as well as potential risk factors for disease, such as obesity, high blood pressure, and substance use (Pascoe & Smart Richman, 2009). Researchers have consistently shown how AAWs' perceptions of discrimination contributes to health behaviors that have clear associations to unfavorable disease outcomes, such as smoking alcohol and substance abuse, as well as nonparticipation in behaviors endorsing good health, such as cancer screening, diabetes management, and condom use (Pascoe & Smart, 2009). Over 20 years of studies and evidence give way to the early beginnings of social stress theory and its connection to critical race theory (CRT). Today's researchers, including this study, continue to acknowledge the social sources of racial health disparities in the United States (Boen, 2016). However, with the most recent emergence of critical race theory, we begin to see just how wide-ranging and prevalent health disparity gaps are for African American women (AAW).

Theoretical Background

Meyers et al. (2003) described a conceptual framework of minority stress that may explain how racism, discrimination, and even social stigma help to foster a stressful atmosphere often experienced by marginalized populations subsequently leading to adverse health outcomes. Measures aimed at understanding the sources of racial health disparities in this country have found that the observed Black-White gaps in health can be explained by racial differences in socioeconomic status (SES) (Boen, 2016). As mentioned above, cultural stereotypes adopted by healthcare workers can lead to unintended biases known as implicit bias (Chapman & Carnes, 2013). Dominant societies as well as minority populations are vulnerable to implicit biases, and physicians are not immune.

Empirical analyses suggested how implicit biases may influence disparities in health outcomes by manipulating the behaviors, actions, and attitudes of physicians resulting in differences in medical care concerning race, ethnicity, gender, or other characteristics (Chapman & Carnes, 2013). What some may call cultural barriers develop into biases endorsed by healthcare professionals, and demonstrate evidence contributing to lower quality in medical services (Michalopoulou et al., 2009). Upon completing several years of education and bestowed a medical degree, most new doctors are administered the Hippocratic Oath, and pledge to treat all patients as respected individuals (Chapman & Carnes, 2013). Now that coursework for physicians is behind them, they must apply principles of evidence-based medicine and often meet performance metrics put in place by their institutions, which that are intended to produce consistently high-quality medical care. However, notwithstanding these practices, disparities in healthcare remain prevalent in this country. The Institute of Medicine (IOM) implied these variations are the result of several components. However, the IOM reiterates how biases, stereotyping, prejudiced behaviors, actions, and attitudes expressed by healthcare providers play a role in disparate health outcomes among AAW (Chapman & Carnes, 2013).

The continued development and expansion of social stress theory (SST) is often referred to as minority stress and focuses on the superfluous amounts of stress people from marginalized social and economic statuses are exposed to as a consequence of their minority position in life (Meyer, 2003). This development of a model of minority stress theory (MST) is not purely derived from a single theory. In fact, MST is not commonly used by researchers. The conceptualization of MST can be inferred from various sociological and social-psychological theories. Sociological and social psychological theories tend to debate the harmful effects of poor social conditions, such as discrimination and prejudice in the lives of affected persons and groups (Meyer, 2003). The development of MST came out of the need to examine and explore how stressors experienced distinctively by minority groups may relate to physical and mental health disparities (Balsam et al., 2011). Stressors associated with minority groups may have direct effects on one's health through constant biological stress mechanisms. This may lead to psychological distress, and/or influence risky health behaviors and affect the frequency with which minority groups use health services (Balsam et al., 2011).

Social stress often presents itself in several diverse ways (Balsam et al., 2011). Both highlight the impact of societal stressors on marginalized groups such as AAW. Previous researchers directed their focus on major discriminatory incidents, it was not until recently that researchers started to explore the occurrence and frequency of microaggressions occurring in daily life. The author described microaggressions as “brief, daily assaults on minority individuals, which can be social or environmental, verbal or nonverbal, as well as intentional or unintentional” (Balsam et al., 2011. p. 163). These interpersonal interactions involving microaggressions are often not apparent as discriminatory by perpetrators who often believe their actions are innocent or harmless with total disregard or understanding of the budding impacts of these behaviors on recipients. Subsequently, they have shown how these encounters have harmful effects on the mental health of the target (Balsam et al., 2011).

Black males who experienced microaggressions also reported several areas of psychological distress including anxiety, feelings of helplessness, hopelessness, and fear

(Balsam et al., 2011). In 2009, researchers found a positive association between depression and perceptions of racial/ethnic discrimination in a large Latinx sample group. In addition, racial microaggressions have also been shown to impact health-related behaviors, as well as the utilization of health services. Balsam et al. (2011) reported on a 2007 empirical study demonstrating African Americans' satisfaction with European counselors was negatively associated with the frequency of perceived racial microaggressions experienced during the counseling sessions. They also demonstrated how microaggressions can lead to unsatisfactory work relationships or perceptions of hostility in school settings. Researchers also documented how doctors and other healthcare workers support noticeably false and non-scientific beliefs regarding biological differentiations between Black and non-Hispanic or White patients (Gilmore-Bykovskyi et al., 2023; Hoffman et al., 2016; Smith et al., 2007). The known disparities in wide-ranging healthcare delivery for AAW necessitate interventions addressing obstructions at societal, governmental, and clinical levels. Racial and ethnic minorities in the US regularly received lower-quality healthcare than White patients (Smith et al., 2007). This phenomenon is also present in studies where critical factors such as socioeconomic status, education, and access, are controlled. Researchers suggested healthcare professionals take on the responsibility to learn more about these factors and the roles they can play in eliminating healthcare disparities. However, there is a scarce number of curricula that center on understanding and addressing racial and ethnic health disparities. In addition, generally accepted models of what and how to teach in this intricate area are lacking across the board (Smith et al., 2007). This study explored how AAW perceive their lived experiences in the U.S. when accessing healthcare from cultural, societal, and legal aspects that are often known to stigmatize sexual minorities.

Situation to Self

The emphasis on self as the basis for unqualified truths of the way things happen or occur is the first and leading phase in communicating knowingly with others (Moustakas, 1994). As a researcher, I am the person attached to the external community. The process of self-truth results in reflectively coming to understand the meanings that stir in my consciousness (Moustakas, 1994). The normative process of probing into the meaning of something involves epoche, or a transition toward looking before judging, while creating a space within us where one can perceive what is before us and in us (Moustakas, 1994). The process in and of itself encompasses phenomenological reduction to take us from absolute declarations to various themes to indispensable textures and inspired images (Moustakas, 1994). Through the process of examining each of these, I may reach the cruxes of my research connected with “universals of temporality, spatiality, body hood, materiality, causality, relation to self and others” (Moustakas, 1994, p. 14). The anticipated results are to know for myself, from my experiences of others, and from my reflections on these occurrences. They are coupled with the meanings and essences of entities and experiences in the everyday world (Moustakas, 1994). Instead, this interpretive phenomenological analysis will give meaning to the lived experiences of AAW and their access to health care. The phenomenon of AAW avoiding care, being misdiagnosed, over-diagnosed, ignored, and unheard may contribute to the health disparities of a marginalized population. There is a repeated phenomenon of discrimination, disrespect, mistreatment, and discomfort when dealing with White healthcare professionals that can potentially lead to extreme levels of stress for AAW when accessing healthcare.

Problem Statement

African American women often find themselves facing increased levels of stress and poorer physical and mental health when compared to their White or Latina counterparts as a result of obstacles to healthcare that are steeped in discriminatory practices (Williams & Sternthal, 2010). As previously mentioned, defensive health effects such as financial and educational resources along with psychological assets, are well-known (Assari, 2018). The lack of those same resources and assets significantly contributes to the spatial health gap in this country. W.E.B. DuBois (1899) once wrote,

> …the most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference (Williams & Sternthal, 2010).

Due to structural barriers AAW face in their daily lives, the very same resources and assets generate reduced health gains for ASWW when compared to their White counterparts (Assari, 2018). Sadly, even when equal access to resources and assets is present, inadequate health gain continuously breeds a racial health gap between Blacks and Whites in the U.S. (Assari, 2018).

Current researchers showed how significant healthcare disparities exist as it pertains to access to healthcare, societal judgment, and heightened health risks for AAW when compared to non-racial women (Assari, 2018; Meyer, 2003; McIntosh, 2023; Nowaskie, 2020). AAW are much more likely to be confronted with inadequate opportunities to battle and defeat breast cancer when contrasted with White women (White-Means & Muruako, 2023). One would expect any U.S. city with a large percentage of African Americans would be likely to yield comparable racial disparities in breast health. Yet, this is not the case (White-Means & Muruako, 2023). Similarly, researchers have shown how AAW endure an increased mortality rate in addition to chronic disease burden compared to White women (Dixon et al., 2023). Understanding the disease problems for AAW is extensive and exist across various health outcomes, creates an imperative for interventions established specifically to combat these issues and contemplate all aspects of AWW's lives as probable avenues for health interventions (Dixon et al., 2023).

Although AAW in the United States have generally been able to experience substantial improvements in health during the last century, the aforementioned health disparities persist (Chapman & Carnes, 2013). African Americans are at a more heightened risk for cognitive decline and development of Alzheimer’s Disease than all other ethnic populations (Johnson, 2023). Systemic and economic obstacles prevent access to healthcare in many African American neighborhoods, stopping even the possibility of evaluation and proper medical care (Johnson, 2023). Statistics show AAW in the U.S. are three to four times more likely to die from childbirth and have a 2-fold greater risk of maternal morbidity than their White counterparts (Hamilton et al., 2021). Researchers theorize the disparity is associated with variations in access to healthcare or socioeconomic status (Hamilton et al., 2021). Hamilton et al. (2021) reported AAW die from pregnancy-related complications at 2.5 times the rate of White women and 3.5 times the rate of Hispanic women in this country. Racial healthcare disparities such as the ones described above have been chiefly credited to access to healthcare in addition to other social determinants of health (Henandez, 2023).

Non-Hispanic, AAW have been dying at overwhelming proportions as a result of health difficulties at the hands of the United States healthcare and legal systems (McIntosh, 2023). Unfortunately, this has been a long-standing issue, fully researched and documented. The alarming rates described above continue to plague this country due to its enduring past practices of racism, including the institution of slavery combined with over 100 years of African Americans suffering through Jim Crow laws layered with many of the known socioeconomic shortcomings AAW disproportionally face (McIntosh, 2023).

To continue to advance the field of study of minority access to healthcare, it is necessary for investigators and funding authorities to construct research that uses improved epidemiological methodologies (Meyer, 2003). This paper will add to the somewhat limited existing qualitative phenomenological research on AAW access to healthcare (Chinn et al., 2021). The majority of the research reviewed in this paper is quantitative in nature and lacks deeper analysis as it pertains to the lived experiences of AAW and access to healthcare. From a quantitative aspect, racial disparities in healthcare access are well documented in the literature (Adebayo et al., 2022; Lundeberg et al., 2023; McIntosh, 2023; Schorpp et al., 2021; Tien et al., 2023). We find many researchers have demonstrated AAW received lower-quality care in addition to differential treatment when accessing medical and psychological services, directly associated with their racial identity (Adebayo et al., 2022). However, qualitative analysis of AAW access to healthcare is limited (Chinn et al., 2021). The focus of this study was a qualitative interpretive phenomenological analysis of AAW and their lived experiences with access to healthcare as demonstrated by the stated need from existing research.

Purpose Statement

The purpose of this interpretive phenomenological analysis was to explore the lived experiences and perceptions of access to healthcare of African American Women (AAW) in midwestern towns. At this stage in the research, access to healthcare is defined as satisfaction with healthcare providers concerning the needs of African American Women. One author succinctly defined access to healthcare as the “concept representing the degree of "fit" between the clients and the system” (Penchansky & Thomas, 1981, p. 128). This author generally views access as a construct encapsulating a group of identifiable areas of fit between the patient and the health care provider or system. These specific areas of concern are availability, accessibility, acceptability, accommodation, and affordability (Penchansky & Thomas, 1981).

The theories guiding this study are a combination of social stress theory (SST) and critical race theory (CRT). Critical race theory as a more recent field of study will be used to buffer the argument originally generated out of the field of study found in SST And CRT used together. An interpretive phenomenological approach will address the issue of gaps in this field of research as it relates to AAW and access to healthcare.

Significance of the Study

Researchers who specialize in racial issues explore ideas of how racism generates rates of morbidity, mortality, and overall well-being, which vary depending on socially assigned race classes (Ford & Airhihenbuwa, 2010). Seemingly lofty ideas such as eliminating racism are therefore key to achieving health equity but demand new theories that are receptive to structural racism's contemporary impact on health, health inequities, and research (Ford & Airhihenbuwa, 2010). Critical race theory is a promising inter-disciplinary, race-equity methodology that began in legal studies and is rooted in social justice. CRT's instruments for leading research and practice are envisioned to interpret current racial phenomena, expand the vocabulary with which to discuss intricate racial concepts, and challenge racial hierarchies. Sadly, race is still very much a prominent factor that overwhelmingly influences public health in a variety of ways. The traditional public health theoretical and methodological frameworks ineffectively address the intricacy with which structural racism affects both health and the construction of knowledge about population, health, and health disparities (Ford & Airhihenbuwa, 2010).

Many researchers fall short of clarity in terms of the nature of racial stratification. They theorize, measure, and analyze race and race-related factors employing means better suited for studying other risk factors (Ford & Airhihenbuwa, 2010). Supporters of CRT argue against the reduced rate of racial reform in the United States (Ladson-Billings, 2010). The thought guiding the theory opens with the premise that racism is normal in American society. A unique characteristic is it departs from mainstream legal scholarship by employing storytelling (Ladson-Billings, 2010). Furthermore, as an academic framework, it is used to examine how systems, the law, and policies perpetuate system racism (Jones, 2021). The early pinning of CRT launched in the 1970s, as several lawyers, activists, and legal scholars across the U.S. understood how strong advances of the civil rights era of the 1960s had halted and seemed to be rolling backward (Delgado, 2017). Recognizing additional theories and strategies were necessary to defeat the indirect forms of racism that were gaining ground, early adopters and influencers, such as Bell, Freeman, and Delgado, joined forces to breathe life into what is presently known as CRT. Not long after, they were soon joined by others, including researchers, and the group held its first workshop at a convent outside Madison, Wisconsin, in the summer of 1989 (Delgado, 2017).

The tenants of CRT argue that racism is a widespread, social disease rooted in the sociocultural, political, and educational fabric of Western society and one that not only holds steady systems of privilege and oppression but is disseminated through efforts to diminish the racialized experiences of persons of color (Acheampong et al., 2018) Through the use of a critical race scholarship paradigm, qualitative inquiry can be an effective resource for giving voice to the stories and lived experiences of AAW, which in turn serve as counter-stories contesting philosophies of colorblindness and divulge the true intersections of racism, oppression, and privilege (Acheampong et al., 2018). Racism is a primary cause of racial and ethnic disparities in health outcomes (Butler et al., 2018). Academic researchers have an essential role to play in challenging racism by understanding it and interfering with its impact on the health and well-being of AAW. To do so, the emergence of new paradigms and theoretical frameworks must be developed that are responsive to structural racism's present-day impact on health, health disparities, and research. To engage upon the complexity with which racism influences both health and the construction of knowledge about marginalized groups such as AAW, the field of CRT must hasten the professional growth of researchers who are dedicated to eradicating racial and ethnic health disparities and ultimately achieving health equity for AAW (Butler et al., 2018).

Research Questions

The purpose of this research was for AAW to describe the meaning and impact of healthcare access in their lives. The researcher will explore the following Central Research Question (CRQ):

CRQ: What do the experiences associated with healthcare access mean to African American Women?

The researcher will explore the lived experiences of AAW as they encounter medical professionals and describe in narrative form the details of each experience by answering the CRQ. The Guiding Question for this study is:

GRQ: How do African American Women (AAW) describe the impact of race and racism in relation to healthcare access?

The researcher will address the effect of their experiences and its influence on health outcomes through the GRQ.

Definitions

Access to healthcare - is generally defined as the satisfaction of healthcare providers concerning the needs of minorities (He et al., 2020).

Cultural competency - the ability of the mental healthcare provider to understand the cultural influences necessary to guide the treatment of patients belonging to a specific community (Whaibeh et al., 2019)

Healthcare utilization - is the use of services for the treatment of conditions such as HIV and sexually transmissible infections (He et al., 2020).

Mental health conditions - “a range of disorders that impact one’s mood, thinking, and behavior,” (Whaibeh et al., 2019)

Stigma - “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised” (Hatzenbuehler et al., 2013)

Summary

Researchers have shown health disparities among AAW and their White counterparts. Many demonstrated AAW have higher rates of physical and psychiatric disorders associated with experiences of discrimination, racism, and prejudice

(Acheampong et al., 2018; Adebayo et al., 2022; Butler et al., 2018; Hilliard et al., 2023; Thomas et al., 2021; Wright et al., 2022). These studies prompt the need for future research to use an interpretive phenomenological approach. There is a need to access specialized healthcare in an open atmosphere for AAW (Adebayo et al., 2022). I aimed to describe AAW access to and experiences with healthcare in midwestern towns by way of eliciting common themes and patterns across research participants.

Chapter Two: Literature Review

Overview

In this review I introduced and presented findings on critical race theory (CRT) as the theoretical framework of this paper. I will begin with a definition of the framework, its history, and its correlation to social stress theory as well as how it applies to African American women (AAW). Using ahistorical analysis, I described the origins of the framework as it applies to AAW, barriers to healthcare, cultural competencies, and the impact on AAW and concluded the theoretical framework with a description of how it is used with AAW.

This research was conducted through the use of the Jerry Falwell Library at Liberty University, and Google Scholar. Several research databases were used to conduct this study including Health & Medical Collection (ProQuest), Health Source: Nursing/Academic Edition, Health Policy Reference Center, Access Medicine, DynaMed Plus, PubMed Central (PMC), and JAMA. Keywords used in each of the searches include *health disparities, African American access to healthcare, qualitative, race, mental health, discrimination, stress, minority stress, and culturally competent healthcare providers.* The general focus of the review was to find qualitative research directed to the experiences of AAW and their lived experiences of discrimination, stress, cultural competency of healthcare professionals, and other social determinants of health.

Theoretical Framework

Background of Social Stress Theory

Social stress theory (SST) suggests those who are perceived to have a lower social standing or disadvantaged social status may face two main challenges (Hamilton et al., 2021). The first challenge is that they may inherently be subjected to more stressful circumstances than those in a privileged social status. Secondly, persons belonging to marginalized groups often have access to fewer resources than their more advantaged counterparts (Pearlin, 1999). The culmination of these experiences regularly results in mental health issues (Dohrenwend, 1961) Through an attempt to minimize health disparities of marginalized populations in the U.S. such as AAW, social stress researchers have often examined how social stressors, such as racism, discrimination, and prejudice, influence both physical and mental health outcomes (Clark et al., 1999). SST academics demonstrated how stress resulting from racism, stigma, prejudice, and discrimination is distinctive and dissimilar from other social stressors (Clark, 2004; Meyer, 2003). They have also shown how minority populations may be exposed to more stressful situations than SST can normally predict, and psychosocial stressors can form health inequalities (Thomas-Tobin et al., 2021). It is a prevailing context used to examine group differences in health and conceptualize psychosocial resources as individual-level characteristics that progress over time within the circumstances of one's social interactions and experiences (Thomas-Tobin et al., 2021). One of the earliest empirical studies of stress and societal factors began in 1953 (Rennie et al., 1957). Two years later in Atlantic City, Rennie presented preliminary findings at the American Psychological Association (APA) meeting (Rennie et al., 1957). The threefold purpose of the investigation was demonstrated through its epidemiological approach, (a) To establish the prevalence in the study population of various forms of mental health and illness across the entire mental health spectrum; (b) to determine the differential distribution of these variants of mental health among the many cross-cutting demographic subgroups within the study population; (c) to trace factors etiologically significant for mental disturbance to their sources in specific socio-cultural situations (Rennie et al. 1957).

By understating the early underpinnings of SST, the researcher was able to document a history of theory dating back to the mid-1950s based on how marginalized populations are treated in this country. CRT is the basis of the theoretical framework for this research because AAW find themselves as a double minority, first as a gender minority and then as a racial minority. Throughout history and across the world today, men typically have greater access to both resources (Huis et al., 2017). The gender power model outlined by (Pratto & Walker, 2004) suggested power is in fact gendered. The authors further explained how relationships among men are more volatile and lethal than relationships among women (Pratto & Walker, 2004). Explicitly, men when compared to women have greater access to the use of force, greater access to resource control, fewer social obligations to uphold, and more advantageous cultural ideologies (Huis et al., 2017). This gender inequality can be observed in several aspects of daily life such as access to health care, education, job opportunities, and economic resources (Huis et al., 2017)

More than 50 years of studies show the stigma associated with multiple circumstances such as race, gender, and often mental illness disadvantage the stigmatized population in question and is a major source of stress in their lives (Hatzenbuehler et al., 2013; Hollingshead & Redlich, 1958; Kawaii-Bogue & MacNear, 2017; Pearlin, 1999). Identifying discrimination or stigma as a significant source of stress and social disadvantage, one may conclude it also has considerable outcomes on population health (Hatzenbuehler et al., 2013). The term stigma is defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised" (Hatzenbuehler et al., 2013, p. 813). It often overlaps with racism and sexism (Hatzenbuehler et al., 2013), again pointing to AAW being stigmatized as a double minority.

When understanding SST and its connection to CRT, it is imperative to note how researchers analyze disadvantaged groups to advantaged groups (Hamilton et al., 2021). They use SST to explain observations about stress, an aspect of social life (Manojkrishnan & M., 2020). The causal relationship between social conditions or circumstances and stress for members of a generally marginalized population such as AAW is an additional component of the theory (Manojkrishnan & M., 2020). The researchers looked at how overt, as well as covert racism, discrimination, and biases against AAW through the practices and behaviors of healthcare professionals, led to elevated stress factors and other health disparities. Furthermore, proponents of SST suggested that as a result of perceived marginalized status, members of stigmatized social groups (this includes AAW) should display worse mental health as a direct impact of their elevated exposure to stressors by way of socioeconomic deficiency, racism, and discrimination (Hamilton et al., 2021; LeBlanc et al., 2015).

The researcher followed an interpretive phenomenological approach to collecting and analyzing the qualitative data. A combination of survey questionnaires and interviews were used to conduct the research based on the central research question and the guiding question. The answers were collected and presented in the final results of this study. The following theoretical framework was used to explain the context and implications of STS as a precursor to CRT Through a pretextual understanding of CRT as a more advanced and comprehensive framework, the subsequent literature review conveys the multiplicity of levels of stress as perceived by AAW as it pertains to access to healthcare.

Key Elements of Stress Among AAW

As more studies began to establish their framework, a standard and conceptual definition of stress also began to solidify. Stress was deemed to consist of seven key elements (Farrington, 1986). The following seven requirements outline a structure for measuring and conditioning stress (a) Stressor stimulus or series of Stressor stimuli), (b) the objective reality of a particular Stressor stimulus, independent of any cognitive processes of perception or definition on the part of the individual or social system which is being stressed, (c) the definition of the situation arrived at by the individual or social system, (d) the response capabilities possessed by the individual or social system, from which the actor or social system can make responses to the stressor stimulus(i), (e) the coping behavior(s) actually utilized by the individual or social system in response to the stressor stimulus(i), (f) changes in the stress level of the individual or social system, as a result of the stress experience, and (g) the possible consequences of the stress experience (Farrington, 1986).

The presence of stress stimuli is one of the first key indicators to consider. Representation of AAW and access to healthcare as a community is a developing area of research that is beginning to inform our understanding of the intersection between racial identity and health risks (Butler et al., 2018). The collective experience of minority stressors has been known to cause continual activation of stress systems (Butler et al., 2018). This stress leads to allostatic functioning, the process by which the body responds to stressors to regain homeostasis, damages many regulatory systems ultimately leading to a varied assortment of health concerns (Butler et al., 2018). Prolonged stress and allostatic load have been associated with poorer health conditions (Hamilton et al., 2021).

The second key element of stress, the objective reality of stressor stimulus focuses on the individual perceptions and lived experience of the individual in relation to the stress stimuli. It is how AAW perceive the stress that places an additional burden on them as a racial minority over and beyond the normal or everyday stress experienced by non-Hispanic White Americans (Meyer, 2003). AAW are often subjected to minority stress as it relates to overlapping identities and personal characteristics such as gender, race, and socioeconomic class (Hamilton et al. 202; Jackson & Garcia, 2014). The effects of being a double, triple, or even quadruple minority create a certain level and perception of stress that is unique, separate, and apart from their counterparts. Advancing concepts of how people experience stressful incidents and chronic stressors throughout their lives have greatly influenced current understandings of the social factors of well-being (LeBlanc et al., 2015). As a framework for analyzing the origins and influences of social stress on health, the objective reality and perception of AAW through their lived experiences of stress stimuli is crucial to understanding the health disparities among the community of women.

The third element of stress relates to the definition of the situation arrived at by the individual again can be gleaned from personal narratives. AAW has increased rates of physical and mental health disorders that have been linked with lived experiences of racial and or gender discrimination (Adebayo et al., 2022; Brown et al. 2023; Wright et al., 2022). Jackson et al. (2010) reported Blacks overall have a lower average life expectancy than Whites (ranging from 70 to 77 years old) with Black men having 66 life expectancy years. Maternal care is specifically an area of concern for AAW. The Centers for Disease Control reported the pregnancy-related mortality ratio for Black women with at least a college degree, was 5.2 times higher than their White counterparts (Adebayo et al., 2022). Additionally, of the evidence-based mental health service delivery protocols examined for racial and ethnic minority groups, most are still significantly underdeveloped (Kawaii-Bogue et al., 2017). There is a need for easy access to specialized healthcare in an open atmosphere more specifically in primary healthcare settings, which is generally the first point of contact (Adebayo et al., 2022; Assari, 2018; Jackson & Garcia, 2014; Kawaii-Bogue et al., 2017). Discrimination is often a personal observation and feeling. AAW may describe their feelings of discrimination in various situations when accessing healthcare, whether it is finding a culturally competent provider relatively close in proximity to their home or finding a healthcare provider trained in their physical and mental healthcare needs.

Response capabilities, the fourth element, is a result of better healthcare provision and is a factor of AAW becoming more comfortable with their racial identity and social identity, along with how they may change over time with little benefit (Chinn et al., 2021). One school of thought focuses on how medical and psychological disclosures may make it easier for people to be confident about their racial identity with those similar to themselves, therefore increasing the need for more AAW healthcare workers (Adebayo et al., 2022). The premise comes full circle when a better integration of the social determinants of health related to AAW coupled with the cultural competency of healthcare providers can lead to greater openness with physicians enabling them to be better suited when they adapt to meet the specialized needs of this marginalized community. Arriving at a point where AAW are comfortable sharing their narratives of their stressful situations can often be an extraordinarily lengthy process in achieving sufficient response capabilities, the fourth element of this long and perplexing journey.

The coping strategies possessed by a person within a marginalized community, such as AAW are the fifth element of stress. Mental health conditions which have been defined as "a range of disorders that impact one's mood, thinking, and behavior," are a mounting public health concern across the United States (Whaibeh et al., 2019, p. 424). Researchers found one in six adults live with a mental illness (Whaibeh et al. 2019). Of the nearly 45 million U.S. adults living with mental health conditions in 2018, only 19.2 million (43.1%) of them received treatment (Whaibeh et al., 2019). Less than 30% of AAW with a mental health issue utilize or seek structured mental health services (Coombs et al., 2022). The sixth element, changes in the stress level is quite common with AAW as they go through their everyday lives. When considering AAW, studies have shown that they have elevated mental health needs that are linked to depression, anxiety, and substance use because of poorer coping skills (Chamik et al., 2018; Whaibeh et al., 2019). Despite their elevated need, AAW continue to face personal as well as universal barriers to accessing effective mental health services. Racism and discrimination have a substantial impact on the mental health of minorities (Whaibeh et al., 2019). AAW who suffer from some form of mental illness often encounter double-edged discrimination and stigma. The first is associated with their mental illness and the other is related to their racial identity along with other social determinants of health that may contribute to their minority status (Adebayo et al., 2022; Assari, 2018; Brown et al., 2023; Hilliard et al., 2023; Jackson et al., 2010). AAW have dealt with societal stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion, and family rejection (Adebayo et al., 2022; Assari, 2018;

Balsam et al., 2011; Brown et al., 2023; Jackson & Garcia, 2014). For most AAW, the absence of meaningful coping strategies is very pronounced in their lives. Lastly, consequences of the stress experience, element seven, have been noted throughout and will be one of the prevailing themes of the personal narrative of this study. Many studies have linked the instances of social determinants of health including racism, societal stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, and social exclusion as described from the lived experiences of AAW to the mental and physical healthcare disparities in this country (Anderson et al., 2004; Assari, 2018; Blair et al., 2013; Boen, 2016; Butler III et al., 2018; Gulliford et al., 2002; Jackson et al., 2010; Meyer, 2012; Rattan, 2022).

Application of Stress Theory

Through the application as described above, AAW can be said to be under stress if, "the response offered in the face of a stressor stimulus is insufficient to adequately minimize or otherwise negate the demand generated by that stimulus" (Farrington, 1986, p. 133). The author asserted the overall stress model has been intentionally devised to be valid to many unique levels of analysis since it is based upon the assumption that stress is a multilevel idea, which is useful when studying individual persons and social systems with equal validity (Farrington, 1986). Early social stress theorists (Hollinshead & Redlich, 1958; Rennie et al., 1957) posited that, just as individual persons can be said to be experiencing "stress," so too can units of social reality for example, social groups, social organizations, and social systems (Farrington, 1986). As such, sociological curiosity in stressful life circumstances originated to account for associations between markers of social positioning such as class, gender, and minority group status along with rates of mental and emotional disorder (Aneshensel et al., 1991). Initial social causation viewpoints reasoned that low-status social groups such as AAW, demonstrated high rates of disorder because members of these groups disproportionately encountered difficult, harsh, or traumatic life conditions (Aneshensel et al., 1991; Balsam et al., 2011). Higher rates of disorder were also attributed to restricted group access to social, economic, or personal resources/assets that reduce difficult life circumstances and lessen their mental health concerns often common among AAW (Aneshensel et al., 1991).

Structural or systemic stigma, "sensitizes us to the fact that all manner of disadvantage can result outside of a model in which one person does something bad to another" (Hatzenbuehler et al., 2017). There is a mounting acknowledgment of how systemic stigma may be an underrecognized catalyst in creating health disparities between AAW and their non-Hispanic White counterparts. However, there is a scarce amount of research connecting specific instances of structural stigma to adverse health outcomes such as higher stress levels, creating minority stress (Hatzenbuehler et al., 2017).

Sociological examination commences with specific social structural arrangements and looks onward toward a comprehensive assortment of likely consequences; the sociomedical archetype starts with a unique disorder and looks backward toward a broad range of potential precursors of the disorder (Aneshensel et al., 1991). These viewpoints outline the beliefs inherent in each model (Aneshensel et al., 1991). Sociological theory illuminates how standardizing social arrangements can generate conditions that damage the emotional core of people's lives (Aneshensel et al., 1991). Elevated rates of disorder among certain social groups including AAW are often seen as the inescapable by-product of everyday facets of social determinants of health), facets that are often beneficial to other social groups (Aneshensel et al., 1991). Minority stress theory has widespread empirical support in explaining health disparities experienced by sexual and gender minorities. However, less is known about how minority stress affects marginalized communities, such as AAW (Lundeberg et al., 2023). Advocacy for cultural competency training and AAW research is necessary in multiple scientific areas (Kawaii-Bogue et al., 2017; Sue, 2006). Many medical students and professionals lack moralistic preparation in marginalized population health. There are very few studies identifying effective intervention approaches for reducing mental health disparities in AAW (Adebayo et al., 2022; American Psychological Association [APA], 2003; Lundeberg et al., 2023; Sue, 2006).

Dohrenwend (1961) noted the rise in the number of studies beginning to lay the groundwork of theory and fact, in regard to relationships between social-environmental factors and mental illness. The particular studies Dohrenwend (1961) referenced differed from previous studies in several ways (Hollinshead & Redlich, 1958; Rennie et al., 1957). The most noticeable difference was the particular social and cultural factors emphasized in each of the studies, in addition to the variations in the population (Dohrenwend, 1961). Other changes included whether they have attempted to assess untreated, as well as treated prevalence, and the definitions of mental disorders utilized in the studies (Dohrenwend, 1961).

The studies also share distinct commonalities, which build upon the conceptualization of social stress theory. The first commonality central to the studies is the emphasis tends to be on gross environmental characteristics illustrated throughout, such as social disintegration or social class, and on mental disorder (Dohrenwend, 1961). This distinction remains relevant today as AAW are still considered a double minority, and as a result, face discrimination and racism. The outcomes contribute to exaggerated stress levels, which eventually develop into disparate health outcomes for AAW (Adebayo et al., 2022; Balsam et al., 2011). Other commonalities among the studies include, they all set forth a very similar central assumption, purporting the theoretical position that stressful social and cultural circumstances are causally related to mental disorder. The theorist reported on the strong relationships between several social and cultural factors, along with mental disorders (Balsam et al., 2011; Dohrenwend, 1961; Hirsh et al., 2016; Jackson & Gracia, 2014; Jackson et al., 2010; Lundeberg et al., 2023). The basis for doctor-patient dealings is established during medical school. The healthcare education they receive greatly affects the attitudes, knowledge, and skills of students, influencing not only future care, but also likely wider social equity and discrimination (Lundeberg et al., 2023; Sue, 2006).

One development out of social stress theory is minority stress, which distinguishes the additional stress those from marginalized social groups such as AAW are faced with as a consequence of their social position, which designated them as a minority (Meyer, 2003). Again, being deemed a racial and/or gender minority, AAW are often faced with the absence of or limited culturally component providers (APA, 2003; Sue, 2006). Conflict with the beliefs and actions of the dominant culture constitutes a surplus of stress common to minority populations such as AAW They are likely to be exposed to such conflicts because the dominant culture, systemic social structures, and norms do not characteristically reflect those of the minority group (Meyer, 2003). An example of a conflict between dominant and minority populations is the high rate of infertility or infant mortality of AAW. As they explore options to procreate and embrace motherhood, just as any other race, pervasive healthcare risks arise. They enter healthcare facilities and unescapably notice an absence of healthcare workers who look like them. They have to put their lives and the lives of their unborn children in the hands of healthcare workers potentially steeped in bias and influenced by racist discriminatory ideology. They rarely receive a sense of safety, warmth, or trust, which does not promote a feeling of connectedness with their provider. Connections with society afford AAW with information on the construction of the world in which they live. Both mental health and physical health can become compromised when such information is unrelated to the minority person's experience in the world or when their access to social systems such as health care is compromised as a result of their racial identity (APA, 2003; Sue, 2006).

Social comparison and symbolic interaction theorists perceive the social environment as a means of offering people meaning to their world and a process of organization to their lived experiences (Meyer, 2003). Social psychological theories such as minority stress and critical race provide a solid foundation for comprehending dominant and minority group relations along with the impact of minority position on health (Ford & Airhihenbuwa, 2010; Meyer, 2003). The developers of these frameworks suggest the process of categorization or the distinction among social groups initiates important intergroup processes like competition and discrimination while also providing an anchor for group and self-definition (Adebayo et al., 2022; Ford & Airhihenbuwa, 2010; Meyer, 2003) The theorist proposed destructive regard from others outside one’s group leads to negative self-regard (Meyer, 2003). Likewise, a basic principle often regarded by theorists is that human beings learn about themselves by comparing themselves with others (Meyer, 2003). This type of theoretical perspective posits negative assessment by others such as stereotypes and prejudice specifically targeted at minority populations can lead to adverse mental health outcomes (Meyer, 2003).

The callousness of healthcare staff and harmful experiences with the healthcare systems have been attributed to racial disparities among AAW (Adebayo et al., 2022). Researchers have shown how AAW have a greater proportion of physical and mental disorders than non-marginalized groups in the US (Wright et al., 2022). Their studies demonstrated how Black Americans when contrasted with White Americans of European descent, have greater physical health morbidity and mortality at every age across the life spectrum (Jackson et al., 2010). One investigator documented how Black women are twice as likely as White women to die of hypertensive cardiovascular disease. They also reported that Blacks have a lower mean life expectancy (70 years) than Whites do (77 years). In addition, Black men have a life expectancy of only 66 years. While there are numerous causes of these differences, data consistently reveals physical health disparities favor Whites over Blacks (Jackson et al., 2010).

Jackson and Garcia (2014) underscored how residents of the United States face a plethora of health challenges including rising healthcare costs, the need for a strong public health workforce, and persistent inequalities among racial/ethnic minority groups and underserved populations such as AAW. Notwithstanding major medical advances in this country, critical threats to the country’s public health remain paramount. Imminent threats adversely affecting AAW include workforce shortages in the medical field in general, along with limited nursing, laboratory sciences, and environmental health staff, which present serious threats to protecting the health of individuals, families, and communities. Those who are most vulnerable and least able to help themselves face higher risks. The authors pointed out how AAW are leaders in these vulnerable populations.

Intensifying the issue, coast-to-coast data revealed, unlike the general population, racial/ethnic minority populations have inferior health outcomes from preventable and remediable diseases, such as cardiovascular disease, cancer, asthma, and human immunodeficiency virus/acquired immunodeficiency syndrome (Jackson & Gracia, 2014). Subsequently, there is an increasing body of evidence authenticating the variances in access to health care, the quality of care, and health measures, including life expectancy and infant mortality, among these groups (Jackson & Gracia, 2014). Public health experts described how the social environment in which people live, learn, work, and play directly impacts healthcare disparities and access to healthcare. They highlighted how a person’s social environment is one of the chief determinants of health throughout the course of their life (Jackson & Gracia, 2014). Researchers found no apparent consensus regarding precise stress developments directly affecting AAW, but psychological theory, stress literature, and research on the health of the AAW as a whole provide some ideas for articulating a minority stress model (Adebayo et al., 2022; Sue, 2006). Minority identity is associated with a number of stress processes. Some AAW are cautious in interactions with others due to expectations of racism, microaggressions, and rejection. They may find themselves shying away from or avoiding preventative health care altogether for fear of harm (Adebayo et al., 2022; APA, 2003; Balsam et al. 2011; Blair et al., 2013; Boen, 2016; Ford & Airhihenbuwa, 2010; Ladson-Billings, 2022; Meyer, 2003; White-Means & Muruako, 2023). However, AAW can counteract the effects of minority stress by forming alternate structures and values that favorably augment their group (Meyer, 2003).

Related Literature

There is a rather extensive body of literature connecting many forms of racism and discrimination to health outcomes (Adebayo et al., 2022; Anderson et al., 2004; Blair et al., 2013; Boen, 2016; Butler III et al., 2018; Chinn et al., 2021; Coombs et al., 2022; Kawaii-Bogue et al., 2017; Rattan, 2022; Thomas Tobin et al., 2021). AAW are susceptible to poorer mental and physical health in addition to social consequences as a result of societal marginalization, racism, and implicit bias against racial and gender minorities (Blair et al., 2013; Dixon et al., 2023; Hamilton et al., 2021; Jackson & Garcia, 2014; Jackson et al., 2010). For example, Adebayo et al. (2022)'s nationwide empirical study demonstrated that AAW are two to three times more likely to die from pregnancy-related difficulties when compared to White women Researchers have recorded mental health disparities characteristically negatively affect AAW. Current literature is devoid of an integrative framework for mental health service delivery to meet the unique needs of African Americans (Kawaii-Bogue et al., 2017; Rattan, 2022). Most recently, a 2023 study reported that urban areas that dominate racially segregated low-income Black households are more likely to experience inequalities in access to primary breast care than their White counterparts (White-Means & Muruako, 2023). Additionally, in 2019 it was reported that mortality rates were highest for AAW (44.0 per 100,000) when compared with non-Hispanic White (17.9) and Hispanic (12.6) women (Lundeberg et al., 2023). Although Black women in the United States have experienced substantial improvements in health during the last century, health disparities persist (Chinn & Redmond, 2021). I sought to highlight how social determinants of health contribute significantly to the above-cited statistics among AAW.

The problem this researcher sought to address was the gap in the literature related to the lived experiences of AAW and access to healthcare (Brown-Iannuzzi et al., 2014).

There continues to be a scarcity of accessible data examining the diverse and unique needs of AAW with respect to their interactions within the healthcare system (Chinn & Redmond, 2021). Negative health outcomes include both physical and psychological aspects of one's health (Chamik & Bovet, 2018). Healthcare professionals are likely to assume the mental and physical health needs of AAW are identical to those of non-Hispanic White people. However, researchers demonstrated this does not appear to be the case and a plethora of social determinants of health contribute to systemic health disparities among AAW (Chamik & Bovet, 2018; Chinn & Redmond, 2021). Primary care clinicians serve as the cornerstone of the healthcare system and are required to possess many skills (Blair et al., 2013). The importance of the doctor-patient relationship is emphasized by proven associations between the quality of the relationship and other facts including patients' adherence to medical advice, the choice to remain with a clinician, satisfaction with care, and clinical outcomes of care (Blair et al., 2013).

Increasingly, the notion that health can be determined by factors outside of what is traditionally known as a healthcare setting has become a recognized approach to mitigating public health gaps and addressing health disparities among AAW. Jackson and Garcia (2014) referred to these factors as social determinants of health (SDH). Commonly recognized factors in this group of SDH include housing quality, access to healthy foods, and education, emphasizing the importance of considering nonclinical conditions when providing quality care within the health-care system. AAW experience adverse SDH in addition to being disproportionately represented among the uninsured.

The Institute of Medicine reported, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, defined crucial recommendations from this innovative study that described the need to increase the proportion of underrepresented minority groups (AAW) in the healthcare workforce. Jackson and Garcia (2014) suggested integrating cross-cultural education into healthcare training, along with advancing research efforts to identify sources of disparities and promising interventions. As the U.S. populace becomes more diverse, obtaining the goal of cultural competence in the workforce and healthcare system has emerged as a top strategy for minimizing health disparities and access to healthcare.

Healthcare professionals have a role in propagating these healthcare disparities, by what they endorse or ignore Jackson and Garcia (2014) defined cultural competency as "the ability of healthcare providers to function effectively in the context of cultural differences, which has been shown to improve the quality of healthcare received by racial/ethnic minority groups." (p. 58) For example, a culturally competent approach establishes ways to address communication barriers with people of limited English proficiency or low health literacy. Racial/ethnic diversity in the healthcare workforce, a type of organizational cultural competency has also been well correlated with the delivery of quality care to minority populations. Increasing underrepresented groups within the healthcare workforce supports the diversity of values and beliefs of the entire population and heightens cultural awareness in healthcare service delivery.

The goal of this study was to give meaning to the lived experiences of AAW and access to healthcare and how those experiences lead to healthcare disparities in the United States. Many researchers have demonstrated how AAW present a higher threat of developing physical health conditions such as cardiovascular disorders, pregnancy-related complications, cancer, and greater physical health morbidity and mortality when compared to women of other races in the US. They also show increased rates of mental health disturbances such as mood disorders, anxiety disorders, substance use, and self-injuring or suicidal behavior (Adebayo et al., 2022; Balsam et al., 2011; Jackson &Garcia, 2014; Jackson et al., 2010; Kawaii-Bogue et al., 2017; Rattan, 2022; Wright et al., 2022). Jackson et al. (2010) concluded these mental and physical health disturbances appeared to be linked with minority stress. However, social stress presents several gaps in the literature that correlate to the experiences of AAW with healthcare because the greater emphasis has been on sexual minorities as opposed to racial minorities. While some researchers have used mixed methods and compared sexual minorities along with racial minorities, far more have been centralized to sexual minorities (Balsam et al., 2011; Hatzenbuehler, 2009; Hatzenbuehler et al., 2013; Meyer, 2003; Meyer et al., 2008; Meyer, 2012). These gaps overlook the intricate nuances of race relations in this country and the effect on AAW as they seek healthcare. The lack of studies specifically addressing the healthcare needs of AAW, as well as challenges identifying and accessing culturally competent healthcare providers, heightens the need for interpretative phenomenological analysis of the lived experiences of AAW and their access to healthcare. I sought to add to the literature by outlining potential areas of growth and application for this field of study by directly exploring the narratives of AAW as they relate to their experiences with healthcare access.

Public Health Issues and AAW

Pointedly weakened healthcare distribution and adverse health consequences are well documented for the AAW in the United States when compared with the population at large. In fact, infertility is a major public health issue affecting more than six million women in the United States (Missmer et al., 2011). Healthcare access refers not only to the geographic availability of quality health services but also to financial, social, cultural, and structural issues associated with care (Heck et al., 2006). The previously mentioned researchers have shown how marginalized groups, such as LGBTQ+, People of Color, and those of low socioeconomic status, often struggle when trying to gain access to healthcare (Heck et al., 2006).

Obesity in the U.S. is a top public health problem because of its high occurrence rates, along with being a predictor of other serious medical conditions including diabetes, heart disease, cancer, and stroke (Bower et al., 2015). The markedly high prevalence of obesity among AAW in this country is a significant public health problem. Between 2007 and 2008, the age-adjusted obesity rate was 33.8 % for all Americans, 32.2 % for men and 35.5 % for women. However, racial disparities in obesity are significant, especially as it relates to AAW. During this same time frame, the prevalence of obesity was 33% for White women, 43.0 % for Hispanic women, and 49.6 % AAW. These disparities still persist even after controlling for socioeconomic factors and other social determinants of health (Bower et al., 2015).

Ross et al. (2019) examined the intersectionality of socioeconomic status (SES) and race and gestational diabetes (preeclampsia). They found that when compared to White women, AAW were found to be at a much higher risk for preeclampsia. Interestingly, a higher SES reduced the risk for preeclampsia in White women but had very little effect on AAW. Likewise, a higher SES incidentally projected longer gestational length through reduced preeclampsia risk among White women, but again, not for AAW. The results of this study are consistent with diminishing returns of higher SES for AAW with respect to preeclampsia.

Sociologists have grown progressively more alarmed by relentless racial disparities in health, a problem brought to the forefront of public health debates by the COVID-19 pandemic (Kirksey, 2021). AAW, a subset of Black Americans, suffer from greater seriousness of disease and higher rates of death than White Americans in both long-term and acute illness (Kirksey, 2021). Sadly, even after controlling for SES, these disparities remain the same. Early researchers focused on racial health disparities and merely documented the disparities. However, more recent social science examinations have sought to provide details into the social and historical conditions that give rise to them Kirksey (2021) demonstrated many overlapping causes of racial health disparities, which included interpersonal and systemic racism and discrimination, chronic stress, and residential segregation. Critical race theory is largely based on race equity and social justice principles while encouraging the advancement of solutions that bridge gaps in the areas of health, housing, employment, and other factors that influence conditions of living or have been deemed social determinants of health (Ford & Airhihenbuwa, 2010).

Physical Health Challenges of AAW

Lundeberg et al. (2023) reported AAW in the U.S. die at two and a half times the rate of White women and three and a half times the rate of Hispanic women. Epidemiologists have shown AAW experience some diseases at a higher rate. However, those risks should be diminished by access to universal healthcare. Researchers have largely attributed these racial healthcare disparities to access to healthcare, as well as several other social determinants of health. Numerous racial inequalities exist throughout modern medicine and have become the hub in distinguishing and addressing modifiable risk considerations for diseases.

Health disparities are viewed through several considerations including infant mortality, heart disease, and cancer (Gee & Ford, 2011). Racial health gaps date back to some of the earliest health records in this country with AAW having poorer health than Whites across a broad range of health status markers (Williams & Sternthal, 2010). There is ample quantitative data on the continued existence of racial health disparities that remain in 2023. Studies researchers conducted as far back as the 1950s show how both race and gender are key variables in health outcomes (Williams & Sternthal, 2010). When considering how racism affects the lives of People of Color, it seems not only practical but essential to examine the hypothesis that racism affects health inequities (Gee & Ford, 2011).

For decades, researchers debated how racism works at multiple levels, ranging from the individual to the structural (Gee & Ford, 2011). One author made the analogy of an iceberg where individual acts of racism such as a cross-burning are likened to the tip of the iceberg and operate at a micro level while laws and governmental practices operating at a systemic level are more dangerous, broad, and wide-reaching, just as the base of an iceberg below the sea level (Gee & Ford, 2011). Interventions and strategies that transform the iceberg's tip may do little to alter its base, resulting in structural disparities that remain intact, though less visible (Gee & Ford, 2011). Structural racism refers to the pathways in which implicit or explicit discriminatory practices based on race are rooted in equally reinforced systems of housing, education, employment and earnings, criminal justice, and healthcare policies that systematically handicap racial and ethnic minorities (Brown et al., 2022). As a result of these structural inequities, AAW often craft unhealthy social conditions in which they live, work, seek care, and age (Brown et al., 2022). Long-term exposure to social determinants of health may give way to continual and avoidable disparities in chronic illness (Brown et al., 2022).

According to Homan et al. (2021), intersectionality has become an introductory theory in contemporary social science research. A principle understanding from the literature on intersectionality is that methods of oppression such as racism, sexism, and classism are interlocking, mutually constituted, and reinforcing. Surprisingly enough, a large and influential body of work has developed within the field of medical sociology utilizing intersectional attitudes to make important provisions to the understanding of population health. Although new AIDS/HIV diagnoses among women in this country have declined in recent years, 7312 women were diagnosed in 2017.

Rosenthal and Lobel (2011) reported 60% of women diagnosed with HIV were Black, 20% were White, and 15% were Hispanic/Latina. One year earlier, women accounted for 24% of persons living with HIV in the U.S. In an estimation of just over one million persons living with HIV infection, 240,306 were women while 58% were AAW, 16% were White women, and 20% were Hispanic/Latina. Notwithstanding the disproportionate representation of AAW and Hispanic women/Latinas among U.S. women diagnosed with and living with AIDS/HIV, these marginalized groups are less likely to have access to or utilize HIV treatment and care services. AAW generally reported social and structural barriers such as HIV-related stigma by healthcare professionals, inadequate social support, and unmet needs beyond HIV treatment and care services (e.g., limited economic stability and lack of childcare, housing, and transportation) as reasons they did not seek healthcare services and or treatment. As a result, these barriers to HIV services function as a two-edged sword and contribute to escalated HIV-related morbidity and mortality.

Mental Health Challenges and AAW

An imbalance between stressors and stress responses has been known to be a causal indicator of physical ailments such as high blood pressure (Inoue, 2014). Hypertension or what is commonly known as high blood pressure, is a weighty public health concern affecting nearly 80 million American adults (Spence et al., 2019). Furthermore, high blood pressure is a chief or contributing cause of death for more than 400,000 Americans each year and poses a risk factor for other health issues such as heart disease and stroke (Spence et al., 2019). AAW fall prey to a sizable number of barriers to mental health services that are partially the result of the historical treatment and abuse, coupled with the contemporary issues of anti-Black racism (Coombs, et al., 2022). Major depression is a leading cause of disability in the United States, yet AAW continue to endure real treatment barriers, available to White Americans but elude AAW. Many of these barriers to mental healthcare services are created out of historical and ongoing issues of racism that operate on systemic, institutional, and interpersonal levels throughout the daily life of AAW. For example, treatment barriers can include stigma and distrust of medical organizations, both of which have been influenced by a long history of misdiagnosis and pathologizing of AAW (Coombs, et al., 2022). Researchers have documented racial disparities in the mental healthcare system (Kawaii-Bogue et al., 2017). However, evidence-based mental health service delivery protocols for racial and ethnic minority groups in the U.S. are still considerably underdeveloped (Kawaii-Bogue et al., 2017).

As mentioned, social determinants of health influence how mental health care is delivered (Kawaii-Bogue et al., 2017). However, AAW have remained on the edges of both public policy efforts and social science research (Erving et al., 2021). On March 22, 2016, Congress announced the formation of the Congressional Caucus on Black Women and Girls. This caucus was the first of its kind and devoted solely to public policy efforts that remove barriers and disparities experienced by Black women and girls (Erving et al., 2021). The goal of the caucus was to “give Black women a seat at the table for the crucial discussion on the policies that impact them while also providing a framework for creating opportunities and eliminating barriers to success for Black women,” (Erving et al., 2021, p. 116).

Researchers whose focus is on AWW, revealed social determinants of health for both specific gendered and racialized groups (Erving et al., 2021). For clarity, combining intersectionality and stress theory, allows researchers to highlight why there maybe heterogeneous health effects among AAW while understanding how the stress process model focuses on what possible causes or factors may contribute to AAW's health (Erving et al., 2021). Previous investigators demonstrated how AAW contend with a complicated system of unequal and ineffective mental health care experiences. Although they have a reduced occurrence of mental illnesses than other ethnic groups, mental illnesses are significantly more severe and persistent in AAW, possibly due to ineffective access and treatment generally offered to marginalized population groups (Kawaii-Bogue et al., 2017).

With a special focus on the specific social positioning of people at the juncture of multiple-layer systems, the intersectionality basis stresses the interwoven yet equally supporting relationships among multiple systems of oppression (Erving et al., 2021). One form of stratification such as racism cannot be wholly comprehended without giving equal consideration to how it works in tandem with another form of stratification, sexism (Erving et al., 2017) when it comes to examining access to healthcare in the US by AAW.

Furthermore, Lopez (2013) suggested race and gender must be taken seriously by health disparities researchers and implicitly calls them to anchor empirical research in racialized-gendered social determinants of health frameworks (Erving et al., 2021). Tying it all together, stress theory in the sociology of mental health research tradition can offer descriptive processes for understanding AAW's health and their access to healthcare. The stress process model suggests that lower social status is linked with higher exposure to stressors that yield a higher risk for mental and physical health problems (Erving et al., 2021). The stress process model further posits how prolonged exposure to stress is correlated with poorer physical and mental health (Pearlin, 1999), and can develop across different contexts such as the workplace, healthcare organizations, home, or social relationships, and romance. By establishing how AAW pilot their social lives through the eye of their racialized and gendered experiences, some stressors are more likely to affect their health (Pearlin, 2012). Finally, the stress process model floats the likelihood that the stress-health association may differ by social status, race, and gender, giving way to the notion that specific new and specifically designed interventions are necessary as a means to reduce the health disparities for this population (Erving et al., 2021). Sociologists who have identified certain social strata as being especially high risk for mental disorders, also seek to explain why these differentials exist (Pearlin, 2012). There remains a multiplicity of fields participating in the undertaking of discovering the root causes of mental illness However, a crucial component of phenomenological research focuses on the relationship between these causes and a person’s position within the culture (Pearlin, 2012).

Discrimination and Health

Discrimination, whether it is experienced as unfair or prejudicial treatment due to personal characteristics, has been experienced to some degree by close to two-thirds of the US population at some point in their life (Donnelly et al., 2019). The most frequently recognized reasons for experiencing discrimination are race/ethnicity, gender, and sexual orientation although individuals also experience discrimination due to other personal characteristics, such as age, weight, disability, and physical appearance (Donnelly et al., 2019). It seems as though the appearance of outright discrimination has been somewhat abbreviated in recent decades (Lennartz et al., 2019). However, a deeper look reveals that more understated, yet prolonged forms of discrimination are still real for many groups in our society (Lennartz et al., 2019).

Early theorists such as Hollinshed and Redkich (1958), Leighton (1959), and Rennie et al. (1957), laid the foundation work connecting the effects of discrimination and social stress to the health disparities of minority populations, such as AAW (Dohrenwend, 1961). Researchers found evidence from both laboratory and community studies describing the damaging health effects of discrimination across a variety of mental health outcomes including depression, psychological distress, anxiety, and well-being (Donnelly et al., 2019; Hatzenbueler & Gates, 2017; Lennartz et al., 2019). Culturally competent healthcare providers are crucial to the efforts that successfully grasp, cut down, and eventually phase out healthcare disparities affecting AAW.

Thoitis (2010) also demonstrated evidence that women, racial and ethnic minorities, sexual minorities, and members of other marginalized groups reported both more lifetime discriminatory events and day-to-day discriminatory stressors than their higher-status counterparts. Unfortunately, this is the case in healthcare settings. The patient-provider relationship for AAW is often less than optimal due to perceived discrimination (Washington & Randall, 2023). Perceived discrimination is defined as “a behavioral manifestation of a negative attitude, judgment, or unfair treatment toward members of a group.” (Washington & Randall, 2023, p. 883). With consideration for AAW, perceived discrimination is a chronic stressor adversely affecting their physical and mental health along with their quality of life (Washington & Randall, 2023).

AAW reported experiencing discrimination in numerous medical settings (Washington & Randall, 2023), even across multiple socio-economic demographics. Discrimination in medical settings has shown itself to be harmful. It can weaken and sometimes destroy the patient-provider relationship as a result of miscommunication and a perceived lack of respect. The results often negatively affect the quality of the overall healthcare experience. Lastly, provider-based discrimination can lead to greater unmet needs, dissatisfaction with healthcare interactions, and ultimately a delay in seeking care altogether (Washington & Randall, 2023).

Obtaining and attending to patient preferences is central to creating a therapeutic alliance when constructing treatment plans with individuals with depression (APA, 2018; Gelhorn et al., 2011). Empathetic care and concern for patient preferences result in better outcomes, increased compliance, and more cost-effective care for depression in addition to other mental health conditions (Sonika et al., 2020). However, eliciting preferences for depression treatment among racial/ethnic minorities is complex. In most instances, those with diverse cultural attitudes towards mental healthcare are more prone to have experienced discrimination in past healthcare encounters and face large disparities in access to care generally and to psychiatric medications specifically (Sonika et al., 2020). These factors may directly influence treatment preferences or change how patients value treatment options in tradeoffs with factors such as provider trustworthiness or accessibility.

Social Stress and Systemic Barriers to Health Care Access

With regard to healthcare practice and policy, the research on access to healthcare is large, diverse, and complex (Dixon-Woods et al., 2006). The research on access to healthcare includes empirical work using both qualitative and quantitative methods, in addition to editorial comments, theoretical work, case studies as well as policy documents and political statements (Dixon-Woods et al., 2006). The general phrase "access to healthcare" has not been consistently defined or operationalized across a field of study. Furthermore, there is substantial additional literature, including those on quality in healthcare, priority-setting, and patient satisfaction (Dixon-Woods et al., 2006). One researcher defined access to healthcare as the satisfaction of healthcare providers with respect to the needs of minority populations (He et al., 2020). The author continued the argument by adding healthcare access, which generally refers to the feasibility of obtaining needed medical services and includes having health insurance, affordable copayments, and primary care providers (He et al., 2020).

Prompt access to mental health care is critical for the success of the treatment (Whaibeh et al., 2019). This is especially so for persons with severe or chronic mental illnesses (Whaibeh et al., 2019). The Institute of Medicine (IOM) (2011) defined access to healthcare as "the "timely use of personal health services to achieve the best possible outcomes" (IOM, 2011, p. 61). Barriers to accessing high-quality care can be deemed both personal and structural, with many AAW facing both types of barriers (IOM, 2011).

Personal-level barriers include individual expressions of racial discrimination, stigma, bias, or cultural competency, which create significant obstructions for AAW who attempt to access high-quality care.

Whaibeh et al. (2019) referred to structural-level barriers as health care systems at the institutional level. These barriers operate despite the attitudes of individuals. An example is how excessively long waiting lists to access outpatient appointments have been known to discourage those in need of care from seeking the help they need. Other examples of such barriers include health insurance, lack of training in ethnic health received by providers, and the location of the healthcare facility.

Researchers documented the substantial differences between the numbers of psychiatrists in urban areas as opposed to rural areas. Whaibeh et al. (2019) reported how care settings have found it particularly challenging to recruit mental or physical health care providers in rural regions, thus limiting the access of such communities to needed services. Accordingly, patients in more rural areas have to travel long distances to reach a provider or end up being discouraged altogether by the geographical barrier and travel costs associated with this over-extenuating barrier to health care. Because many healthcare providers are located in more urban and metropolitan areas, transportation becomes critical for the elderly, people living with disabilities, and those living in distant rural areas. AAW in the US who encounter the above challenges are poorly served by the healthcare delivery structure, while at the same time facing discrimination from certain healthcare providers and prejudice from medical institutions.

Careful consideration must be given to additional barriers at the state level. For example, lawmakers in Idaho passed two bills consenting businesses to legally refuse service to clients solely based on their alleged sexual or gender minority status, as well as withdrawing local laws that ensured the civil rights of AAW to healthcare (Whaibeh et al., 2019). Such laws magnify social stress, stigma, and discrimination against AAW, prevent them from searching for mental and physical health care services, and in many cases, discourage them from divulging important health information to their providers (Whaibeh et al., 2019).

Social and ethnic inequalities in access to and outcomes of healthcare services among patients are well documented (Nyholm et al., 2018). Some of the primary reasons for the disparities include a complex interchange of circumstances at the patient, provider, and organizational level (Nyholm et al., 2018). Examples of these circumstances and influences may include few psychosocial resources, low health literacy, language obstacles, and shortage of time. It is also important to note how healthcare professionals' lack of cultural competencies often affects the inequalities in access and outcomes for AAW (Nyholm et al., 2018). In many cases, disparities are generally measured from a population level. However, social classifications such as ethnicity and social position are not fixed, but rather complicated, variable, and context dependent. In healthcare exchanges, social classes reveal an institutional context of differential relations of power between patients and their healthcare professionals (Nyholm et al., 2018).

Cultural Competency

Another significant barrier to healthcare access that AAW faces is often the scarcity of culturally competent clinicians. Cultural competency is defined as “the ability of the healthcare providers to understand the cultural influences necessary to guide the treatment of patients belonging to a specific community” (Whaibeh et al., 2019, p. 426). The National

Alliance on Mental Illness (NAMI) advocates for community partners and healthcare providers to employ the use of culturally competent staff to understand the needs of AAW (NAMI, 2014). Current literature on the health disparities of AAW has studied systemic barriers to healthcare. Mental and physical health clinicians are expected to have some level of self-awareness of the direct as well as indirect assumptions, biases, and values they demonstrate to their patients (Whaibeh et al., 2019). The unavailability of culturally competent clinicians originates from the lack of training of healthcare providers on how to address care with diverse individuals (Whaibeh et al., 2019). It has been noted that when cultural competence training is available, it is rarely a mandatory requirement for healthcare professionals (Whaibeh et al., 2019). Continued experience with AAW patients and formal education on their specific health needs may be necessary to achieve cultural competency (Nowaskie, 2020).

Hatzenbuehler (2009) and Meyer et al. (2008) investigated how social factors, such as discrimination and social exclusion, expose AAW to stressors that intensify their risk for undergoing physical, as well as mental health problems. Romanelli and Hudson (2017) defined access to healthcare as a sequence of occasions to “identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to be offered services appropriate to the needs for care" (p. 715).

Healthcare access problems at the systemic level often result in barriers to healthcare for AAW seeking care. The lack of competence in ethnic and racial care is another problem for AAW. As suggested by the aforementioned minority stress model, explicit stigma and prejudice can lead to the internalization of stress (Meyer, 2003; Nowaskie, 2020). Accruing continual amounts of stress over time can ultimately present adverse health outcomes. In addition to demonstrating their shortcomings in education and cultural competency, providers can harbor prejudices and negative attitudes (Nowaskie, 2020). Noting past studies, Nowaskie (2020) related that increased amounts of contact with varying types of racial minorities can lead to reduced levels of implicit bias while delivering cultural competency training renders improved knowledge that includes best practices for treatment, diagnoses, and medications for diverse patient ethnicities. As a result, it may require both exposure to patients and formal education to provide the desired level of cultural competency with respect to minority populations (Nowaskie, 2020).

There has been a highly noticeable increase in the impetus to ensure culturally competent provision of health services (Sue, 2006). This momentum has been coupled with questions about the meaning, usefulness, and precision of cultural competency. The philosophy and practice of cultural competency have emerged, largely due to past inadequacies in health care and research with culturally diverse populations. Cultural competency has been acknowledged as being critical in encouraging effective health care to all populations (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2001), in addition to the notion that strategies for cultural competency have been established not only state and local level, but also national organizations (APA, 2002) and federal agencies (Center for Mental Health Services, 2000: Sue, 2006).

Impact of Stress on AAW

Health disparities among AAW are pronounced, persistent, and pervasive (Sonika et al. 2020). Racism can be considered one the basis of these inequities. Empirical research finds AAW who report facing racism suffer worse health outcomes than those who do not report it (Gee & Ford, 2011). Significantly, this method of research has been vital in moving the debate from inherent differences in biology or culture to social exposures. However, insufficient consideration of the multiple aspects of racism, particularly structural racism, becomes a constraint. Stressors such as unequal access to healthcare, are explicit examples of minority stress directly affecting the psychological health and well-being of AAW (Arguello, 2020). They are linked to increased risk for depression, anxiety, chronic stress, and other physical as well as psychological and mental health outcomes. When making an allowance for AAW, minority stress takes into account five interacting components that are attributable to elevated stress levels of sexual minorities (Meyer, 2003).

Consider as an example, how an experience of racial violence or discrimination is likely to intensify awareness and expectations of mistreatment. It is common for minority status to lead to personal identification with the person’s minority status. As a result, minority identification can lead to supplementary stressors aligned with an individual's sensitivity to the self as a stigmatized and devalued minority (Meyer, 2003). In light of involving self-perceptions and appraisals, these minority stress processes are more proximal to the individual (Meyer, 2003).

The field of stress research is characteristically viewed as a sub-specialty within medical sociology, a point of view that conceals commonalities with more conventional sociological fields of study (Aneshensel, 1992). This elevates in importance when it comes to social stratification. This is a result of stress researchers adopting ways of organizing theory and research more applicable to medicine than sociology. To illustrate this, stress research is typically concerned less with the sources of stressful life experiences than with the effects of such experiences in terms of illness or psychological disorder (Aneshensel, 1992). Kawaii-Bogue et al. (2017) reported on the stressful effect of discrimination in healthcare, which contributes to increased rates of psychological disorders among AAW. However, as STS progressed, it became increasingly apparent how social associations matter to both the roots and significances of stressful life experiences (Aneshensel, 1992). Stress is a widely known contributor to many healthcare issues, both mental and physical. As a minority population, the level of stress endured by AAW goes far beyond the everyday life stressors (Aneshensel, 1992). This is due to unwarranted social stress that can be systemic in multiple areas of life for AAW. Discrimination, stigma, bias, marginalization, abuse, and violation of civil rights factor into how, when, and if AAW access health care when needed. Social Stress has accounted for many of the access to health care issues identified by AAW. National data has shown racism, bias, stigma, prejudice, and discrimination that AAW experience as ’minority stressors’ can adversely affect health and well-being (Fingerhut & Frost, 2020). Mental as well as physical health professionals must be able to draw upon evidence-based protocols and best practices to ensure the healthcare system is meeting the mental health needs of racially and ethnically diverse clients (Kawaii-Bogue et al., 2017).

Stressors, attributable to experiences of discrimination in social environments, such as healthcare settings, are undesirable to marginalized populations (Aneshensel, 1992). The model of social stress extends stress theory by proposing that circumstances in the social environment, in addition to personal events, are foundations of stress that may lead to mental and physical ill effects (Meyer, 2003). It is concluded that social stress can potentially be projected to have a robust influence on the lives of people belonging to marginalized social categories, including those related to socioeconomic status, race/ethnicity, gender, or sexual minorities (Meyer, 2003). With regard to these constructs, prejudice and discrimination related to low socioeconomic status, racism, sexism, or homophobia, can prompt changes necessitating manipulation of self and can therefore be theorized as stressful (Meyer, 2003). An early adopter, Dohrenwend (1973) described life-event stressors as “objective occurrences of sufficient magnitude to change the usual activities of most persons” (Aneshensel, 1992, p, 17). The initial thought of any change as stress-provoking has given way to an understanding of how adverse events are almost always psychologically distressing, while other attributes such as whether events can be manipulated or predicted are of secondary importance (Aneshensel, 1992).

Over the years, consideration has shifted to social-psychological factors, which regulate the impact of stress (Aneshensel, 1992). Dohrenwend’s 1973 study documented that social stress and psychological symptom scores were positively correlated. The study amplified a link between the biased social system and the distress of the individual (Dohrenwend, 1973). One of the most preeminent factors is the concept of social support (Aneshensel, 1992). Descriptions of support are plentiful, but most take into account whether a person's basic social needs such as affection, esteem, approval, belonging, identity, and security, are satisfied through interaction with others (Aneshensel, 1992). Socioemotional support is associated inversely with assorted types of psychological disorders, physical morbidity, and mortality (Aneshensel, 1992). A chief concern is whether social support behaves as a stress buffer, improving its harmful effects (Aneshensel, 1992). Aneshensel (1992) described the mental health effect of stress as buffered by emotional and recognized social support, and not merely by membership in social networks Supporters of early social stress perspectives argued that low socioeconomic groups and other marginalized groups such as sexual minorities, demonstrated high rates of disorder because members of these groups disproportionally faced difficult, harsh, or traumatic life conditions (Aneshensel, 1992). The fundamental viewpoint on social stress theory recognizes stress both as a consequence of a person's location in the social system and as a contributing factor to some unknown outcome typically in the realm of psychological distress (Aneshensel, 1992). The central connections are between social position and psychological distress (Aneshensel, 1992).

With over 50 years of study, the amassed body of knowledge concerning social stress theory has significantly influenced the understanding of the forces affecting the well-being of people (Pearlin, 1999). Empirical analyses of stress have transitioned in many directions, assessed multiple levels of social and personal life, and engaged in an array of issues related to stress (Pearlin, 1999). STS cannot be boxed into a set of rules, used to rigidly follow all inquiries into social stress (Pearlin, 1999).

STS was envisioned as useful to sociologists who seek to integrate and underscore characteristics of social and economic life into accounts of the health and well-being of people (Pearlin, 1999). STS offers a practical theoretical framework to explain health disparities among marginalized groups (Meyer et al., 2008). This framework, labeled as a sociological concept, views social conditions as a source of stress for members of disadvantaged social groups (Meyer et al., 2008). This stress, in turn, can cause disease or lead to mental disorders (Meyer et al., 2008). Even today, with the increased marginalization of groups, social stress is a key variable in the complicated and multifactorial etiology of numerous psychiatric disorders (Troisi, 2020). Loneliness, discrimination, financial hardship, stigma, marital conflict, unemployment, infertility, or death of a loved one, are life events or conditions linked to a greater risk of psychopathology (Troisi, 2020).

Within the last two decades, social stress theorists' understanding of the aspects connecting social stress and disease risk has markedly expanded (Troisi, 2020). Troisi (2020) published a review tackling the relationship between stressful life events and increased risk for medical and psychiatric disorders. The researcher examined the pathogenic effect of stressors considered hazards to one's social status, self-esteem, identity, or physical well-being, all interconnected to the lived experiences of AAW and their access to healthcare (Troisi, 2020). As hinted by the thought-provoking title, *Ten surprising facts about stressful life events and disease risk*, the crucial message was to highlight the continuing misinterpretations and limitations in the literature making it problematic to provide clear responses to the question of how stressful events might alter disease pathogenesis (Troisi, 2020). Nonetheless, many empirical and clinical matters are still under debate (Troisi, 2020). I sought to add to the existing findings by exploring AAW narratives of life experiences when accessing healthcare.

Summary

AAW have specific healthcare needs but are susceptible to disparities. A lack of skills and knowledge on the part of healthcare providers can hurt their ability to access care and improve health outcomes. Unfulfilled mental and physical health care needs as a result of perceptions of access to culturally competent health care providers are quite common among AAW. Often having their needs overlooked or overshadowed by systemic norms of the dominant culture greatly reduces mental and physical health access to health care for AAW.

In conducting this study, I explored AAW perceptions of the knowledge and attitudes of medical professionals they have encountered and their health needs. One of the limitations was the lack of interpretive qualitative studies on AAW as a group. Instead, most studies group AAW in with the other minority groups, or fail to address the interconnectedness of race, gender, and socioeconomic status. Lastly, this study was conducted as a means to improve access to healthcare for AAW, minimize the disparities in healthcare outcomes of AAW, and emphasize the importance of establishing pro-active healthcare standards geared specifically for the needs of AAW, in an effort to thoroughly develop culturally competent healthcare providers.

Romanelli and Hudson (2017) offered a working definition of access to healthcare as "a series of opportunities to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use healthcare services, and to be offered services appropriate to the needs for care" (p. 700). Existent quantitative literature demonstrated significant health disparities between AAW and other minority women as well as White women in regard to physical and mental health outcomes. What is not known is how AAW perceive access to healthcare from an interpretive qualitative analysis.

Chapter Three: Methods

Overview

The objective of this phenomenological study was to explore the perception of access to healthcare through the lens of AAW in small Midwestern towns. Phenomenology is a method of study that originated as a philosophical undertaking focusing on the nature of experience from the perspective of the person experiencing the phenomenon (Connelly, 2010). This narrative has become to be known as known as “lived experience” (Connelly, 2010). As a phenomenological researcher, I will explore the qualities or heart of the experience through the use of interviews and stories of AAW about their experience with access to healthcare. Close attention is focused on the consciousness, as well as the content of the conscious experience, such as judgments, perceptions, and emotions of AAW and their access to healthcare (Connelly, 2010). Phenomenology places emphasis on humans as embodied beings, giving significance to how each experiences life through their physical bodies (Connelly, 2010). By doing so, this phenomenological researcher reveals what the experience was like to be in it and live it (Connelly, 2010). This research does not simply reveal the person’s reaction to the experience but delves deeply into the meaning it held for them (Connelly, 2010).

Design

In actualizing the outcomes of this qualitative phenomenological study, I explored the meaning of healthcare access among AAW. The study was conducted through the use of semi-structured interviews of AAW. As noted above, qualitative phenomenological methodologies are one of the most commonly used research designs (Simon & Goes, 2011; Smith, 2017). They are used to identify and define the meaning, structure, and the true essence of the lived experiences of a person, centered around a specific occurrence or experience (Simon & Goes, 2011). This design was used to make sense of and meaning of human behavior through the perception of AAW in the study.

The qualitative phenomenology design focuses on the lived experience of AAW accessing healthcare. Interpretive phenomenological analysis (IPA) was chosen as the design method because it was originally designed within the field of psychology to investigate the personal lived experience of research participants (Smith, 2017). IPA is a highly effective methodology used in the field of psychology to explicate the meaning, structure, as well as essence of the lived experiences of the person(s) or phenomena under investigation (Simon & Goes, 2011). As aforementioned the vast majority of current literature has been quantitative in nature and thus lacks a deeper understanding of human behavior when it comes to AAW and access to healthcare. IPA was used as a design method to go beyond current literature in an attempt to understand the discriminatory behaviors of healthcare providers from the viewpoint of AAW. IPA allows the meaning of a phenomenon to be described and understood through the eyes of the research participants (Simon & Goes, 2011). In addition, IPA employs a double-hermeneutic in that on one hand, the participant is trying to make sense of the world, while the researcher is trying to make sense of the participant trying to make sense of their world (Smith, 2004). IPA was chosen as the best option for this study because it offers manageable guidelines for understanding and using the methodological approach. Although readily available to use, the guidelines are generally high-level suggestions that can be adapted and developed by each researcher (Smith, 2004).

Phenomenological qualitative designs are common across multiple disciplines including psychology, education, and health care (Connelly, 2010). There are two chief phenomenological approaches used across studies, descriptive and interpretive (Connelly, 2010). Descriptive phenomenology was developed by Husserl, and interpretive phenomenology by Heidegger, one of Husserl's students who subsequently modified and built on Husserl's earlier work (Connelly, 2010). The approaches have developed in a widely used methodology called hermeneutic phenomenology. Clark Moustakas is cited as one of the foremost writers of phenomenological research, building on Husserl's original work (Simon & Goes, 2011). Husserl focused more heavily on the "whatness" of something. Followers often hold intuition and logical thinking as the primary avenue to arrive at a true understanding of a phenomenon (Simon & Goes, 2011). Moustakas, on the other hand, is credited for suggesting that research should place concentration on the wholeness of experience and a search for the essence of those experiences (Simon & Goes, 2011). Moustakas viewed both behavior and experience as a cohesive and inseparable relationship of a phenomenon with the person. The description of a heuristic process of phenomenological analysis includes immersion, where the researcher is involved in the work of the experience; incubation, a space for awareness and understanding; illumination, the active process to understand the experience; explication, or reflective actions; and creative synthesis where the researcher brings collected data together to show the patterns and relationships (Simon & Goes, 2011).

This history of phenomenology takes into account how human science makes the assumption that lived human experiences are always more intricate than the result of a single explanation. Users anticipate accessing an available component of indescribable parts of life (Slon & Bowe, 2014). Adopting this as a human science allows the researcher to gain added insight into the intricacy and breadth of peoples' experiences as they engage with the world in which they live (Slon & Bowe, 2014). Phenomenology takes on a rational perspective of life (Slon & Bowe, 2014). One can start with a broad definition of phenomenology by understanding it is a theoretical viewpoint advocating for the study of individuals’ experiences realizing that human behavior is determined by the marvels of experience, as opposed to objective, physically defined reality external to the individual (Slon & Bowe, 2014). It can be considered a methodology when it is used to harvest meanings for individuals through the examination of their language as spoken or written (Slon & Bowe, 2014). Employing hermeneutic phenomenology as a methodology necessitates the researcher to examine text or personal narratives, to reflect on its content in an attempt to learn something 'telling', 'meaningful', and 'thematic' (Slon & Bowe, 2014).

Novice researchers employing an analytical qualitative method must be careful not to make mistakes in identifying experiences and defining the meaning of a research participant’s experience (Slon & Bowe, 2014). One’s phenomenological view of experience is complex and often multi-dimensional (Slon & Bowe, 2014). Hermeneutic phenomenology when used as a research methodology, provides the greatest chance to ‘give voice’ to the experiences the researchers find in the context of the study (Slon & Bowe, 2014). The goal of a phenomenology study is to explain the meaning, structure, and essence of the lived experiences of a person, or a group attached to an explicit phenomenon (Simon & Goes, 2011). In the case of this study, the perceptions of AAWs' experiences with access to healthcare is the point of exploration. Phenomenological researchers attempt to understand human behavior through the eyes of each participant in the study (Simon & Goes, 2011). Obtaining a correct understanding of a personal narrative or text necessitates a hermeneutic analysis (Moustakas, 1994). The hermeneutic process is comprised of a circle through which scientific enlightenment transpires. By correcting biases or setting them aside, researchers can hear “what the text says to us” (Moustakas, 1994). Through this process, biases and prejudices are resolved in light of the text (Moustakas, 1994).

Using Phenomenology in Psychology Research

Beginning with the mid-1990s, there has been a substantial increase in the standardizing of using qualitative analysis in psychology research (Smith, 2004). As a result, the number of methodologies and approaches increased as well. One particular method that has seen widespread use in the field of psychology is interpretative phenomenological analysis (IPA) (Smith, 2004). IPA is a qualitative method established within psychology for the investigation of personal lived experiences (Smith, 2017). IPA is typically characterized as having three wide-ranging fundamentals, an epistemological position, a set of rules for leading research, and a mass of empirical research (Smith, 2004). When used, IPA supports the discovery of details of the participants' individual lived experiences and how they make sense of what occurred (Smith, 2004). However, IPA also distinguishes that the chief role of the researcher is to make sense of what the participant shares their unique purview. Consequently, it is strongly associated with hermeneutic tradition (Smith, 2004).

IPA is significant because it is specifically focused on establishing empirical methodology (Smith, 2017). In fact, IPA functions as a double hermeneutic, because the researcher is trying to make sense of the participants, trying to make sense of their world (Smith, 2017). As a researcher, a significant skill in utilizing IPA is the ability to produce an interpretative study that is intricately connected to the account experience of the research participant (Smith, 2017).

Research Questions

Quantitative researchers use procedures to explore research questions in regard to causality, generalizability, or magnitude of effects (Fetters et al., 2013). In contrast, qualitative measures are applied to research questions to explore “the why” or “the how” a phenomenon occurs, to describe the nature of an individual’s experience, or to develop a theory (Fetters et al., 2013). The purpose of this research topic is for female minorities to explore and describe the meaning and impact of healthcare access in their lives. I explored two research questions:

CRQ: What do the experiences associated with healthcare access mean to African American Women?”

The CRQ assisted in exploring the experiences of African American women as they lived through each encounter with a medical professional and described those experiences.

GRQ: How do African American Women (AAW) describe the impact of race and racism in relation to healthcare access?

The GRQ explored the outcome of their experiences and how they were affected by them.

Setting

The researcher recruited participants from various social media platforms using Midwestern towns in the United States as a selection criterion to conduct the interviews. Before the 2020 census, the population of each town ranged from 5,000-198,000. Each of the cities was considered inner-city or suburban. No rural sites were selected. I selected cities of assorted sizes to increase variation. In order to capture multiple perceptions, the researcher allowed for maximum variation (Creswell, 2013).

Using Google Form to screen potential research participants, invitations to participants were placed on the researcher's Facebook and Instagram social media platforms. Word of mouth was also used to direct potential participants to the online Google Form. A brief phone conversation was held with each participant to discuss the purpose, timeframe, research questions, confidentiality, and format of the interviews. Interviews were scheduled within a three-week timeframe and took place at pre-determined times via Zoom or MS Teams.

Participants

The researcher selected 11 participants with several levels or categories of participant sampling (Creswell, 2013). Premier researchers in the field of qualitative studies have found that 10 interviews of participants are the ideal number to reach saturation, this study sought to include one to two participants per decade from the 1940’s-1990’s to increase variation (Creswell, 2013). Participants identified as African American. Participants interviewed were between 25 and 76 years of age, who were not currently employed in a direct care healthcare job, as this was an exclusion. All persons of varying socioeconomic status were invited to participate in the study. Snowball and convenience sampling were allowed as a means to garner referrals for the study (Velez et al., 2023). Snowball sampling is a method used to expand the sample population by having participants recommend other potential participants (Bogdan & Biklen, 2007). Each participant who completed the interview received a personalized thank-you card.

Procedures

Before beginning any sort of data collection, I submitted my proposal to Liberty

University’s Institutional Review Board (IRB) to ask for permission to conduct this study and collect all the necessary data. I have attached my approval letter and appendix to this study. I created a Google Form that interested participants could fill out with their contact information and answer screening criteria questions. The screening questions on the Google form ensured each participant is over the age of 18 and that they identify as an African American Woman. The questionnaire was displayed on Facebook and Instagram social media accounts for three weeks.

Once I received ten to fifteen responses to the Google Form and began the individual screening process. The first 11 participants to meet the screening criteria received a phone call to discuss the purpose, research design, and expectations for the study. At the end of the conversation, we scheduled an interview date. After my initial contact with the participant, I followed up by emailing a recruitment letter to confirm the details of our discussion. The recruitment letter and consent form were emailed to confirm participation and the requirements for completing the study. Data collection began immediately following the initial contact and the interview schedule was confirmed.

In an effort to ensure participation, I scheduled each interview on a day and time that was convenient for the participant. Prior to starting any interview, I asked each participant to sign a confidentiality agreement that explained my role as an instrument to collect data. Each video was recorded in addition to any personal notes I wrote during the interview. After each interview, I transcribed my notes while they were fresh, and to avoid lack of recall. The video recordings were not transcribed until after the completion of the last interview.

The Researcher's Role

One of the chief roles of the researcher is to conduct ethical research (Poth, 2019). This responsibility entailed accurately describing the procedures approved by the IRB to conduct the study and record the results of the interviews (Poth, 2019). As a researcher, I took certain care to protect the identity of the participants and the data gathered throughout this study. To mitigate researcher bias, especially since the study involved the personal narratives of human stories, the researcher gave special consideration and priority to removing content that could be considered prejudiced (Hogan Chapman, 2014). Past researchers have led readers to question findings because they believed there was evidence leaning toward a researcher's personal perspective or agenda (Hogan Chapman, 2014).

Data Collection

In-depth structured or semi-structured interviews are the most common method of data collection used in phenomenological studies (Simon & Goes, 2011). Utilization of this method was to yield the best results in garnering the research participant's detailed characterizations of their own experience (Simon & Goes, 2011). The goal of IPA research is not to confirm or refute stated hypotheses based on present literature, but rather the pronounced goal is to develop more comprehensive research questions that can ultimately lead to the collection of more extensive data (Smith, 2004).

The goal of data collection was to achieve observable, verifiable, and confirmable evidence responsive to the research questions, which will be outlined later in this chapter (Durdella, 2020). A qualitative design was selected as the method of choice because the goal was to understand and describe the meaning behind the words, terms, phrases, sentences/statements, and descriptive details each research participant shared (Durdella, 2020). The data was collected by talking with participants and listening to their personal narratives, and often traumatic experiences about their lives (Durdella, 2020). Adopting a theoretical framework, practical guidelines, and a widely used approach were effective applications of empirical research. It was also important to understand the importance of flexibility, responsiveness, and adaptability to changes that emerge while working in the field and was vital to the success of this study (Durdella, 2020). The human condition as a variable was not overlooked. As the success of the data sources of research participants evolved or fluctuated, it necessitated the researcher to adjust in a new direction while continuing to collect and gather data (Durdella, 2020).

Interviews

This researcher interviewed 11 AAW using a semi-structured interview process. The interviews began with the same nine questions, at which point the research participants began to share their lived experiences regarding accessing healthcare in a small Midwestern city in the United States. The semi-structured interview began with the following questions:

- Tell me a little about yourself in terms of the hobbies you like to do when you are not working.
- Tell me how you like to spend your holidays. With friends? With family?
- Please walk me through your experience as an African American Woman.
- How do you find culturally competent healthcare providers?
- Describe conversations and interactions with your healthcare providers as an African American Woman.
- Describe the difficulty of culturally competent access to healthcare as an African American Woman.

- How have your experiences with access to healthcare as an African American Woman impacted your life?
- How has your race contributed to increased levels of stress when it comes to accessing healthcare?
- Describe experiences of discrimination, prejudices, bias, and/or microaggressions in regard to your race and how it has affected your access to culturally competent healthcare providers.

Data Analysis

When conducting interpretive phenomenological research, it was important to ensure a good approach toward data analysis by using standardized techniques. As a researcher, I understood my objective during the data analysis phase was to make sense of the collected data as well as, identify recurrent patterns, similar themes, and relationships as well deeply delve into the information to reveal a novel understanding of the lived experiences of AAW and their access to healthcare (Braun & Clarke, 2021). This was done by immersing myself in the data, often reading and re-reading it several times. As a result, coding and mapping the data was a primary focal point of the analysis phase that took more than four weeks. Using an MS Excel Spreadsheet to transcribe, group, code, and sub-code over 200 data elements ultimately led to a total of four themes.

Errors in coding can result in misunderstandings or a distortion of the evidence. Interpreting the data is the dominant factor in IPA where the goal is to understand each participant's vantage point and how they make sense of their lived experiences (Smith et al., 2021). As an interpretive phenomenological researcher, it was critical to preserve a focus on the individual, emphasizing the unique personal experience of human nature, as well as an inductive approach to ensure the data for each of the participants was analyzed individually, eliminating as many theoretical constraints as possible (Smith et al., 2021). This process necessitated that the data for each research participant be copiously investigated on their own standings by executing a sole case breakdown of each participant's story (Smith et al., 2021).

The Process of Thematic Analysis (TA)

Reflexive thematic analysis consists of six steps as outlined in Braun and Clark (2021). It was important for the researcher to understand how TA is a system for "developing, analyzing and interpreting patterns across a qualitative dataset, which also involves logical processes of data coding used to develop themes. As a researcher, the ultimate goal and purpose of research is the development of "themes" (Braun & Clark, 2021, p, 4). Therefore, an understandable repetitious process is necessary. The first step in this process was to familiarize myself with the dataset. By doing so, I became profoundly and intimately familiar with the subject matter of my dataset, by immersing myself emotionally and intuitively in the dataset. In practice, this entailed a process of reading and re-reading my data, or listening to each of my recordings and making concise notes about any analytical thoughts or insights I may developed related to each data item or the dataset as a whole (Braun & Clark, 2021).

The second phase of thematic analysis is where the coding of the data begins (Braun & Clark, 2021). This is where I worked scientifically through my dataset with a fine-tooth comb looking for small elements of data that I coded as a theme. This process involved identifying segments of data that appear, "potentially interesting, relevant or meaningful for my research question", and where I applied succinct, analytically meaningful descriptions known as code labels to them (Braun & Clark, 2021, p. 35). The coding process was a specific and detailed focus, aimed at obtaining single meanings or concepts. In reflexive TA, the researcher codes across a series of levels (Braun & Clark, 2021). These levels can include anything from very explicit or surface meaning, called semantic, up to more conceptual or implicit meaning, or latent (Braun & Clark, 2021). This is how the researcher deduced the sub-codes from the more general codes.

Phase three is where I began generating initial themes (Braun & Clark, 2021). This process involved efforts aimed at identifying “shared patterned meaning” (Braun & Clark, 2021, p. 35) across the dataset. I assembled groups of codes and sub-codes that seem to reveal a common core idea or concept, and which might provide a meaningful ‘answer’ to my research questions. The process of theme development was an active process. Most researchers generally construct themes from the data, the research questions, as well as the researcher’s knowledge and insights. Summarily, codes generally capture a specific or a particular meaning, while themes describe broader, shared meanings (Braun & Clark, 2021).

In phase four, I continued to develop and review themes (Braun & Clark, 2021). The task in this phase is to assess the initial fit of my originally identified themes from the data and the viability of my overall analysis, by going back to the full dataset for review. This iterative process of development and review involved checking that themes make sense in relation to both the coded extracts, and the full dataset (Braun & Clark, 2021). Initial themes (sub-codes) were collapsed together, while others split into new themes. Additionally, there were a few that were discarded altogether if they were found to have no relevance to the research questions (Braun & Clark, 2021).

In phase five, a good deal of work was done to refine, define, and name themes (Braun & Clark, 2021). In this phase, I fine-tuned my analysis by ensuring each theme was distinctly differentiated and built around a strong core concept or essence. Important actions in this phase involved choosing a concise, effective, and informative name for each theme (Braun & Clark, 2021).

The sixth and final phase was where I wrote up my findings from this process (Braun & Clark, 2021). It makes sense that writing is an essential phase of the analytic process for TA, so it was just as important to start writing early in the analysis. In reflexive TA, formal analytic writing most often starts in Phase 3; however, more informal writing (notes for me) was typically done from the start of the process. Techniques such as familiarization notes and reflexive journaling fed into the more formal writing. In the last step of TA, compilation consisted of finessing and finishing the writing process (Braun & Clark, 2021). Following each of these six steps in this process allowed me to "weave together my analytic narrative and vivid data extracts, to tell my reader a coherent and persuasive story about the dataset that addressed my research question" (Braun & Clark, 2021, p. 36).

Understanding Interpretive Phenomenological Analysis

Emphasizing the unique personal experience of human nature required engaging in an in-depth manner with the transcripts and participant stories, making probing notes on the participant’s explanation, identifying practical declarations from the notes, gathering them together into a logical format, and constructing an individual table of personal experiential themes for the case (Smith et al., 2021). The interpretive analysis involved reporting my understanding of the participant’s account of and reasoning about their experience as opposed to capturing an untainted experience in itself. My goal was to move beyond a purely descriptive presentation of the data to a formalized interpretive presentation. IPA proposes an intensive collection of procedural steps as outlined in this section, which qualifies all claims made to be evidenced-based, ultimately resulting in an increased validity of my findings (Smith et al., 2021). I set out to conduct a very thorough thematic analysis of the data collected by ensuring a systematic approach to coding the data as I sought to uncover themes (Braun & Clarke, 2021). This design involved a reflexive approach as a subjective, situated, aware, and questioning researcher, which is a fundamental characteristic of thematic analysis (Braun & Clarke, 2021). Researchers using reflexive analysis practice critical reflection on their role; as well as the process taking place (Braun & Clarke, 2021). It is a very disciplined practice of critically interrogating what we do as a researcher, the hows and whys of what we do, and the influences of our actions on our impending research (Braun & Clarke, 2021). This is a significant shift from the more traditional paradigms of quantitative research. Qualitative paradigms can generally be broader, focused on meaning, and aim to generate contextualized knowledge (Braun & Clarke, 2021). Quantitative paradigms have traditionally been geared more toward recording and understanding truth while seeking to explain models and theories (Braun & Clarke, 2021). Another distinct difference between qualitative and quantitative paradigms is in the researcher's role. Qualitative research calls for the researcher to become a situated interpreter of meaning, and a subjective storyteller, as subjectivity is valued in qualitative studies (Braun & Clarke, 2021). Conversely, quantitative researchers are impartial observers of the object of the study and an unbiased reporter of the facts.

Researchers in the field of qualitative study would argue that there is no solitary or absolute correct IPA methodology (Smith et al., 2021). However, the objective of the analysis progression and the write-up that follows is to advance through an orderly sequence of steps that are documented in such a way that another researcher could review and replicate the audit trail the previous researcher followed (Smith et al., 2021). Braun and Clarke (2021) outlined six phases of thematic analysis: (a) the dataset; (b)coding the data; (c) the initial generating of the theme; (d) theme development; (e) refining the theme; and (7) writing up their findings or what was uncovered. Combined, these skills are critical to qualitative research (Braun & Clarke, 2021). Throughout the course of the investigation, an interest in process and meaning is developed and outweighs cause and effect. The researcher utilizes a critical and questioning approach to life, as well as knowledge (Braun & Clarke, 2021). The researcher also employs them to actively read and listen to the data in an analytical fashion. In some cases, it involves the ability to tolerate to a certain degree, a level of uncertainty (Braun & Clarke, 2021). When all are achieved, Braun and Clarke (2021) described the researcher as having attained qualitative sensibility.

Ten Core Assumptions of Reflexive Thematic Analysis

The first assumption is a researcher's subjectivity is the primary or foremost tool for practicing reflexive thematic analysis. They understand knowledge generation is fundamentally both situated and subjective (Braun & Clarke, 2021). The subjectivity of the researcher is to avoid mitigating, controlling, or managing but rather used as a resource for doing qualitative analysis. As a result, researcher bias has no bearing and makes little sense within the realm of reflexive thematic analysis (Braun & Clarke, 2021). The second assumption is when conducting qualitative research, analysis, and interpretation of data cannot be deemed accurate or objective but can be determined as weak or strong. This means data may be underdeveloped, unconvincing, superficial, or even shallow. When this occurs, the researcher seeks to find ways to make the data more compelling, complex, nuanced, insightful, or deeper (Braun & Clarke, 2021). Good coding is the focus of the third assumption and may be achieved alone or through the use of a collaborative effort (Braun & Clarke, 2021). Collaborative coding boosts understanding, interpretation, and reflexivity, as opposed to reaching a consensus about the data coding itself. The fourth assumption finds its way into the application of reflexive thematic analysis through a dual process of immersion and depth of engagement, coupled with giving the developing analysis some distance to engender good quality codes and themes (Braun & Clarke, 2021). The fifth assumption ascertains that themes are patterns fastened by a mutual idea meaning, or concept. In other words, themes are not simply brief summaries of everything concerning a topic (Braun & Clarke, 2021).

Themes are analytic outputs, built from codes and cannot be rushed or identified prior to the analytic process (Braun & Clarke, 2021). Understanding analytic outputs is the sixth assumption of reflexive thematic analysis. Assumption number seven posits that themes typically do not inertly appear from the data, but rather actively shaped by the researcher through a methodical engagement with the dataset (Braun & Clarke, 2021). Assumption number eight confirms data analysis is always reinforced by theoretical assumptions requiring recognition and reflection (Braun & Clarke, 2021). Finally, assumption ten relates data analysis is conceptualized by the experts in the field as an art, and not a science. (Braun & Clarke, 2021). A researcher's creativity is central to the process. In summary, one of the important advantages of reflexive thematic analysis is it affords qualitative researchers a great deal of flexibility. This changeability of reflexive thematic analysis is one of the motives behind the researcher needing to be active, engaged, and considerate about the approach they take (Braun & Clarke, 2021).

In many cases, the composition of a qualitative study involves a single case study. However, this interpretative phenomenological analysis (IPA), had a number of participants. Consequently, once I independently explored and examined all accounts, the subsequent phase encompassed comparing across cases (Smith et al., 2021). This phase of the analysis involved looking for common patterns and idiosyncratic differences within those similarities and how one case may shed light on another (Smith et al., 2021). I wrote out the results of interviews from the recorded session of each research participant and discussed the responses in a later section of this paper. My results include direct quotes from research participants who express lived experiences as a female sexual minority. I followed Yin's (2011) process of qualitative data analysis, which involved compiling data into a database or spreadsheet, disassembling or coding the data, finding themes, and reassembling the data as patterns emerged.

Braun & Clarke (2021) suggested there are multiple methods of conducting a thematic analysis of the data. When coupled together, the interpretative and analytic tools reflexive TA delivers can be used to yield robust analyses from comparatively straightforward descriptive records to more intricate, theoretically embedded ones (Braun & Clarke, 2021). The steps I took to analyze the data included familiarizing myself with the data, coding the data, developing theses, refining and defining the themes or patterns, and finally documenting the outcomes.

Trustworthiness

The trustworthiness of this research fell in line with Nutt et al., (2008) groupings of trustworthiness as it pertains to qualitative analysis, which includes the integrity of the data, the balance between subjectivity and reflexiveness, and clear communication of the results. Collectively, trustworthiness emphasizes the importance of the transferability, dependability, credibility, and confirmability of the research (Nutt Williams & Morrow, 2009). The researcher also took heed of the four characteristics of trustworthiness for qualitative researchers, applicability or transferability, consistency or dependability, truth/value, which is deemed as credibility, and neutrality or confirmability.

Credibility

Credibility is generally deemed to be the equivalent of internal validity in quantitative research (Thomas & Magilvy, 2011). It characterizes the degree to which the results of the study accurately describe reality (Thomas & Magilvy, 2011). Credibility depends on the richness of the information gathered and on the analytical abilities of the researcher. In interpretive phenomenological studies, it is the factor that affords others the ability to distinguish the experiences confined within the study through the interpretation of each of the participant's individual experiences (Thomas & Magilvy, 2011).

This researcher worked toward achieving credibility by examining the research for the representativeness of the data by assessing the individual transcripts from the interviews and looking for similarities within and across study participants (Thomas & Magilvy, 2011). The researcher established credibility by producing a truthful description and interpretation of the lived experiences of AAW's perceptions of access to healthcare. The researcher also used reflexivity, member checking, and peer debriefing to establish credibility (Thomas & Magilvy, 2011). Informant feedback/member-checking was achieved by returning to the persons from whom the data was collected as a means of confirming each interpretation established patterns, and categories, which was recognized by the participants as accurate representations of their experiences (Thomas & Magilvy, 2011).

Dependability and Confirmability

Dependability and confirmability are terms familiar to qualitative researchers and are equivalent to reliability in quantitative studies (Thomas & Magilvy, 2011). Dependability is achieved when other researchers can track the decision path unitized by the researcher (Thomas & Magilvy, 2011). This researcher used six elements to help establish an audit trail, including describing the purpose of the study, outlining how and why each participant was selected, detailing the data collection process, detailing the interpretive analysis of the data, presenting the interpretive analysis or findings, and establishing the credibility of the study (Thomas & Magilvy, 2011).

This researcher also established confirmability, which is similar to objectivity in quantitative analysis (Thomas & Magilvy, 2011). Confirmability is the culmination of transferability, credibility, and dependability (Thomas & Magilvy, 2011). This researcher took into account reflexivity, which necessitates a self-critical attitude in regard to how the researcher's personal preconceptions can likely affect the research. Practicing reflective research permits an all-encompassing view with interpretations that yield new understandings, permitting the developing confirmability of the research, which leads to the reader of the study to develop a sense of trust in the resulting credibility of findings and applicability of the study (Thomas & Magilvy, 2011).

Transferability

Finally, this researcher considered transferability as a significant facet of qualitative research. Transferability considers the possibility that what was found or observed in one context was applicable to another context. In qualitative language, transferability refers to the study's ability to transfer research findings or methods from one set to another investigation (Thomas & Magilvy, 2011). Transferability is equivalent to external validity in qualitative research (Thomas & Magilvy, 2011). The strategy this researcher used to establish transferability is providing a solid description of the people studied by providing descriptions of demographics and geographic boundaries used (Thomas & Magilvy, 2011).

Ethical Considerations

When conducting research on human subjects, practical, ethical, and even theoretical implications or boundaries are inevitable. Those vulnerabilities are even more heightened when researching areas involving minorities, as they have been known to reject traditional labels and be identified as a marginalized population. In consideration of this, surveys, questionnaires, or structured interviews were deemed appropriate or the best method to fully capture the lived experiences of AAW and their perceived access to health care. A semi-structured interview composed of open-ended questions requested each participant dig deep into their lived experiences and verbally recall their personal narratives, to produce the level of understanding and meaning for AAW in regard to healthcare access.

This study complied with all ethical codes and considerations outlined by the American Counseling Association (ACA). The researcher adhered to the basic ethical principles of human research participants such as respect for persons, beneficence, and justice described in the Belmont Report (1979). Respect for persons warrants that research participants are provided the prospect to elect what will or will not happen to them. When acceptable standards for informed consent are fulfilled, respect for the person is achieved. The researcher submitted this proposal to the Liberty University Institutional Review Board to obtain permission to conduct the study before initiating any contact with potential or actual participants.

Upon IRB permission, each research participant was asked to read, sign, and review a confidentiality agreement in the presence of the researcher. The researcher discussed all potential limits of confidentiality and fully disclosed how the participants' privacy would be protected by using pseudonyms for their names, and the names of the towns in which they live. The names of any local organizations, hospitals, persons, or entities mentioned in the interviews will also be changed to protect the privacy of the participants. The names of the locations of each interview were also protected. All data collected, and recorded was guarded by an encrypted cloud service accessed through my password-protected computer device.

Summary

The researcher conducted an interpretive phenomenological study focused on exploring the lived experiences of African American Womens’ perceptions of healthcare access. The purpose of this chapter was to provide specifics that described the design, the rationale, the participant selection process, preliminary research questions, the site description, and overall procedures for the study. I also described the role and significance of the researcher, in addition to the methods of data collection and analysis techniques for the study. Semi-structured interviews along with a demographic questionnaire were used to collect data. I conducted my role as a researcher by recording live interviews with each participant during the semi-structured interview. The data was coded to find patterns and themes for analysis and presentation of the research findings. Final transcriptions were reviewed with research participants to ensure accuracy.

Chapter Four: Findings

There are a significant number of empirical research projects revealing how AAW receive inferior quality service and care in addition to several degrees of difference in treatment when accessing healthcare in the U.S., as a result of their racial identity (Adebayo et al., 2022; Assari, 2018; Brown et al., 2022; Chinn et al., 2021; Dixon et al., 2023; Erving et al.,2021; Gee & Ford, 2011; Kawaaii-Bogue et al., 2017; Schorpp et al., 2021; White-Means & Muruako, 2023). These researchers have also reported overt as well as covert racism and micro-aggressions experienced by AAW in healthcare settings across disciplines, i.e. primary care, dentists, OB/GYN, mental health therapists, etc. Many of the authors documented experiences of limited information disclosure by healthcare providers, verbal dominance or condescending tones in conversation, dismissive attitude of healthcare providers toward patients' concerns (National Public Radio, 2017), as well as overall low-quality care (Adebayo et al., 2022). The purpose of this interpretive phenomenological study was to explore access to healthcare through the lens and lived experiences of African American women (AAW) in Midwestern towns throughout the United States. The Central Research Question (CRQ) of this interpretive phenomenological study was: "What do the experiences associated with healthcare access mean to African American Women"? The Central Research Question (CRQ) assisted in the exploration of the lived experiences of AAW as they encounter medical professionals and described in narrative form the details of each experience. The Guiding Question of this study was "How do African American Women (AAW) describe the impact of race and racism in relation to healthcare access? The Guiding Question addressed the outcome of their experiences and how they were affected by them.

Research Questions

The purpose of this research topic is for AAW to describe the meaning and impact of healthcare access in their lives. The Central Research Question (CRQ) this study will explore is: What do the experiences associated with healthcare access mean to African American Women? The CRQ will explore the lived experiences of AAW as they encounter medical professionals and describe in narrative form the details of each experience. The Guiding Research Question is: How do African American Women (AAW) describe the impact of race and racism in relation to healthcare access? The Guiding Research Question will address the outcome of their experiences and the effect.

In this chapter, I present the findings of the research. This includes expounding upon common themes that naturally developed during the researcher's exploration of responses to the nine semi-structured interview questions. Following this, I offer a reflexive self-analysis of the uncovered research. The researcher conducted a semi-structured interview with 11 AAW ranging in age from mid-twenties to late seventies. Each interview was conducted via MS Teams and lasted anywhere from 45 minutes to one hour and twenty-five minutes. I took notes and asked follow-up questions when necessary. The interviews were recorded with permission from each participant.

In Chapter Three I explained the six steps incorporated into the process of reflexive thematic analysis (RTA) used to conduct this research (Braun & Clarke, 2022). The steps were very closely followed to increase the validity and credibility of the research. By doing so, this research can be potentially replicated and conducted by other researchers. The author's RTA system has been widely used by researchers for "developing, analyzing, and interpreting patterns across a qualitative dataset" (Braun & Clarke, 2022 p. 4). When used properly, RTA employs logical processes of data coding or mapping, which supports the researcher in developing themes.

Process of Data Collection & Data Analysis

There was a total of 11 AAW interviewed for this study. Each of the women ranged in age from 25 to 77. Although each of the participants regularly visits OBGYN doctors, three of the participants have not had children. Of the three women who have not birthed children, only one of them is still within childbearing age. Two of the participants have not sought out mental health care professionals. The average age of the participants was 48 years old. All the women lived in the Midwest for at least 15 years of their lives. The interview consisted of nine interview questions, two of which were used to put the research participant at ease with the interview process by asking general conversational questions about their lives. The remaining seven questions were related to each of the research questions above. Follow-up questions were used with each participant to dig deeper and elicit organic meanings to the participant’s lived experiences. The interviews were conducted virtually using Microsoft Team. I took notes during the interview in addition to asking each participant if the session could be recorded. After each interview, the recording was downloaded and then manually transcribed using MS Excel. Once the final interview was transcribed, the researcher began organizing and reorganizing the data into distinct categories assigned to tabs within the Microsoft Excel spreadsheet. To ensure reliability and eliminate the possibility of researcher bias, I reviewed each of the videos for a second time and compared them to the transcriptions entered into the spreadsheet. Any missed data was added to the appropriate category in the spreadsheet. The researcher reviewed the data daily for three weeks, moving data from tab to tab, becoming intimately familiar with the dataset. This in-depth data analysis is the first step in RTA according to Braun and Clark (2022).

Additionally, I made phone calls to specific participants to ask clarifying questions in regard to data that was not easily transcribable. This process is called member checks (Merriam, 2016). The use of member-checking, which is also referred to as respondent validation, captures the original responses to initial findings from some of the participants who were interviewed (Merriam, 2016). The researcher employed this credible technique to ensure the true meaning of the respondents' answers to the questions. “This is the single most important way of ruling out the possibility of misinterpreting the meaning of what participants say and do and the perspective they have on what is going on, as well as being an important way of identifying the researcher's own biases and misunderstanding” (Merriam, 2016, p.246). The objective of this iterative process was to allow participants to identify their lived experiences contained within the researcher's interpretation. In some cases, the member-check process yielded some fine-tuning of the ideas shared during the interview resulting in a more precise perspective of the participant (Merriam, 2016).

As the researcher became more comfortable with the acquired dataset, they spent about 52 hours coding each element of the dataset to ensure the 63 categories of data contained within each of the tabs in the spreadsheet could be condensed down to a much more manageable size of seven sub-codes. The codes were used to group similar experiences and perspectives that were shared during the interview process. The process involved moving around more than 279 data elements between the seven codes. I consistently made reference to the recorded sessions, again to ensure accurate capture and depiction of the data elements. The coding process moved in three different directions as the researcher sought to make meaning of each specific response to the interview questions. Referring back to the research questions helped to ensure alignment with each data element. In a small number of cases, some data elements were not used after they were coded because they were not relevant to the study. This would not be possible without the researcher having spent detailed hours coming through the data.

As described above, ample examination and processing of each data element collected is another approach that serves well for researchers aiming to produce the most accurate picture of each participant's understanding of a phenomenon (Merriam, 2016). In regard to this particular research study, the number of people who needed to be interviewed was initially difficult to ascertain because the answer was dependent on the direction of the semi-structured interview and its results. Merriam and Tisdal (2016) suggested a good rule of thumb is to ensure the data and the early findings are saturated. In other words, the authors explained how researchers will begin to hear similar lived experiences or perspectives across several participants while little to no new information emerges as more data is collected. Other premier researchers in the field of qualitative studies have found 10 interviews was a good estimate to plan to reach saturation (Creswell, 2013). I captured the data elements from 11 interviews.

Theme Development

Through the exploration of the research questions, three common themes emerged among each of the AAW who were interviewed through the data collection, transcription, coding of the interviews, and member-checking. The process was iterative and involved laborious hours of reflection on the data. The resulting three themes were correlated to each of the research questions.

Participants

There were 11 African American Women participants selected for this study ranging from 25-77 years of age. The selection survey or screening questionnaire employed specific criteria used to exclude women who did not identify as African American and who currently provide direct care in a hospital or medical facility. Each of the participants was randomly selected after responding to a flyer posted on Facebook. One of the participants resulted from snowball sampling, as she was referred to the study screening questionnaire by her grandmother. The first 11 participants who met the selection criteria were contacted via E-mail and followed up with a phone call to discuss the interview logistics. During the preliminary screening phone call, the researcher reviewed the research title and research questions in addition to explaining the purpose of the research. I explained that each of the semi-structured interviews would take place virtually after the participant returned their consent form. The participants were informed that the semi-structured interviews were comprised of nine initial questions that should take no longer than one hour. However, in the event follow-up questions were necessary, the interview could take up to two hours, giving the researcher time to take notes. Finally, I explained that the participant was allowed to take short breaks during the interview or could stop at any time during the interview should triggering questions cause the participant any level of undue stress. They were assured the researcher would be watching for distressing signals if the interview caused the participant to have strong emotions reliving the experience.

The participant demographics ranged quite significantly, proving a good sampling and decreasing the possibility of bias. The participant demographics are contained below. They provided their lived experiences as AAW who were just entering their professional career, as well as women who were retired. The median age of the participants was 49.6. years old. Four of the 11 participants were married, and two were retired. Nine of the participants had some college experience, and six had achieved advanced degrees. Four of the participants sought medical care only in suburban areas, while five participants received all their care from inner city or major metropolitan areas. Two participants were regularly treated in both suburban areas as well as inner-city, large, metropolitan areas. Lastly, five of the participants had received health care benefits through government assistance for six months or more.

P1-NN

Participant P1-NN is a valued human resource professional with over 20 years of working for the city government. She has a bright and bubbly personality with a generally optimistic but cautious outlook on life. A former teen mom, Participant P1-NN stressed that, “from a young age I understood the importance of good healthcare and finding healthcare providers that you can trust.” P1-NN admitted that at 16 years of age, she was unfamiliar with the term culturally competent but knew the significance of, finding a good doctor who looked like me and understood the issues affecting Black maternity health. Additionally, P1-NN has an older sister who was in medical school when the participant became pregnant, and P1-NN considered it a, “salute to my older sister to find a Black OBGYN to deliver my first child.” Since then, P1-NN has always intentionally sought care from Black health care professionals.

P2-RH

Participant P2-RH is a highly educated AAW earning her doctoral degree in her early 30s. She is a qualified math educator who was originally born and educated in the

Deep South but moved north right before junior high school. Although she has made northeast Ohio her home since moving from the south, she regularly frequents the south to visit relatives. P2-RH stated that being raised in the South, she was no stranger to racism. Her first encounters with racism came in her early childhood at school. She described how she experienced it in her neighborhood grocery store, church, and family doctor, and added how encounters with racism followed her through college and into her career as a math educator. Participant P2-RH discussed how she was disappointed with the events currently happening in the US. She recounted how as a little child she thought things would be different if not better as she matured.

P3-CR

P3-CR similar to P2-RH had experience living in the north and the south, experiencing racism in both places. P3-CR recently relocated from the Midwest to the South and expressed how it was more prevalent in the South. She also faced racial discrimination in the workplace, and stated she found it, harder to attain promotions and advancements even though she excelled beyond her White peers. When P3-CR relocated to Georgia five years ago, she was excited to live in a middle-class Black community. However, she found her excitement soon to be overshadowed by both the overt and covert racism of the south, when going outside of her neighborhood to shop, visit her doctor, or enjoy weekend entertainment.

P4-NJ

Participant P4-NJ is also a career professional, employed for more than 12 years as a social worker. P4-NJ offered that although she has full healthcare benefits through her employer, she has confronted what she described as "poor-quality care, being ignored, intimidated, and overall disrespect of healthcare providers." This was similar to what she felt those she served experienced. She stated that she often advocates harder for her clients than she does for herself, but said she was going to work on advocating harder for herself. P4-NJ shared:

> It's sad but, my client base is low/no-income African Americans with little to no education and I feel that I have had many of the same experiences of discrimination, disrespect, and poor quality of care when dealing with White healthcare professionals as my clients.

She went on to express how socioeconomic status should not determine the treatment provided to those in need.

P5-KBF

P5-KBF is a career professional and community activist highly visible on a regular basis in her community. She holds an advanced degree, cherishes time with her children and grandchildren, loves traveling overseas, and believes in equal access and protection for all. Similar to P4-NJ she has had continuous healthcare insurance coverage and because she had been diagnosed with juvenile diabetes, it was, "poured into me as a child the importance of access to good healthcare." P5-KBF stated that when she was a young adult, the race of her doctor was less significant to her than the relationship they shared. She stated, "I needed to be able to trust my doctor more than anything."

P6-FCL

Participant P6-FCL is a former healthcare industry licensed professional who had been exposed to discrimination and racism at an early age. She and her siblings were one of four African American families at her high school. Her older brother, sister, and she as the baby of the family were the only graduating African Americans in each of their classes. Participant P6-FCL said:

> I remember teachers seemingly purposefully mispronouncing my name every single day throughout the school year…even despite my daily, deliberate, and articulate, correction of the short, and phonetically, accurate pronunciation of my name. I felt shunned, singled out and sort of made a spectacle on a daily basis going through this charade with some teachers. All it did was highlight the fact that I was the only African American kid in the classroom. It was as if my teachers put a daily spotlight on me and screamed through a bullhorn, "Hey, there's a Black kid in the classroom; and she’s different from us.

Participant P6-FCL fully admitted that during those early years of her academic journey, she was not familiar with the term stress, and did not fully appreciate the meaning of stressful situations, PTSD, anxiety, or microaggressions. However she offered, “I knew those experiences were not right, they were unfair, and they always made me feel uneasy. P6-FCL also shared that as an adult she has been a victim of workplace bullying, discrimination, racism, and microaggressions. Her frustration was directed at understanding how challenging it would be to break through the multiple barriers even after nearly 30 years of a stellar career in her chosen profession. Overlooked, passed up, and pigeonholed by who she described as, "less educated and less qualified White co-workers.” P6-FCL explained, “discriminatory practices have touched almost every area of my life from childhood through adulthood.”

P7-AB

Participant P7-AB is a young mom of one daughter who enjoys taking day trips together to visit museums, parks, and outdoor recreational activities. She has high expectations for her two-year-old daughter and is planting the seeds for her to be the family’s fourth-generation college graduate. Participant P7-ABgrew up in a suburban home in the Midwest, but now resides in a southern state. Understanding there what she described as, “significant differences in the two healthcare systems.” When participant P7-AB became pregnant with her daughter, she knew immediately she had to find an African American OB/GYN to provide health services through the pregnancy and delivery. At the onset of some complications late in her pregnancy, participant P7-AB felt unheard by her initial White doctor and regretted not following through with her first thought to find an African American OBGYN. After a series of emergency room visits and short hospital stays resulting in ongoing unanswered questions regarding her care, participant P7-AB called her mother 600 miles away in Ohio for help. Her mother bought a plane ticket and boarded a flight the same night. She drove participant P7-AB to Ohio the next day. Her mother had already made arrangements for her to be seen by her sorority sister at her OBGYN office. Participant P7 says she often thinks about other AAW who do not have those same resources and are not fortunate enough to be what she captured as, “blessed with the connections me and my mom have.”

P8-JB

Participant P8-JB was 76 at the time of her interview and was excited to be coming up on her 77th birthday. She has been retired a little over 10 years and enjoys spending time participating in a senior bowling league and walking her beloved dog who was given to her as a Christmas present from her daughter and granddaughter. Participant P8-JBgrew up in the age of a dawning civil rights movement, where racism, discrimination, bias, mistreatment, and abuse were common practice in this country. She recounts the story of the now infamous Tuskegee Experiment, where 600 African American men were recruited to take part in a medical experiment. They were promised medical care in an effort to find a cure for syphilis. Nearly 15 years into the study, it was uncovered that the men were not receiving medical care, but simply being monitored for the progression of the disease as it ravaged their bodies causing blindness, insanity, and other medical conditions; some died (Jones, 1981). Participant P8-JB shared:

> …effects and details of this study have always haunted me, and I have never trusted medical professionals as a young adult until now, especially White doctors. Although I don't trust White doctors, I’ve never sought out African American doctors but I’m always super excited when I happen to receive care from a Black doctor.

When she is randomly assigned an African American doctor, P8-JB says it gives her a sense of comfort and she is more compliant with their directives. P9-FDT

Participant P9-FDT is a retired high-level government administrator who has always been a stellar student from grade school through law school. She has one bi-racial biological child and one bi-racial adopted child who both identify as African American. Participant P9-FDT stated that she her government position afforded her the ability to have private healthcare. Additionally, the participant indicated that, “although, I lived in a suburban area I was always within 10 minutes of a major world-renowned hospital known for its quality care.” Participant P9-FDT stated that because the healthcare system she had used all her life was so widely known, she assumed they were culturally competent which led her to not seek out African American healthcare providers. Participant P9-FDT's father was a dentist and acknowledged her dentist was always Black. Her PCP was White, and she had been with her most of her adult life. However, she had to locate a new provider because of her pending retirement. She admitted not wanting to take the time to find a new practitioner.

P10-DB

Participant number P10-DB was the youngest research participant and had recently turned 25. She shared that she was:

> …beyond excited to participate in this study because I have zero trust in today's healthcare system and have high hopes that this study will shed light on the lived experience of African Americans and their access to healthcare. Just the thought of going to see a doctor gives me anxiety. Most times I feel like I am just a statistic to them. I am only five feet tall with a slightly heavier build, and my doctor only wants to focus on my weight even if I am describing symptoms to them that have nothing to do with my weight. Everything always comes back to my weight. I have years of healthcare providers repeatedly ignored my concerns, and as a result, a major health issue was overlooked.

Participant P10-DB adamantly prefers African American doctors, but they are often hard to find, especially specialty fields like mental health therapists and nutritionists.

P11-QP

Participant P11-QP is a top career professional in her field of technology where she admits that she:

> …cannot adequately put a number on the instances of racism and sexism that I have experienced throughout my life. I can recall a traumatic experience in my eleventh-grade year of high school where a White teacher that I had been having problems with for two years handed me a toothbrush and a trashcan in front of the entire class and told me to "get on your hands and knees and clean it because that's all you'll ever amount to I was humiliated that this exchange occurred despite the fact that I was in the top 10 in my class. I couldn't reckon that an adult would tell any child such a thing, especially one who was excelling in school.

Participant P11-QP admitted, “instances of overt racism from her youth motivated me to pursue higher education and even dedicate my doctoral dissertation to the teacher who told me that I would be scrubbing trash cans with a toothbrush the rest of my life.” Now as a double minority, her lived experiences paint a detailed picture of the intersectionality of gender and race and its impact on mental and physical health.” She further explained:

> It's hard enough working in a male-dominated field as a woman, but to be an African American Woman means you are going to be marginalized, questioned, doubted, discriminated against, and sexually harassed. I have had to constantly prove my worth in my company. I get so frustrated feeling like my level of education, certifications, and experience didn’t even get me a seat at the table! Sometimes, it got bad…it was sometimes debilitating where I had to pry myself out of bed just to live another day through the same discriminatory and racist practices.

Although P11-QP has never had an African American PCP, she wonders if her treatment and prognosis of some of her hereditary chronic diseases be different, if her provider was African American.

Results

The results of this study are based on a phenomenological approach. Although similar to a narrative approach where the study seeks to identify and account for the stories of experiences of a single individual, or maybe a group of individuals, a phenomenological study describes the common meaning for several individuals of their lived experiences as a general concept or a phenomenon in this case (Creswell, 2016). A phenomenological researcher tends to focus on describing what all participants have in common as they experience the particular phenomena, and in the case of this study, access to healthcare as an African American woman. The basic premise of phenomenology is to reduce single experiences with a phenomenon to a description of its universal essence (Creswell, 2023). In other words, the aim of a researcher who utilizes phenomenology as an approach is to gain a deeper order of understanding of the meaning of experiences in everyday life. The particular human experience for this study is access to healthcare for African American Women.

Guided Approach to Phenomenology

Most qualitative researchers follow a well-documented phenomenological approach to conduct their study. I also followed seven defining features of phenomenological studies to aid in theme development (Creswell, 2023). The first feature of a phenomenological study is to ensure the emphasis is on the phenomenon to be explored. Again, in the case of this study, the phenomenon to be explored is the lived experience of African American women and access to health care. The second step or feature of the study was the exploration of the lived experience with a group of African American women who have all shared similar experiences with access to health care. Because the researcher was also a member of the minority population targeted for the study, they made sure to bracket themselves, ideas, and experiences out of the discussion to eliminate researcher bias. This practice is referred to as reflexivity (Braun & Clarke, 2022), although Moustakas (1994) first coined the practice, epoche, Creswell (2023) credits a similar task to bracketing. Although the author stated these features do not necessarily have to be conducted in exact order, they detail the importance of the fifth feature of a phenomenological study; the interview or data collection phase conducted among individuals who have all experienced the same phenomenon. The purpose of this section Creswell (2023) described as a systematic data analysis approach, takes the researcher from narrow units of analysis to broader units, and then finally a descriptive essence of the phenomenon. The following are the common themes that emerged.

Theme Development

After several weeks of data analysis that included, bracketing and member-checking, three themes evolved from the researcher's dataset concerning the Central Research Question (CRQ): "What do the experiences associated with healthcare access mean to African American Women?" One theme evolved from The Guiding Research Question (GRQ): "How do African American Women describe the impact of race in relation to healthcare access?" During the data analysis phase, I used a process familiar to phenomenological researchers referred to as *clusters of meaning* that support the development of meaningful statements into themes (Creswell & Poth, 2018). The researcher's dataset was extensive, however, each data point was reviewed, analyzed, and explored for relevance, meaning, and impact.

CRQ: Theme One – Lack of Respect

The first theme to evolve was, ‘Lack of Respect.’ Ten of the eleven participants expressed receiving a lack of respect from White doctors. The, “need to be heard or the need to be listened to by healthcare professionals,” ranked high as a concern for AAW. When healthcare providers, failed to listen to their patients, it left them, feeling disrespected. Participants stated feeling invisible and unheard. The need to be heard or listened to in an empathetic manner is paramount to receiving quality care. This deep-seated need materialized in more than 40 of the data elements.

CRQ: Theme Two – Confidence in Level of Care

Lack of trust emerged as the second theme. Although the participants ranged in age from mid-twenties to mid-seventies, most had, little to no confidence in the care they received from White doctors, often second-guessing treatment protocols. A lack of trust in White doctors appeared to be an intrinsic trait of this population group. Many of the participants felt like, doctors who lived shared experiences as their patients, could provide better care. One participant shared a story:

Receiving unnecessary medical procedures, as well as avoidable medical illnesses that were a direct result of their health care providers misdiagnosing or underdiagnosing their symptoms, failing to listen to them, ignoring concerns, over or under prescribing medications and treatments because they were not being taken seriously, or simply feeling so uncomfortable with receiving care from White doctors that they avoid care altogether.

CRQ: Theme Three – Racial Discrimination

The third and final theme to emerge with regard to the central research question was ‘discrimination.’ The researcher analyzed two sub-codes, racism and microaggression that through analysis gave meaning to the final discrimination, theme. The participants shared narratives where they were, treated differently based on the type of insurance they held. Participants P4-NJ and P11-QP are both career professionals but at one point were laid off from their jobs and had to utilize public assistance for a short while. Each shared stories where they perceived a difference in their treatment based on the type of insurance. The researcher noted the intersectionality between race and socio-economic status. Participant P4-NJ also noted that occasionally she would visit her White doctor, dressed in sweats and the healthcare staff would ask her for ID and to pay upfront because they perceived she received Medicaid. She explained that when she visited the same healthcare facility on a day when she was dressed for work, she was not asked for ID or to pay upfront. This type of racism and microaggression was experienced by 10 of the eleven participants when accessing healthcare, and all eleven participants at some point in their life.

Eleven Research Participants Contributing Elements to Theme Development

Participant P1-NN, now in her late 40shad an early exposure and access to healthcare as her older sister is an OBGYN. When asked to describe her access to healthcare, she generally shared very positive experiences, and she attributes those experiences to always subscribing to African American doctors. Participant P1-NN noted she was a teen mom, and in her earlier years, she was subject to whatever healthcare provider her parents chose for her. She also stated that as she got older and started her career, she was excited to finally be in a position to choose her healthcare providers through her employer, and no longer be dependent upon the choices her parents made for her. She explained, "I made a very conscientious decision to always go to Black doctors as a tribute to my older sister.” Since becoming an adult, participant P1-NN claimed:

> I have always had favorable experiences at the onset of meeting her African American doctors. Honestly, I always got the sense that they understood me, that they were listening to me, I just naturally trusted my African American doctors. I wanted doctors that looked like me. If they looked like me, then there was a good chance they understood the pain or discomfort I was feeling right? My experiences with my African American primary care provider, dentist, and OBGYN have always been great. I never felt rushed. I never felt judged.

As the interview continued a warm smile erupted on her face as she said:

> I felt welcomed, like I belonged you know? Never felt like I had to second guess the doctors or question their treatment or diagnosis. I can't say that I always felt that way when I was younger and I had White doctors. Sometimes my doctors shared information about their personal life, like maybe where they went on vacation, or how their kid was acting up in school, and I felt like hey they're no different than I am. It felt good to have something in common with the person who sort of had your life in their hands.

Participant P1-NN shared how she would often get mad at her older sister because she never had time to hang out with her once she entered medical school. She even expressed a little resentment at her sister for always spending so much time in her medical books and for abandoning the time they used to spend together playing outside, going to the mall to shop for the latest fashions, or catching a late-night movie together:

> I'm not going to even lie, I feel a little ashamed now that I acted so juvenile. But then I was a kid. I just wanted my big sister. However, now I have a sincere appreciation for all the hours that my sister sacrificed to become the outstanding Dr. that she is. She's the stick by which I measure all of my doctors. Once my sister graduated and began practicing, her dedication didn't stop. She always went the extra mile. And because of that, I really felt like all Black doctors go the extra mile. And I just didn't see that happening with White doctors. I guess I didn't think they would care as much. I wanted doctors who cared about me.

Participant P1-NN explained that her rationale was:

> … if you cared about me, you would listen to me. If you listened to me, then maybe I could help you understand more about my condition and how to treat me. I didn't want to waste time going back and forth to the doctor. So if you listen to me then you'll know what to do right?

Participant P1-NN admitted holding her doctors to the standard of her sister may not always have been the best decision. She recalled one time when her dentist told her she needed a root canal when she really just wanted to have the tooth removed.:

> I mean it was like on the side toward the back of my mouth. No one would ever know it was gone. My dentist kept insisting that the tooth wasn't too bad and that she could save it if I simply allowed her to perform a root canal and give me a crown. Rather than listening to what my dentist well suggesting, I called my sister and asked her if I could share my x-rays with her and get her opinion on my tooth. What a dummy! Participant P1-NN laughs out loud. I can't believe I actually asked my sister who is an OBGYN to look at my tooth X-ray.

Participant P1-NN changes the trajectory of the interview and goes back to her senior year of high school when she became pregnant with her daughter. After delivering her daughter, she did not immediately bounce back to her pre-pregnancy weight. During subsequent follow-up doctor's appointments, she recalled, "conversations with my White OBGYN about developing high blood pressure and diabetes.” She said she tried to explain to the doctor that she had always been, a little on the chunky side but not too big, and she was never a size 0. But she said:

> I felt that my doctor was being very condescending and that she was not listening to me when I explained that I was regularly active, involved in two different sports, and worked out regularly. I felt that I was in no way at risk of developing either of those diseases because they did not run in my family, I was still very young, and an avid sports enthusiast. Although my doctor was concerned about holding on to some of the baby weight six months after my pregnancy, I was confident that within a year I would be back to my pre-pregnancy weight. I always wondered if I were White, would she doctor be having the same conversation with me? She said the conversation had an overall condescending tone and it left her feeling marginalized, and stereotyped. All of these years later I still feel that same sense of frustration when I run the conversation through my head. It doesn't go away. It's why as an adult I took my well-being into my own hands. I was my own advocate. I didn't know any other African American doctors other than my sister, so I asked her for referrals as well as talking to my friends to see who their doctors were. I still do that to this day. Word of mouth is something that I feel our community has to rely on. It's one of the first things I do if I need a

> new Doctor. I call my girlfriends up, hey who do you go to for physical therapy? Or who was the surgeon who did your carpal tunnel surgery? You know? That's how I do it. It's worked for me all of these years.

Participant P2-RH's Influence on Theme Development. Participant P2-RH was born and raised in the South and moved to the Midwest in her early teen years. When asked to share her experiences as an AAW with regard to her racial identity and access to healthcare she immediately began to take a deep dive into her past educational and career experiences. and how until now She acknowledged not thinking about the similarities among each. She explained how being raised in the South made racism inescapable. Her face looked troubled as she recounted her youth with stories of discrimination and bias.

> Our parents always raised us to be on our best behavior whenever we left so as to not anger any White teachers or other authority figures. I never got so much as a detention in school. I was always afraid that the smallest infraction would result in dire consequences. It was like walking on eggshells all the time outside of our home. Except for when we were at church. Church was different. Church was our community, actually more like our extended family. I went to Sunday school every day since I was three years old through high school. But I never felt the same way and Sunday school that I felt when I was in your school. Is that weird? Now that I look back on it, I think it's because my Sunday school teachers were all African American. They looked like me, so I felt I could relate to them. So I think I also took that mentality into adulthood when I sought medical attention or looked for new doctors.

Participant P2-RH stated that by the time she reached high school, she had been living in the Midwest for about two years. She explained how in her early years living in the Midwest, she noticed some stark contrasts between her years in the South. However, when participant P2-RH entered college, she began to feel less differences between her experiences with people outside of her race. She explained that since the early years of her academic career, she had always been considered a gifted student, even in math said felt it was uncommon for girls to do well in math, especially Black girls. She then begins to ponder and says:

> …well I guess those are thoughts that other people put in my head. Because if I was good at math why couldn't my friends be good at math as well? However, as I progressed through higher levels of math courses, I saw fewer and fewer African Americans, and probably even less than that just women in general. It got to the point that even in my graduate studies I always felt like I did not belong. But it was never because I wasn't smart enough or couldn't handle the material, it was simply because I was not welcomed into the circle of mathematical academia. Even today, I am a college mathematics professor, and most of my White male colleagues barely even speak to me. I think it's because of the years of mistreatment, discrimination, and bias, whether it was from my years as a child in the South, or my more recent years in the Midwest, I don't even bother myself with trying to fit in anymore or trying to convince others that I am enough. I know that I am enough. I also know others like me are enough. I think that's why I purposefully seek out African American healthcare professionals. Just like I spent many years studying my craft and becoming the expert mathematician that I am, I know that our great African

> American doctors will take the time to make sure that I feel like I am enough. I will feel just as comfortable with them as I do with my Sunday school teachers.

Participant P2-RH also attributed the quality care that she received to the superior healthcare systems in the Midwest. She explained that most of the doctors in northeast Ohio have trained at great medical schools and they have one of the world's premier healthcare systems nearby. She admitted being from the South parents were more inclined to take their children to African American doctors. She had received care from White doctors in the Midwest. Participant P2-RH explained:

> …that’s just the way we did things in the South. But up north, there's more integration. I still feel like I can't totally trust healthcare professionals that don't look like me, but I can't say that I will not go to a White doctor. I think it depends on how I feel I'm being treated. Are they listening to me? Because that's important. I don't want to feel like you don't understand what I'm talking about. I hope that makes sense.

Participant P2-RH who is now in her early 40s confered0 that her parents still have a serious mistrust of White doctors, but she says she thinks it's because they are older and lived during the time of the Tuskegee Institute trials. She says she remembers her mother telling her how nervous she was when she first became pregnant with her because she had her later in life. Participant P2-RH’s mother gave birth to her at the age of 42. During those times she was considered old to be a first-time mom. She said her mother told her she was extremely nervous her entire pregnancy because she was considered a high-risk. She was referred to a White doctor whom her mother did not trust” Participant P2-RH shared that her mother was diagnosed with pre-eclampsia during her third trimester and was prescribed medication to treat the condition:

> My mom said she was so nervous about the medication and what it would do to her baby, that rather than ask the White OBGYN whom she was referred to because she specialized in high-risk pregnancy, she went back to her long-time OBGYN and asked her if it was OK to take the medicine. The funny thing is, my mom said her long-time OBGYN had also been a classmate of hers who was just a few years older and they had always stayed in contact. When her friend finished medical school, she opened up a little storefront medical clinic in their neighborhood. My mom described it as something like a rinky-dink mom-and-pop shop, with thrift store furniture in the waiting room. On the other hand, the high-risk White doctor to whom she was referred, was on the other side of town nearly 40 minutes away in a very affluent neighborhood with top-of-the-line medical office equipment and furniture. And yet my mom went back to her neighborhood doctor because she didn't trust the White doctor. Now I don't know that I would have gone that far with it, but I do understand my momma's lack of trust. I think she just wanted to feel something between her and her doctor. Because I get that too. But I think it's harder for older generations to get that sense of connection and Community with other racial demographics when they have a history of not being treated so nicely by them. I can't say that all of my experiences have been bad, so I try to just take each situation they come and deal with them individually. But it's not easy when you go to the doctor seeking care for an illness or condition and you're met with judgment, hostility, discrimination, or even rudeness and

> disrespect. No one goes to the doctor expecting to be belittled or spoken to in a condescending tone. when it happens I’m not shocked by it, but it does make me feel uneasy and makes me question if I am getting quality care.

Participant P3-CR’s Influence on Theme Development. The researcher found several data elements with striking similarities in the lived experiences of participants P3-CR and P2-RH. The pair were only three years apart in age, with both having lived in the South and the Midwest. Participant P3-CR like participant P2-RH started her early academic years in the South and then moved to the Midwest in her preteen years, where she stayed until she moved back to the South two years ago. Participant P3-CR was proud of her African American heritage, which was also mixed with ties to the Caribbean on her father's side, and now her new husband's side of the family. She was a six-month newlywed and a first-time new mom. She felt it important to keep those close ties to her Caribbean roots, which led to the decision of her and her husband to move back to the South where they could catch quick economical flights home to the Caribbean when needed.

Participant P3-CR was also:

> …trained as a little girl that the only people you could trust are the people in your community. This meant the people who looked like you. Think about it. They don't know what we go through on a daily basis, because guess what they're the ones that are often causing it.

Participant P3-CR let out a nervous laughter. She offered that when she was in elementary school in the South, she went to a school mostly comprised of other Black students. She estimated there were about 20% of the students who were of Latin descent, and maybe 2%

of White students in the entire school. She added, “but they were cool, you know what I mean.” Then the nervous laughter returned as participant P3-CR exclaimed:

> …but when we moved to the Midwest, it was the exact opposite! I felt like a fish out of water. I was only one of four African American students in my graduating high school class of about 830 students. And I think I had less than that when it comes to African American teachers. By the time I hit my senior year, I think I had only had 3 Black teachers my entire four years of high school. That's literally less than one a year.

Participant P3-CR described a range of emotions she felt when she moved from the South to the Midwest:

> My parents first said that we were moving to the great state of Ohio I was super excited! I ran around the school bragging to my friends about the new fancy school I was going to, the big, beautiful house I was going to live in, and the suburban neighborhood I was going to live in. I was 10 years old. And I didn't have a clue about anything I was talking about. I had made this whole scenario up in my mind my parents had told me little to nothing about where we were moving to. I knew we were moving because my mom had gotten a promotion on her job, so in my mind, more money meant a fancy school a beautiful home, and a suburban neighborhood. Hey, what did I know? I was 10.

Participant P3-CR explained when she began school in Ohio, “I was immediately stereotyped because I talked with a southern drawl, so I was placed in remedial classes.” She explained how she was never tested, nor were her parents informed she would be in remedial classes. Participant P3-CR discussed how she never received anything lower than a

B in any of her classes when she lived in the South. Although she never understood it, she felt she was not allowed to question the decision. Participant P3-CR expressed that although she was in remedial classes from the beginning of August when classes resumed all the way through the end of January, she never received anything lower than a B in any of her coursework in her new school, similar to the participant. She recalled her remedial class teacher having to take an extended leave of absence toward the end of January for a surgical procedure. An African American took over as her substitute teacher. Participant P3-CR admitted:

> I know it sounds cliche but it was as if the light bulb turned on. Not only did I have an immediate connection with the new teacher, but she understood me. She understood me so much to the point that she did not understand why I was in remedial classes. She went to both the guidance counselor as well as the principal to question why I was in remedial classes. The substitute teacher was told that when I initially enrolled in the school, my academic records had not transferred from my elementary school in the South. However, the substitute teacher did a little research and found that the records were sent to the school somewhere around the first week of September, which happened to be around the Labor Day holiday. At least that's what the principal claimed. Because the records arrived at the school around the holiday, they got shuffled in the mail and we were sitting on a desk mixed in with a bunch of mail for the next four months while I sat in a remedial class doing coursework that I had learned two years prior.
>
> The substitute was able to help with getting my academic records in the system, and led the efforts to have me integrated into a mainstream classroom where I was

> able to not only catch up with all the work that I had missed but excelled to the top of my class. By the time I graduated, I was in the top 20 of my graduating class. If I can remember correctly, I was #12 in my graduating class. I'm pretty proud of that. But I never forgot that whole experience. If it wasn't for that African American teacher, where would I be today? Would I have a college degree now? I think that experience reinforced my distrust in people outside of my community."

Participant P3-C R also stated she believes it's the driving factor behind her, "self-advocacy when I visit any doctor, and always request African American doctors." Again, similar to the experience of Participant P2-RH about her mother having a first-time pregnancy late in life, participant P3-CR became pregnant with her first child at the age of 39. She admitted how terrified she felt. Although she did not have to seek a high-risk pregnancy OBGYN, she too was, "adamant about finding an African American doctor to deliver my first child." Participant P3-CR confirmed that:

> The OBGYN that I had been seeing for years was merely out of convenience. I had been seeing her since my early 20s and just didn't want to go through the hassle of trying to find an African American OBGYN. I felt that my White OBGYN was probably very competent, but she didn't have the best bedside manner. I didn't feel a connection to her. I didn't always feel like she took the time to give me the best care. It was almost as if I was just another number. So, when I became pregnant, I knew that was not going to work. I had too many questions. I had never been pregnant before, I was nervous, I was anxious, and I just wanted the best care for my baby. I had all these fears and questions in the back of my

mind, and I didn't want my baby to suffer because my doctor didn't take the time to listen to me, or heaven forbid, failed to detect some rare maybe even treatable disease common amongst African American babies. I don't know. Was this in a rational thought? Probably. But it's honestly how I was thinking or maybe just feeling. And my husband's first child, my hormones were all over the place I didn't know what to expect. But I felt like if I found an African American doctor, they would be able to ease my fears. I would be listened to. In my heart, I believed that I would get quality care from an African American doctor. When I did find a doctor that I really liked, she was nearly an hour away. For every appointment, my husband and I had to drive 55 minutes. However, my doctor warned us that once my water broke and I went into labor, I may not have 55 minutes to drive to the hospital. I will forever be grateful for her because she did something so sweet and kind, I knew that she genuinely cared for me and my baby. She had a colleague who was also an OBGYN who practiced at a hospital that was less than five minutes from my home. After sharing her concerns with me and my husband about the 55-minute drive, she asked how we felt about transferring my care to him. She said that she would make the call and set up a warmer transfer so that we could meet him first and see if we liked him. So we agreed. After meeting him, it was as if he and my husband had grown up together. They were like kindred spirits. This really made me feel good. You know, all warm and fuzzy inside. I thought it was a wonderful gesture, and he was a warm brilliant doctor as well. He delivered our precious baby girl with no complications! On our second day home from the hospital, he called my husband

> and me just to check on us and see how we were doing as new parents. He encouraged us to make sure we scheduled an appointment for our baby's first check-up and immunizations, and even referred us to a few African American pediatricians. The level of care was just outstanding. And we felt so comfortable all the way through the process.

Participant P4-NJ's Influence on Theme Development. Participant P4-NJ allowed the researcher to explore the intersectionality between race, gender, and socioeconomic status with her. She was born and raised in the Midwest as the eldest of three girls to a single-parent mom. Her two younger sisters are twins and ten years younger than her. For the first ten years of her life, she grew up as an only child. She explained that although her mom was a single parent, as an only child, she did not feel like they were poor. As the first grandchild and only child of her mom and dad, she was often spoiled, and became used to getting all the attention and every toy she ever wanted. She claims as an only child, life was great. Ten years passed when her twin sisters were born. Her mom, now divorced for the second time with three under-aged mouths to feed, participant P4-NJ shared that it was around the time the twins were about four years old, that she began to feel the sting of poverty as her mom's limited resources now had to stretch across two additional mouths. She explained that the twins were probably too young to remember their mom lugging them down to the county welfare department to apply for public assistance and healthcare. During this time, participant P4-NJ was almost 15 years old, so she remembers:

> …being denied care by her long-time pediatrician because his office did not take county insurance. I'll never forget the look on my mother's face. In my mind, because I was almost 15, I felt that I had to be strong for her mom. I sort of

> thought my mom was trying to be strong for me too. We were both embarrassed and a little ashamed, maybe. It gives me an eerie feeling to think about it even now because years later I had to go through a similar experience with my own daughter when I was laid off from work for six months and had to sign up for Medicaid to ensure we had healthcare. What an experience that was.

When the researcher asked a follow-up question to determine exactly what about the experience was so troubling, participant P4-NJ said:

> I don’t even mind getting shots, taking tests, even surgery. I’ve had it all, but finding a good doctor, an African American doctor, and then finding one that will take your insurance is a whole headache. I hated being on Medicaid because I felt like my choices were limited. When I think about what my mom had to go through when I was a child and just watching her being denied healthcare by a White doctor due to the type of insurance she had, it just never left me. The experience never left me.

Participant P4-NJ always sought care from African American healthcare professionals. She explained that even at 15 years old, the experience was troubling, stressful, and that she felt her family was being discriminated against simply because of the type of health care they carried. Participant P4-NJ stated, "being welcomed with open arms by an African American doctor simply confirmed the bias and discrimination I felt when I went to White doctors.” Participant P4-NJ described how she worked for a government agency for 15 years and had really good insurance. She had the option and flexibility to choose healthcare providers as she saw fit. She married quite young and at the age of 20, she gave birth to her daughter. From that point on her primary care provider, OBGYN, and her daughter's pediatrician were all African American doctors. She conferred:

> The relationships were all based on word of mouth or referrals. I have warm, trusting relationships with each of my three doctors, and when my OBGYN moved 120 miles away, I would travel 120 miles once a year for my annual examinations. That tells you how hard it is to find an African American doctor, and how important it is to have a good relationship with your doctor. At least for me, it was. However, when I got laid off and had to go on Medicaid, I had to switch my primary care provider. The funny thing is if I had an appointment right after work, and I was dressed in my business attire, I was always welcomed right in and never asked for my insurance period however if I happen to have a Saturday appointment or an appointment on a day I was not scheduled to work, I would just go to my appointment in my casual warm-up suit. Every single time I was asked for my ID and my insurance, although I had been going to this doctor for about seven months at this time it was so disheartening. I felt judged. I felt like I was being stereotyped. I can remember going to the doctor twice in one month. the first time I went I had an interview earlier in the day, so I was professionally dressed. I was not asked about my insurance or my copay. I had to remind the receptionist at the end of the visit that I had a $20 copay. Two weeks later I had a follow-up appointment, and it was on Veteran's Day. Because on Monday, and I normally go to the gym on Mondays, I had on my gym gear, and I planned to go to the gym after my doctor's visit. The same receptionist who greeted me two weeks earlier asked me for my ID and my copay before I even saw the doctor. As

> I sat in the lobby and watched several White and Asian patients enter the lobby and approach the receptionist, none of them were asked for IDs or their copays. It was clear discrimination and bias. I was infuriated. I was hurt. I knew then, that as soon as I found a job I was never coming back to this doctor.

Participant P4-NJ explained her experiences were different based on whether she had a Black or a White doctor, in addition to if she had private insurance or county insurance. She said her Black primary care provider always listened to her and took detailed notes on her symptoms. She added how he often pushed a holistic approach, whereas the White doctor was quick to prescribe opioids for her. She recounted an instance when she went to the emergency department when her sciatic nerve flared up in her back and down alongside her right leg making it nearly impossible to walk. She said that after receiving an MRI, she was given Motrin and told to go home and try to bear with it until she felt better. The following day she called her primary care doctor who was fully aware that her sciatic nerve had a tendency to flare up a few times of year. He was able to view the MRI that was taken the day before during her emergency room visit and saw she had quite a bit of inflammation around her nerve endings. He remarked that he was amazed she could even walk into the emergency department. She replied, “I didn't and continued:

> They wheeled me in a wheelchair. My doctor kept apologizing on behalf of the hospital and said there was no way that they should have sent me home with just Motrin. He said that he'd seen this before with his African American patients and that his White colleagues sometimes only did the bare minimum, or even misdiagnosed conditions because they just didn't take the extra care when it came

> to patients that didn't look like them. I can't tell you how many times he apologized to me. You, it's said that in this country and in this day and age African American women have to be advocates for themselves, even when their health is not good. If you're going to the doctor or the hospital, it's because something is wrong, right? But instead of laying back and allowing yourself to be treated with the utmost care, you have to second guess, you have to ask questions, you have to push for treatment, and you have to fight, you're sick, but you have to fight Just for health care! It's not right. It's an undue level of stress that should not exist in this country.

Participant P5-KBF's Influence on Theme Development. Although participant P5-KBF was not the oldest participant in the study, she probably had the longest and most extensive history with access to health care in the Midwest. Now in her early 60s, she has more than 50 years of visiting doctors, and other healthcare facilities. At the age of seven, she was diagnosed with type one diabetes. Even in her early years of elementary school, participant P5-KBF became intimately familiar with the healthcare system in this country. By the time she was in junior high school she had become accustomed to monthly routine visits to her primary care doctor to adjust her insulin intake, as well as a few trips to the ER department when her body was failing to produce and pump insulin. Participant P5-KBF said she did not have the luxury of choosing an African American doctor. The choice of who she saw as her doctor was made for her because of her condition. She stated that due to the severity of her condition, she saw her endocrinologist probably more than her primary care doctor:

> My parents and I were not afforded the opportunity to really get to know my doctor and form a connection. Bedside manners weren’t a concern. Whether or not my parents or I liked my doctor wasn't even a concern. My life was at stake. I had to just automatically trust that my doctors were taking the appropriate care, the best care because my life depended on it.

Participant P5-KBF remembered growing up never having a Black doctor, but she is now older and wishes she had one. She was in the process of researching Black doctors who specialize in diabetic care. She said that now she is getting older and understands the importance of making sure the relationship between her and her doctor worked well. She, “needed to be able to trust her doctor.” She felt that she could not have a doctor who did not listen to her, because her symptoms could change at any moment. In her younger years she did not equate quality care to race, she equated it to her survival. Participant P5-KBF shared:

> Once when I was hospitalized, there was a Black doctor who happened to be doing rounds during my four-day stay. It was my first glimpse at the difference in how the patient/doctor relationship can be. I remember him being very warm, and inviting, and feeling like he was listening to me. He was not as nonchalant as I was used to. He made me feel comfortable. I knew my condition was serious, but I didn't feel as stressed when I talked with this particular doctor. I made sort of a mental note, and I think that's what launched my desire to now seek out an African American endocrinologist.

Participant P5-KBF stated that survival is still her foremost concern when it comes to dealing with her chronic condition. However, she believes:

> …experience with the Black doctor when I was hospitalized was an eye opener. I wouldn't go as far as to say he's a better doctor just because he is Black, but I feel like an added level of trust, and ease of conversation can potentially aid African Americans who deal with diabetes. Like, I actually remember one instance when I had heard about a new treatment protocol for adults who were diagnosed with juvenile diabetes, so I asked my long-time doctor what she thought about it. Her response was very off-putting. I feel like she was offended because she asked questions. But I had to know that she was giving me the best care. She was offended that I had done my own research to learn about my own body and my condition. She was totally put off by the fact that I came to an appointment armed with information and questions about what I had dealt with every day of my life for over 40 years. This continued for many years and often included condescending comments and answers to my questions. But again I just chalked it up to being part of the process.

Participant P5-KBF looked a little saddened as she shared how she probably should have taken more steps earlier to seek out an African American doctor, because she thought it would her feel more comfortable. She believes that because her long-time doctor was touted as an expert in the field, she failed to put any effort into finding an African American doctor who was just as good:

> But now I think it's time for me to make a change. I can't state it enough, but I want to live. I want to be here for my granddaughter. I’m very close to my family. Especially the family that I have left. I don't want to be like my mother. She was told by her doctors for many years that she had arthritis. My mother never

> questioned it, she just dealt with the pain. It wasn't until my mom could barely move that I pushed for more tests.

Participant P5-KBF wiped away a tear as she shared that her mother was misdiagnosed, and that she did not have arthritis, but that she had stage 4 cancer. She shared, “I'm not going to let that happen to me. I want to ensure that I have an open and warm, trusting relationship with all my doctors. No more blind trust for me.”

Participant P6-FCL’s Influence on Theme Development. Participant P6-FCL is a former direct care provider for over 20 years. After 20 years of trying to break the glass ceiling in the healthcare field, she reluctantly changed fields. She details a very painful story of being passed over for a promotion four times. Participant P6-FCL discussed how the first time she applied for a position as she was looking to advance her career, her application was rejected, and she was told that she did not possess the appropriate degree. At the time she held an associate degree, but she was told that the position required a bachelor's degree, although the previous person holding the position also held an associate degree. A little taken aback by the response from her company, she enrolled in school and finished her bachelor’s degree.

Years later, with a bachelor's degree in hand accompanied by even more experience, the position came open again and she applied. To her surprise, the criteria for the position had been changed yet again and now it required a master's degree. For each of these positions, she was the only African American person to apply, as a result, the position was given to her White colleague. When the position came open for the third time, participant P6-FCL said she "checked all the boxes.” She now had more than 12 years of experience, a master's degree, and certifications in the field. There were only two candidates to apply. The other candidate had a master's degree, but she only had six years of experience and held no certifications in the field. Participant P6-FCL knew she would be a shoo-in for the position. Sadly, for the third time participant P6-FCL described a very painful conversation where she was yet again denied the position. When she inquired why she was looked over for the third time, participant P6-FCL said that the rationale her employer supplied to change the position requirements for the third time was simply unacceptable. She was informed that because she was not a registered nurse, she could not have the supervisory position although the position did not require any direct care.

Participant P6-FCL promised herself she would never be passed over again simply due to race. She claimed there was simply no other reason that she did not get any of those positions, other than “racism.” These experiences although in her professional career, “left a bad taste in my mouth in terms of healthcare professional” stated P6-FCL. As a result, participant P6-FCL explained she no longer seeks care from anyone outside of her race if she can help it. She intentionally seeks out African American doctors.

Her first method is generally word of mouth, but she expressed her ability to do her own research on doctors. She often uses her insurance app on her phone to find African American doctors. However, she expressed, “whether I’m looking for a primary care physician, dentist, or OBGYN, or even a mental health care professional, for some reason all of the Black doctors are always at the end of the list. You can't tell me that's not on purpose.”

P6-FCL has an inherent distrust of White doctors and recounts a detailed experience where her OBGYN, "failed to properly diagnose her and misdiagnosed her resulting in a near-death experience":

> You know it's sad. I had to diagnose myself. I told my OBGYN that I needed a blood transfusion. By this time, I had had 3 uterine fibroid surgeries, and so I had had a long history of heavy bleeding. I knew my body better than my doctor. But is that right? He's the one that went to medical school. But I guess I should know my body too. I called my doctor after an extremely heavy menstrual cycle in the month of December. I attributed it to everyday stress, stress at work, the holiday season, and preparing my home for some of my husband's family members who were coming to visit, on top of the fact that I normally have a heavy flow. But when I'm stressed it's extremely heavy. So I called and asked for a blood transfusion. And you know what? My doctor laughed at me and said I did not need a blood pressure transfusion. Can you believe that? He laughed at me! He did not listen to me. I'm telling him something's wrong with my body and he's not listening. Does this happen to other people?

Participant P6-FCL explained that she was walking from her car to her office on the way to work one day when she noticed her breathing was very sluggish, her chest was hurting, and she felt extreme exhaustion come over her body. She collapsed just 10 feet away from the door to her office:

> I thank God that I worked in a hospital when I collapsed. Because if I didn't, I don't know if I would have made it. I don't know if I would have had enough time. When I came to, I told them that I needed a blood transfusion. They immediately

> drew my blood to take a blood count and saw that I was down 5 1/2 pints of blood. That's why I was feeling so exhausted and having trouble breathing because I didn't have enough blood in my body to pump through my lungs!" It was God keeping me alive those weeks from Christmas through to January when I collapsed at work because my doctor certainly wasn't.

Patient P6-FCL feels she knows her body, making it important for her doctors to listen to her:

> Because my doctor failed to listen to me I could have lost my life. Because my doctor laughed at me, I could have lost my life. Because my doctor was condescending, I could have lost my life. It's not fair. I have to be my own advocate. I have to make a point of being heard.

Participant P6-FCL described how she would love to just walk into a doctor's office or medical facility and receive the care she needs without all the extras she has to deal with. She stated not wanting to debate if her doctor is providing quality care. She expects not to be talked down to and for her concerns to be considered valid. Patient P6-FCL offered that just because she worked in the medical field for 20 years, she did not go to medical school so she should not have to diagnose herself.

Patient P6-FCL shared how growing up in a small town in the Midwest, there were two hospitals where she received her first few years of training but then moved further north into a larger city. Patient P6-FCL felt because she was born and raised in a small town, she "had to settle when it came to medical care. The larger hospital was over 100 miles away. The most talented doctors graduating from medical school did not want to come to small town USA. This meant the opportunity to choose African American doctors was limited. Receiving “care from non-African American doctors was not a choice, it was a decision that was forced upon people simply based on where they lived.

Patient P6-FCL said she, "endured years of being talked down to, years of discrimination and being stereotyped.” She recalled an instance where she was asked for her Medicaid card. She asked the receptionist "Why do you think I have a Medicaid card?" She explained that she was a college graduate and had been working at the local hospital for three years. She could not understand what about her that would give anyone the impression that she was on Medicaid. She was infuriated by the comment. Similar to participant P4-NJ, she "felt judged.”

Participant P7-AMB’s Influence on Theme Development. Participant P7-AMB is one of the younger participants in this research study. In her late 20s, she too has experienced discrimination, bias, racism, stereotyping, and microaggressions from White medical professionals. Participant P7-AMB described what she recalls as one of the most frightening events of her life when she experienced her first pregnancy and miscarriage all in the span of six weeks just a year after college graduation in her mid-20s. As with most women experiencing their first pregnancy, participant P7-AMB lived through a myriad of emotions from shock to excitement, to fear of the unknown, and even self-judgment wondering if she was ready to be a mom. P7-AMB shared that she miscarried right at six weeks although she had been telling her doctor for three weeks that something was not right. Although participant P7-AMB had never been pregnant before and did not know what to expect, said, "I knew something was not right with my body and with the pregnancy.” Participant P7-AMB fully understood most miscarriages cannot be stopped or prevented, she added, "I always have this recurring thought in the back of my mind that if my doctor had listened to me, would my baby have made it?”

A recent news report documented an Ohio woman who was sent home to have a miscarriage, was then later charged with abuse of a corpse in 2024. Participant P7-AMB was also sent home and told to let nature take its course. She claimed she was not given any information on miscarriages, how to deal with them, what to expect, or any emotional or mental health support.

A few years later, now in her late 20s, participant P7-AMB was pregnant again. This time, Participant P7-AMB acknowledged her level of fear of the unknown bordered on terrified. She admitted that she doesn't know if anything could have changed the course of her first pregnancy but says that she will always wonder if she had an African American doctor, would things have been different. She was now visiting a different OBGYN for her second pregnancy, but she was a White woman. Participant P7-AMB referring to herself as a millennial, said, "although my doctor was often condescending and aloof, my reaction was just to meet her with the same energy."

> When she was condescending. I was condescending. Yes, I'm young, but I'm not stupid. I'm educated. I'm getting my master's degree. I know how to do research, so I ask a lot of questions. I've wanted to do everything in my power to ensure that I did not have another miscarriage. I was going to carry this baby to term no matter what. Even if it meant sacrificing my own life.

Participant P7-AMB acknowledges she did not switch to a new OBGYN immediately. She just began to research African American doctors. She was currently living in the South because she had gotten a job after college, although her initial plans were to move back home. By the time she found an African American OBGYN, she began having some complications with her pregnancy. She called her White OBGYN alerting her of the symptoms and what she was feeling only to have her concerns brushed off. She also informed the OBGYN of her plans to transfer to the African American OBGYN she found and asked to have her records transferred. Unfortunately, the next day participant P7-AMB was hospitalized due to the escalating pregnancy complications.

She described the sheer pain that she was in throughout her stomach, back, and lower extremities. She explained that after a three-day hospital stay and the doctors confirmed that she was not in labor, they released her from the hospital with no explanation. Almost two weeks to the day, she was hospitalized again with the same excruciating pain. This time she did not doubt that she was actually in preterm labor, only to have the hospital confirm again that she was not in labor. She explained that the whole time she was in the hospital she was on the phone with her mom, trying to convince her mom not to drive eight hours to the hospital. Again, four days later she was released from the hospital with little to no information about her pregnancy. She visited her original OBGYN one last time, again with her mom on FaceTime to observe the doctor's office visit. Patient P7-AMB described how the White doctor seemed to be offended that she would allow her mom to ask her doctor questions about her pregnancy. Her doctor refused to speak with her mom. She explained to her doctor that she was remarkably close with her mom and her mother was concerned about her two previous hospital stays that resulted in no information. After leaving, she immediately made a follow-up visit with the African American OBGYN she had found one month prior. Unfortunately, before she could visit the African American OBGYN the mysterious pains returned. She says she called her mom yet again screaming into the phone in pain. Patient P7-AMB shared a similar experience in the fact that she had a personal connection to a Black OBGYN.

Patient P7-AMB says that when she called her mom screaming in pain, her mother called one of her sorority sisters who was an OBGYN and asked her if she were able to get her daughter back home from North Carolina to Ohio, would she be able to provide medical attention and deliver the baby. Her mother's sorority sister agreed. She added:

> My mom who was totally freaking out caught a flight that same night and flew to North Carolina so that she could drive me the 7 and ½ hours back to Ohio because I was too far along to take a flight. My mom packed me up the next day and drove me home to Ohio where her sorority sister performed an emergency cesarean to deliver my healthy baby girl only two weeks after arriving home.

Patient P7-AMB says that when she became pregnant for the second time she immediately began to ask questions of her White OBGYN. However, they were "questions that for the most part went unanswered." She says that she felt discriminated against because she was young, African American, and unmarried. P7-AMB recalled how her mom's sorority sister immediately took control of the situation when she arrived in Ohio. She recounted the following:

> I felt a calm spirit when I walked into her office. Everyone from the front desk staff to the other doctors in the office who were also African American, were all very warm and friendly. I call her Dr. Mary. I love Dr Mary! I don't know that I or my baby would have survived if Dr. Mary had not delivered her. I didn't want a

> C-section. I wanted to deliver naturally. And I told Dr. Mary that. However, she explained to me very calmly and in detail, that I would not only be putting my life at risk but the baby if I did not get a C-section. She explained that because I was young my body would heal relatively quickly, she described all the steps and precautions that would be taken up to entering the birthing room and told me that my mom could be present and even help with cutting the umbilical cord. But my mom's a chicken, she refused to do that.

Patient P7-AMB says that her only regret is that she did not move back home immediately when she was pregnant and began her care under Dr. Mary. Patient P7-AMB explained:

> I get upset when I think about how I was treated during both of my hospital stays. I was just left in her room alone with no one talking to me, or explaining anything that was going on. The hospital staff kept blaming it on COVID-19 protocols. COVID-19 protocols may explain why there were no visitors allowed in the room, but it doesn't explain the cold and callous interactions with hospital staff. It doesn't explain why no one would answer my questions. Doesn't explain why I was afraid for my life and the life of my unborn child. It doesn't explain why what should have been one of the happiest experiences of my life was one of the most stressful.

Participant P8-JB's Influence on Theme Development. P8-JB is a retired great-grandmother who loves spending time with her dog and visiting her 2-year-old great-granddaughter. Participant P8-JB revealed that she, "comes from a time when you don't question people in authority, especially not your doctor. I have had White doctors most of my life, but that's because I didn't think I had a choice.” Participant P8-JB in her 70s, says that she is pretty healthy for the most part. She even bragged that she is the healthiest out of her and her four siblings. Participant P8-JB stated she only goes to the doctor when she has to. “I get a check-up once a year, and then if I get sick, I will go. I try to avoid them if I can.” Patient P8-JB tries to stay away from the doctor as much as possible because although she does not question them, she does not always trust them.

Participant P8-JB discussed how she has always been more of a wallflower, noticeably quiet, timid, and in the background. She explained that she, “is not one to ruffle feathers.” She says that she knows it's not necessarily the right thing to do, but whatever her doctors tell her she just believes them. She recalls one time when she questioned a White doctor about something, and her doctor snapped at her and retorted with a very condescending remark. Participant P8-JB suggested that because she's normally a quiet and sort of timid person:

> That type of response pushes me deeper into her shell. Although I felt extremely disrespected by my doctor's response, and to be quite honest my gut reaction was to leave the office and never return, I did just the opposite. I continued to visit that doctor for many years. And you know what? That was the last time I ever asked a question of a doctor.

When asked why she did not seek out another doctor, participant P8-JB explained:

> I just did not want to have to start all over with a new doctor. My preference would be to start over with an African American doctor, but I don't know where to look. I guess I could ask my daughter. I would have had to ask around, but by

> doing that, I don't want to have to share my experience with my long-time doctor.
>
> I know it might seem like a small thing, but I extremely felt disrespected.

Participant P8-JB confirmed she has always had a distrust of doctors. She was not sure where the distrust originated but could recall hearing her father make negative comments about White doctors. She said he often referenced the 1932-1972 Tuskegee Syphilis Study (Tuskegee Study - Timeline - CDC - OS) whenever he needed to see a doctor:

> My father who was born in the late 1920's and he never liked any doctors. He didn't care if it was a Black or White one. My father always seemed to have a natural dislike of doctors in general, but a total distrust of White doctors. So maybe that's where I get it from. Probably, yes I'm sure that's where I get it from.

Participant P8-JB recently thought she may have been suffering from a bout of depression and decided to get some mental health counseling:

> I initially wanted an African American female mental health specialist, but when I called my insurance company, they only referred me to White male doctors. I didn't think I would find someone as old as I am, but I did want someone a little older, you know experience some things in life. I figured they were probably able to relate better. I don't know why I couldn't find one. It was hard. It seemed like I was gonna have to travel far. I didn't want to do that. Just trying to find a good fit, it's hard. It's stressful. It makes me anxious thinking about it.

Participant P9-FDT’s Influence on Theme Development. P9-FDT is an educated middle-aged woman who is retired from a career in law. However, she decided she was too young to completely retire and has recently begun a new part-time career. She lives in a predominantly White neighborhood, although her two adult children come to visit her often. She

> I have always felt comfortable with each of my doctors, Black or White, and I have never had any adverse experiences with either although I have multiple friends and family members who cannot say the same. I have some very close friends who have shared painful experiences dealing with non-African American healthcare professionals, and just trying to find culturally competent healthcare providers.

Participant P9-FDT learned early in life that she had to "take my health seriously, and that meant being responsible for my own level of care regardless of who was providing the care." As the daughter of a dentist, and many years either helping out around the office or just visiting her father at his practice, she acknowledges her potential bias, but has always greatly admired in how well her father treated his patients. Watching her father with his patients, helped her develop a certain expectation from her doctors. She currently has a White primary care physician and OBGYN, but a Black dentist. One of her children began seeing an African American mental health therapist as a teenager with whom she still has a good relationship.

Participant P9-FDT has worked for the government since she graduated from college, and lives within 10 minutes of three major metropolitan hospitals, including two world-renowned trauma centers. “The reputations of each of the hospitals were enough for me.” She does not believe either of the health care systems would employ doctors who practice any type of discrimination, racism, disrespect, or microaggressions. Participant P9-FDT does not intentionally seek out African American doctors and believes non-African American doctors can be equally culturally competent.

Participant P10-DB's Influence on Theme Development. Participant P10-DB is the youngest participant in the research group. She is in her mid-20s and has already had what she describes as traumatizing experience with White doctors. She revealed her exceptionally large close-knit family gets together for major holidays and several other times throughout the year. Most of her family members are under 5 feet 7 inches tall, with a stockier build. She reported, "we are not fat, but we're not a size zero either." During her annual checkup at her OBGYN, for the past two years, she voiced being left feeling belittled, diminished, and unheard. Although she was not sexually active, her OBGYN kept pushing birth control and weight loss pills. According to her it caused her to have an extremely uncomfortable conversation with her White OBGYN. She explained that the only reason for the visit was a simple annual checkup. Even though she did not ask for birth control pills or weight loss pills the doctor prescribed both for two years in a row." In her attempts to explain to her doctor her comfort with her size because she looked like everyone else in her family. However, her doctor insisted that she needed to lose weight.

Participant P10-DB then explained she began to feel some discomfort in her body and experience other symptoms that were not normal. After making an appointment with her primary care physician who was also White Participant P10-DB divulged:

> I asked my primary care physician to run a complete blood panel. She out-and-out laughed at me and said I didn't know what I was asking for. I asked my doctor was she saying that because I was only in my 20s, or did she not even hear the symptoms I was describing. My doctor responded in a very condescending tone and implied that I was overreacting. I began to start over to re-explain my symptoms that I was

> having, and my doctor cut me off, would not allow me to continue, and told me to just go home and calm down.

Within a month participant P10-DB recognized her symptoms were beginning to worsen, which caused her to make another appointment with her primary care physician. She added:

> I once again asked for a full blood panel to be run. After much pushback, my doctor finally gave in and ordered the panel. I was relieved to finally have the panel run but also angered at the fact that I had to beg for care. I knew something was wrong with my body and I just wanted to find out what it was. I didn't deserve to be treated that way. I didn't deserve to be shut down or minimized and silenced. Within 24 hours, I received a startling call from my doctor with the results of the blood tests. Although I was diagnosed with a treatable disease, the diagnosis was almost two months after I initially shared my symptoms with my doctor. What if it were cancer? What stage would it be in two months later?

Participant P10-DB determined this was a defining moment for her and that going forward she would always seek care from African American doctors. She began to do her research to find an African American OBGYN and primary care physician. Her next steps were to try to locate an African American mental health therapist and an African American nutritionist. From her experience, she offered:

> Trying to find an African American mental health therapist and an African American nutritionist was like finding a needle in a haystack. It took me an extraordinarily long time to find an African American mental health therapist, and I'm still looking for an African American nutritionist. Isn't that crazy? I feel stressed

> every time I think about it. I'm always asking my friends about their doctors. I'm sure I will find what I'm looking for in time, but it's a lot of work. What I learned is that I have to fight for my care. Does the rest of America have to do that? Learned that Healthcare is not the same for everyone. Google Black doctors in the area or sometimes I might call my insurance company.

Participant P10-DB suggested that ultimately, it's word of mouth that gets her the best results when trying to find African American health care providers. Her plans are to take her time to find a good fit and know she can trust them, and they will listen to her. She opined, "If I am putting my life in your hands, I should be able to trust you." Participant P10-DB felt it is important to utilize African American doctors because they understand us:

> They can look at me and tell that I'm not overweight. They're not going to push diet pills down my throat. I feel like I'm just another paycheck. I wanna know do you genuinely care period I feel like African American doctors will genuinely care about my well-being. They're gonna listen to me. They're gonna look at me and see their children.

Participant P11-QP'S Influence on Theme Development. Similar to other participants in this research study, participant P11-QP's experience with White healthcare professionals goes back to her early adult years during her first pregnancy. Participant P11-QP started by sharing her experience when she arrived at the hospital to give birth to her first child. The only questions she was asked were her name and her social security number. She detailed how she arrived at the hospital at 6:00 AM and her daughter was born at 6:50 am, less than an hour after arrival. Participant P11-QP's facial expression was not at ease. She recounted her story of five days in a hospital maternity ward in the early 1990s:

> Although my daughter was born at 6:50 AM, I did not meet her daughter until nearly 10:30 PM that same night. The hospital resident that was on call that day performed an emergency C-section with full anesthesia, and I did not awake from the anesthesia until 9:150 PM that night. When I opened my eyes, I looked around, a little disoriented, and I noticed that I was in a room with about seven other hospital beds. I assumed it was just the recovery room for new moms and that I would soon be moved to a private room and given the chance to meet my new baby. That was not exactly the case. I did meet my new baby daughter, but when they placed her in her arms, I noticed that my baby had stitches on the left side of her face under her eye. When I asked about the stitches, I was told a resident in training did my C-section and cut a little too deep. That’s it. Very cold and matter of fact.

Participant P11-QP continued sharing:

> The next day I asked when I would be moved to my room and was told I would not be moving, and I was going to stay in the same room. A little puzzled, but I did not question it initially. Within an hour I noticed a couple of women coming into the room with clipboards but who didn't look like health care professionals. Each of them was having quiet conversations with the other mothers in the room. Finally, I was then approached by one of the women who asked me for my name and the name of my social worker. I told her my name but asked what she meant by my social worker. The lady with the clipboard identified herself as a county social worker who was assigned to the welfare maternity ward to collect additional information about each of the babies being born.

Participant P11-QP's puzzled look became more defined. Participant P11-QP explained she was not on public assistance and had private insurance. The social worker would not believe her and continued to drill her about her social worker's name and her case number. Shortly after that, a different doctor than the one who delivered her baby came into the room with a nurse and falsely told her the results of her toxicology test came back positive and she had passed an illegal controlled substance onto her baby. Participant P11-QP was completely appalled as she had never even smoked a cigarette in her entire life. She kept explaining to the doctor that there must have been some mistake, but the doctor refused to hear her and continued threatening to have her baby removed from her care if she did not disclose what she had taken.

Participant P11-QP continued by disclosing that after what started as a passionate conversation turned into a full-blown shouting match. The police were called although participant P11-QP was connected to her IV pump and had more than 12 stitches in her stomach from her less than 24-hour old cesarean section." She explained:

> The hospital made several mistakes when delivering my child. Each of the mistakes was all based on, assumptions, bias, discrimination, racism, and stereotypes. When I walked into the hospital just a day before as an American unwed mother, the hospital intake staff made the assumption that I did not have private health care and was on Medicaid. The second assumption was based on the fact that when participant I arrived at the hospital in full labor and although I had dilated almost 6 centimeters, I was not yelling and screaming in pain, so of course I must've been on drugs, some illegal controlled substance as they called it. Based on this assumption the "doctors ran a toxicology chest without my

> permission. The third assumption was also based on flawed logic. When the results of the toxicology test came back positive, the hospital staff made the assumption that it was positive for an illegal controlled substance. You see, in the early 1990s, toxicology tests were two parts. Trained staff new to run the first test to determine if there were any drugs in the sample. The second part of the test was to determine if the drugs were illegal, prescription drugs, or over-the-counter drugs. The second part of the test was never run for me that day because I did not appear to be in pain. I had to fight like the devil and even beg hospital staff to rerun the test! They finally did at the strong urging of my parents. The only thing that was in my system was an over-the-counter antihistamine that I had taken when I had a common cold two weeks earlier. Can you believe that?

Participant P11-QP was traumatized by the all-White staff threatening to take her newborn baby away. P11-QP felt, “Not listened to, but I was also never even given the opportunity to speak. I was not asked for my insurance nor was I asked who my primary care doctor was. I was not asked to give permission for a toxicology test.”

Process of Theme Development

In the following section, I present the results based on the analysis of each data element. This includes the findings for each research question including themes, sub-codes, and codes. As mentioned, three themes were found for the Central Research Question, and one theme was found for the Guiding Research Question.

CRQ: THEME 1 – Lack of Respect

The first theme to emerge was respect. By analyzing the data elements, the researcher was able to categorize each of the participant’s perceived thoughts and feelings as it related to access to healthcare. Whether the participants described interactions between doctors or other healthcare workers, many of them described feelings of disrespect. The two overarching sub-codes were found as a result of analyzing 20 codes or data elements, was the need to be listened to and be heard and to be treated like a person.

As the researcher began an iterative process examining codes and assigning meaning to each of the transcribed data elements, 12 codes related to the first sub-code, “the need to be listened to and heard” described the participant's feelings and perceptions of a lack of respect at various levels from health care professionals. Participants shared how it was not uncommon for White doctors to have poor bedside manner, or a nonchalant attitude. As patients, they felt they were not allowed to fully get their concerns across, often being rushed or made to feel as if their concerns with their bodies were not of high importance. They reported feeling alone, misunderstood, silenced, invisible and even laughed at. Participants said that there were often visits with White doctors made them feel as if they settled. When each of the interview questions was analyzed, 10 of the 11 participants recounted experiences of disrespect that ranged from smaller “micro-aggressions to neglect.”

The second sub-code that contributed to Theme 1- *Lack of Respect* was the perception of not being treated like a person. Similar to the previous sub-code, 10 of the 11 participants described interactions with healthcare professionals where they were not treated kindly. Six participants said their White doctors always talked down to them, belittled them, disregarded their concerns, and disrespected them as a person. Participant P2-RH stated, "I had to remind one doctor that I hold a Ph.D. and the condescending tone was not necessary.”

CRQ: THEME 2 – Lack of Confidence in Level of Care

The researcher combed through twenty-six unique codes derived from the interviews of the 11 research participants. The 24 codes were then narrowed down to two sub-codes that are the foundation for Theme – 2 *Lack Confidence in Level of Care*. The confidence in White doctors among these 11 research participants was significantly low as nine of them were either misdiagnosed, underdiagnosed, over prescribed narcotic medications. One element that also emerged as a high concern for the researcher was the number of participants that had healthcare scares, misdiagnosis, or unnecessary surgeries surrounding their pregnancies or reproductive care. Four participants sought the second opinion of African American doctors when their OBGYN was White. Another commonality among the participants was they reported knowing about the long history of not trusting White doctors, where the research participants punctuated their statements by calling out the horrible practices against African American men in the 30+ year study conducted by the Centers for Disease Control and the Tuskegee Institute.

Additionally, eight participants mentioned they did not trust the care they were getting from White doctors because of how they were made to feel. They lacked feeling, *warm and fuzzy* from White doctors as participants P3-CR and P5-KBF stated. Six participants related childhood traumas in everyday life such as school and shopping, which may have contributed to their lack of trust in White doctors as adults. Each recalled instances where they received the bare minimum or less than a White child, and now often feel they receive the bare minimum of care when dealing with health care professions.

Theme 2- *Lack of Confidence in Level of Care* also had a second sub-code, cultural competency. Nine of the eleven participants described the importance of the doctor/patient relationship. It’s up to you to do your own research on your doctors. Participant P6-FCL stated that she was happy to be living in a big city now because she had fewer choices in African American doctors growing up in a small town. Four participants said, "It's just easier to trust your own community.” Participant P10-DB added, "they look like us, they know us, and they are us, so I feel like they will give me better care.” Participant P11-QP commented, "cultural competency means different things to different people.” Participant P9-FDT strongly believes, "you don't have to be African American to be culturally competent, but anyone who takes extra measure to understand African Americans on a multifaceted level, socially, economically, spiritually, historically and of course medically can become culturally competent.” Participant P2-RH affirmed this sentiment, and conveyed she, looks for doctors who know the importance of being culturally competent when treating their African American patients and this can be someone of any race.

CRQ: THEME 3 –Experiences of Racial Discrimination

The final theme to emerge with respect to the CRQ was *Experiences of Racial Discrimination*. Although each of the 11 research participants shared experiences of some form of racial discrimination in their life, participant P9-FDT said she currently and has always had both Black and White doctors but has never felt discrimination when accessing healthcare. However, Participant P9-FDT added she had repeatedly heard from friends and family of how poorly they were treated by White doctors or the difficulty in finding culturally competent healthcare providers. Racism was an easily apparent sub-code each of the 10 other participants described when accessing healthcare. Seven codes culminated into the sub-code racism where the participants often interjected other “isms” such as sexism, elite-ism, and ageism, illuminating the intersectionality most marginalized groups face.

The three participants (P2-RH, P3-CR, & P7-AMB) who spent more than five years living in both the South and the Midwest expressed grave concerns about access to healthcare. As participant P2-RH expressed, "Racism in the South is inescapable.” Both of participant P2-RH's parents were from the South so she grew up in Southwestern Texas where she stated, “racism was deeply rooted in every aspect of our life.” Even though she’s been an A student from her early years in elementary school, she was always stereotyped, met with hostility, and was educated and worked in non-inclusive environments. She commented about how as a youth she was excited about moving to the Midwest with expectations that things would be different and was quite disappointed to find her experiences with healthcare were not much better in the Midwest than there were in the South.

“Microaggressions flourish in the Midwest, but in the South, they just don’t care. My experience with racism and microaggressions in the South were very overt. It feels like they at least try to hide it through microaggressions that go unacknowledged in the Midwest”, stated P2-RH. The microaggressions sub-code was perceived by nine of the participants when visiting White healthcare providers. One particular covert microaggression as participant P11-QP observed, “They even use technology, to just make it harder.” When she used her insurance app to search for an African American doctor, she had to scroll to the end of the list. Participant P10-DB also stated that she tried Googling African American nutritionist and mental health care provider and was unsuccessful finding either. She made several attempts to refine her search to find one African American doctor.

Participant P7-AMB moved to North Carolina when she was just 18 years old, and now at the age of 29 says the racism she has experienced in the Midwest and the South is bad and it is a little more covert in the Midwest. “Racism is very obvious in North Carolina. You see confederate flags everywhere." Participant P3-CR asserted being shocked at how she was treated in the grocery store and the doctor's office even though she was educated and lived in a middle-class neighborhood when she moved to Georgia at the age of 32. She was always asked for ID when using her credit card, which led her to feel extreme levels of judgment by the staff in her doctor's office.

The Guiding Research Question supported exploring the effect of racial identity on access to healthcare for AAW. The signal theme to emerge was *Elevated Stress Levels*. Nine of the eleven participants expressed feeling anxiety, saddened, no sense of belonging, disheartened and ultimately stressed out when thinking about trying to find culturally competent health care providers, receiving care from White doctors, or interacting with front desk staff in health care organizations.

GQ: THEME: Elevated Level Stress

Accessing healthcare should be a simple and reasonably stress-free phenomenon for most Americans. However, I discovered nine out of eleven AAW interviewed feel they are constantly mindful of their race, and how their racial identity is perceived by the dominant culture. Believing some White doctors perceive them as different and racism is often the driving factor, finding culturally competent healthcare providers is a top priority that in some cases has been unsuccessful. Now living in the Midwest, participant P2-RH divulged all but one of her doctors are African American. "I did it, but it wasn't easy." She used word of mouth and did a little research on her own to find culturally competent doctors.

> Each of the nine participants expressed everything from mild microaggressions to extreme levels of depression when describing experiences with accessing healthcare. Participant P5-KBF described encounters that were "off-putting", but she dealt with them

> because she was diagnosed with a chronic disease. Recognizing her need for ongoing care for the rest of her life, she realized the relationships needed to work. The relationship wasn't perfect, and there were certain things I just wasn't going to take. But my life was at stake, so I had to trust them. Ending the relationship is not always easy, because you have to find the right doctor and they have to be in-network with your insurance. It's stressful!

Participant P3-CR had a much more extreme response to the maltreatment she received during her pregnancy. She was misdiagnosed twice and forced into an emergency C-Section when her blood pressure spiked as a result of the stress. Participant P10-DB explained, "just thinking about finding a doctor gives me anxiety." She likens it to going down a rabbit hole. Participant P8-JB shared how condescending tones and lack of quality care have caused her to shut down feeling sad and unvalued. She said when she thinks about it, she believes it can be attributed to her bouts of depression.

Summary

Nearly 250 years ago, seven words were written into The United States Constitution that set out to define the foundation of this country; "life, liberty, and the pursuit of happiness." Even at the birth of our nation, values such as equality and equal opportunity were profoundly entrenched in the ideology of what this country stood for (Weinstein et al., 2007). However, these words were not written for every American, and the concept that everyone has a fair shot to succeed with hard work sadly has been overshadowed by the racism and bigotry of this country, even when accessing healthcare (Weinstein et al., 2007). Notwithstanding, the social and economic well-being of this country is subject to the overall welfare of its communities, even while many are facing seemingly insurmountable obstacles (Weinstein et al., 2007). Across the country, there are communities with insufficient access to healthcare, jobs, adequate transit, safe and affordable housing, parks and open space, healthy food options, or quality education, all necessary conditions and opportunities to fully thrive (Weinstein et al., 2007).I sought to explore the lived experiences of AAW and access to healthcare to help shine a light on the lack of opportunity and access contributing to the disparities existing in health status and health outcomes of African American Women.

Chapter Four detailed the lived experiences of 11 AAW and their narratives describing access to healthcare in the Midwest. This chapter listed the demographics of each participant and their contributions to the two research questions. Next, data that was collected from the semi-structured interviews was analyzed and presented with regard to the Central Research question. During this analysis, three themes emerged: Lack of Respect, Lack of Confidence in Level of Care, and Experiences of Racial Discrimination. The Guiding Question addressed the outcome of their experiences and how they were affected by experiences of racial discrimination. One theme emerged with respect to the Guiding Question: Elevated Levels of Stress. By using Elevated Levels of Stress as a theme and was used to give meaning to the lived experiences of African American women and access to healthcare.

Chapter Five: Conclusion

Overview

This interpretive phenomenological analysis was designed to explore and describe AAW lived experiences when accessing healthcare. Health disparities in this country have been widely addressed, however, this research sought to specifically study the experiences of African American Women and how the impact of accessing healthcare plays out in their lives. As a result of this study, the researcher was able to take the data elements from each interview and draw out three common themes concerning the Central Research Question and one common theme from the Guiding Question. Each of these themes gives meaning to the experiences of African American Women when accessing healthcare, and further highlights the tragic healthcare disparities mentioned above. This researcher will share a) a Summary of the Findings, b) a Discussion, c) Implications, d) Limitations, and f) Recommendations for Future Research.

Summary of Findings

I outline the summary of findings by answering the Central Research Question and The Guiding Questions. The Central Research Question (CRQ) this study explored was: “What do the experiences associated with healthcare access mean to African American Women”? The CRQ explored the lived experiences of AAW as they encountered medical professionals and described in narrative form the details of each experience. The Guiding Question was “How do African American Women (AAW) describe the impact of race and racism in relation to healthcare access”? The Guiding Question addressed the outcome of their experiences and how they were affected by them.

(CRQ): “What do the experiences associated with healthcare access mean to African American Women”?

The first theme to emerge was *Lack of Respect* as it synthesized how the treatment each of the participants received made them feel. I also described the expectations for receiving treatment from both Black and White healthcare professionals. The sub-code the participants described was the need to be “Need to Be listened to and heard.” For example, participant P4-NJ said she often felt disrespected because her concerns were disregarded and dismissed when she complained of extreme lower back pain in her local emergency department when her sciatic nerve flared up. Because she had a long history of the condition, when she followed up with her African American primary care provider, they were extremely alarmed to find out that their patient was sent home from the hospital with nothing more than Motrin. They explained that her level of care had been minimized and that there were much more effective treatment protocols to help Participant P4-NJ deal with the pain. This was a clear example of where Participant P4-NJ’s concerns and asks for care were neglected although she described her excruciating pain to the emergency department doctors who were all White, demonstrating what she framed as poor bedside manner and rushing her out the door.

Participant P6-FCL and Participant DB-10 described experiences where they were each disrespected when their doctors, laughed at them when they requested specific care. Both participants were even more appalled that they had to, fight for care by repeatedly asking for a blood transfusion and a blood panel respectively. Each of the participants explained they regularly had to advocate for themselves. Participant P7-AMB was sent home from a multi-day hospital stay two times late in her pregnancy and was not informed of her status, which brought her to the hospital.

Being Treated Like a person was the second sub-code contributing to *the Lack of Respect* Theme. Participant P8-JB shared how she was often met with what she described as, “condescending tones,” and even felt demeaned when she asked her White doctor a question. Participant DB-10 said she uses African American doctors because she does not want to be what she felt was,” like a number.” Participant CR-3 said she has experienced a difference between Black and White doctors as the White doctors she received care from were often rude. Participant P5-KBF explained that living with a chronic condition since her early years in school, she knew the importance of access to healthcare and there were certain behaviors she was not going to accept, including microaggressions. The significance of the doctor-patient relationship was a fundamental staple in ensuring the quality level of care that her life depended on.

The second theme, *Lack of Confidence in the Level of Care* materialized from two sub-codes, lack of trust and relevance of cultural competency. As mentioned above, Participant P6-FCL and Participant DB-10 were mocked and laughed at by their doctors who not only failed to listen to them but misdiagnosed them as a result. A lack of confidence in care has been a common theme for many African Americans for many years in this country and goes back several generations. Participant P8-JB the eldest research participant in this study, reminisced about how her father who was born in the late 1920's never held a general mistrust of all doctors, but wholeheartedly did not trust any White doctor. Participant P8-JB explained that the Tuskegee Institute Study was a driving factor behind most of the mistrust her father held, and as a young child listening to his stories probably picked up on the lack of trust and then carried it to adulthood.

Participant P11-QP also questioned if African Americans could trust any White doctor after what she described as,” horrific practices of the Tuskegee Institute,” could happen in this current time frame. She mentioned she was always questioning the quality of care she received from White doctors. Participant P1-NN shared how she once left a White dentist only to go home and call her sister who was an OBGYN to confirm the treatment she received. Similarly, Participant P2-RH reported that when her mother was pregnant with her, she went to a childhood friend who was now an OBGYN to make sure the White doctor had given her the proper information regarding her pregnancy.

Participant P2-RH, Participant P3-CR, and Participant P7-AMB each lived in parts of the south for at least seven years ranging. They resided in states from Texas to Georgia to North Carolina, and also shared how experiences in their early childhood included racist behavior from medical professionals, which influenced their need to question White doctors. Each of them expressed that they felt what they expressed as, “warm and fuzzy” when visiting Black doctors, and always trusted them to beyond standard procedures. On retorted, “Black doctors to go the extra mile.” Participant P4-NJ explained how it is often difficult to find a doctor you feel confident enough to trust your care to. Her example was her recounting of having to travel 120 miles each way to visit her primary care physician when he moved his practice.

The relevance of *Cultural Competency* when accessing healthcare was the second sub-code contributing to the Lack of Confidence in the Level of Care theme. Although Participant P9-FDT felt cultural competency was an easily attainable skill for physician and

Participant P11-QP explained how there were varying perspectives, but P10-DB disagreed. She explained she felt more comfortable with Black doctors because as she stated, "they know us because they have shared our same experiences.” Participants P1-NN, P2-RH, P3-CR, P4-NJ, P7-AMB, and P10-DB all expressed feeling connected to their African American doctors, which was different from the distance they experienced when interacting with White physicians. Participant P2-RH said it reminded her of your youthful days living in the South where everyone focused on the community as a whole and trusted those living in close proximity The third theme to emerge with respect to the (CRQ) was *Experiences of Racial Discrimination* when accessing healthcare. Each of the participants described experiences that ranged from microaggressions to judgment to racial discrimination. Participants were denied health care on the basis of their insurance carrier. Participant P4-NJ explained that she had been a long-time patient of her White doctor. When she got laid off from work and had to use Medicaid as her medical insurance, her doctor terminated her as a patient. She also explained how she was made to show identification and pay upfront, when she received care, even after she was no longer on Medicaid and was using her private health care insurance through her employer. P10-DB shared conversations she held with her White OBGYN who repeatedly prescribed her birth control pills and was laser-focused on her weight as opposed to the participant's primary concerns for visiting her OBGYN. She felt that her doctor was only having these conversations with her because she was a young African American woman. She questioned if the doctor would still be practicing in the same manner if she were White.

Participant P3-CR, P2 - RH along with participant P7-A MB recounted several experiences where they felt they could not escape racism as long as they stayed in the southern region of the country. They shared feeling racism was a part of their everyday experiences. These four participants also questioned if racism or sexism was the more prominent factor in the poor quality of care they received. This question pointed out the intersectionality of racism and sexism as well as socioeconomic status. Each participant was educated, with participant P2-RH holding a terminal degree. They lived in middle-class neighborhoods, however nine of the 11 participants expressed feeling judged when visiting White healthcare professionals. They described the experiences as "hostile and non-inclusive.”

One theme emerged with respect to the (GRQ), *Elevated Stress Levels*. All 11 participants indicated that accessing quality care was not as straightforward for Blacks and felt there were different stress factors reported. Participant P10-B explained how when she attempted to access healthcare, the simple thought created high levels of anxiety for her. Seven of the participants indicated they tried to mitigate some of the stress in trying to find culturally competent healthcare providers by asking their friends and families for referrals to African American doctors. Word of mouth has been the number one tool used to find African American doctors. Participants P1-NN, P3-CR, P-NJ, t P7-A MB, P6 - FCL, and P10-DB hated that they either used Google, or the insurance app on their phones to research African American doctors. Oddly, the African American doctors seemed to always be last on the list. This caused them to take extreme amounts of time trying to find the right doctor, which added to their stress levels.

Participant P3-CR and P7-AMB each had pregnancy scares that caused elevated blood pressure levels as a result of the stressful situations, they felt they were placed in by their White doctors. P8-JB explained that conversations with her White doctors caused her so much stress that she often shut down and felt the experiences contributed to bouts of depression. Participant P-NJ described experiencing anxiety and stress similar to her feelings as a teenager when her mother was forced to go on Medicaid. The emotions returned years later when she was laid off from her job and had to use Medicaid as their primary medical insurance.

Discussion

The purpose of this section is to discuss the study findings in relationship to the empirical and theoretical literature reviewed in Chapter Two. The discussion section is designed to consider the study's findings in connection to the themes that emerged from this phenomenological study and utilized data elements gathered from 11 research participants who described their lived experiences of access to health care in the Midwest. These discoveries revealed valuable insights and subject matter for discussion, which were then compared with existing literature. The purpose of the discussion section is to link the findings of the research to existing research. The researcher will present the following subsections: Implications, Delimitations Limitations, and Recommendations for Future Research.

As mentioned in Chapter one, African American Women find themselves dealing with increased levels of stress and poorer physical and mental health when compared to women of other racial backgrounds due to impediments to healthcare that are rooted in discriminatory practices (Williams & Sternthal, 2010). The purpose of this interpretive phenomenological study was to explore the lived experiences and perceptions of African American Women and their access to healthcare in midwestern towns. I relied on the narrative of 11 AAW research participants through semi-structured interviews. The following discussion section I describe the meaning of this research. correlations to existing literature, as well as the revealing of new discoveries as outlined by the research participants (Joyner et al., 2018).

Links to Existing Empirical Research

As recent as 2023, researchers have reported that statistically AAW have an unequal opportunity to survive breast cancer when compared to women of another racial background (White-Means & Muruako, 2023). Additionally, Adebayo et al. (2021) reported that AAW are nearly four times more likely to die from pregnancy-related complications when compared to their White counterparts. Homan et al. (2021) asserted one significant factor based on existing literature on intersectionality s that systems of oppression such as racism, sexism, and classism are interlocking, mutually constituted, and reinforcing. Consequently, the morbidity and mortality rates for AAW dealing with an array of health conditions continue to be worse when equated with White women. Sadly, these rates remain stable even when compared to women who are at the same levels of socioeconomic status (SES) (Okoro et al., 2020).

Theme 1 Lack of Respect

Interpersonal factors, and doctor/patient relationships are key predictors of patient satisfaction (Molina et al., 2014; Oparah et al., 2018). A lack of trust in healthcare systems and professionals has important implications for satisfaction particularly relevant for AAW in this country are living in the setting of historic and ongoing occurrences of racism in medical settings (Molina et al., 2014). Participants described a long history of having a less than satisfactory relationship with their White healthcare providers. The particular and severe methods of racism AAW experience, including microaggressions and overt interpersonal racism by healthcare providers, have been known to contribute to higher levels of medical mistrust and lower satisfaction (Molina et al., 2014; Oparah et al., 2018). One study cites a perceived barrier to effective care is ineffective doctor/patient communication (Dahlen et al., 2015). Specifically, the qualities of doctor/patient interaction deemed essential by AAW included active listening skills, asking psychosocial questions, and clearly explaining diagnoses (Dahlem et al., 2015; Oparah et al., 2018) Moreover, AAW expressed the need for healthcare providers to treat them with respect and deliver compassionate care (Dahlem et al., 2015). The medical mistrust observed among AAW can be reflected as a consequence of marginalization, as well as the daily exposure to implicit and explicit interpersonal and systemic practices of racism. Medical mistrust of the healthcare providers has been linked to anxiety, depression, and perceived lower-quality care among AAW (Molina et al., 2014).

Theme 2 Lack of Confidence in Level of Care

Pregnancy-related deaths are three times more likely in AAW than in White women (Okoro et al., 2022; Wright et al., 2022) These inequalities in pregnancy-related mortality endure even after adjusting for educational attainment and income level, even though most pregnancy-related causes of death are preventable (Okoro et al., 2022). Results from epidemiological examination indicated a robust correlation between chronic stress and increased CVD risk. Historically and even presently, AAW experience extremely high exposure to several chronic stressors including structural, institutional, and interpersonal discrimination. This includes other social injustices and inequities such as the burden of caregiving, socioeconomic disadvantage, lack of access to high-quality care, and many other social determinants of health (Okoro et al., 2022). Each of these factors culminates in healthcare provider’s perceptions of AAW with low SES, which influences clinical decision-making and delivery of care (Okoro et al., 2022).

Penchansky and Thomas (1981) defined healthcare access as, “a concept representing the degree of "fit" between the clients and the system (p. 128).” Much like the narratives shared by the 11 participants in this study, gaps in healthcare access were demonstrated in diagnostic testing, routine examinations for chronic conditions, recommendations for necessary procedures, and referrals to specialties. Furthermore, individuals of low SES who are from racially marginalized populations such as AAW, continue to report the attitudes of healthcare providers are perceived as dismissive or demeaning (Okoro et al., 2022).

Theme 3 Experiences of Racial Discrimination

Studies conducted at the turn of the century held that AAW face an intricate system of inequitable as well as ineffective healthcare practices (Kawaii et al., 2017). Still comparing AAW to their White counterparts, AAW are overly affected by mental illnesses. This is in part due to structural barriers affecting their access to mental healthcare access (Kawaii et al., 2017). (Kawaii-Bogue, Williams, & MacNear, 2017). To reduce the presented racial disparities in mental health care for AAW, there is a necessity to increase culturally effective access and treatment systems that are operationally designed to meet the particular needs of AAW (Kawaii et al., 2017).

This research highlights how current models of access to care likely need to shift from targeting simple affordability to coupling that with a contextual background that takes into consideration the subtleties in the ways that marginalized persons interact with healthcare providers (Allen et al., 2014). Accordingly, the structural racism in this country will need to be destroyed if the intention is to increase access of minority populations such as AAW to housing, neighborhood and educational quality, employment opportunities, and other desirable resources in society such as access to healthcare (Assari, 2018). Secondly, cultural racism operates through stereotypes both at the societal and individual levels. Generating a culture and a policy environment that is hostile to egalitarian policies, triggers the continuation of negative stereotypes and discrimination detrimental to one's health and fosters health-damaging psychological and behavioral responses (Assari, 2018). Lastly, racial discrimination has been known to function as a unique psychosocial stressor at the interpersonal and personal levels, (Assari, 2018) diminishing the inclusiveness of healthcare (Assari, 2018). As demonstrated through the narrative stories of each of the 11 research participants, experiences with racial discrimination adversely affected their access to healthcare.

Links to Theoretical Research

Critical race theory (CRT) is an interdisciplinary philosophy that presents a construction for studying the experiences of racially marginalized populations in the U.S. (Adebayo et al., 2022). Although this theory was developed as the collaborative product of U.S. scholars Bell, Freeman, and Delgado, its application has extended to other parts of the world (Adebayo et al., 2022). The link to this research is based on one of the principal tenets of the theory, which is to critique the idea that racism is ordinary and normal. This notion of normality of racism in the US spreads, "*color-blind, or formal,* conceptions of equality, expressed in rules that insist only on treatment that is the same across the board, can thus remedy the most extreme forms of discrimination" (Adebayo et al., pp.1138). Although CRT is a developing transdisciplinary, race-equity theoretical construct with its roots deeply planted in legal studies and grounded in social justice. Along with Ford and Airhihenbuwa (2010), researchers seek to launch CRT into the public health community by highlighting key features such as race consciousness, emphasis on contemporary societal dynamics, and socially marginalized groups by describing its contribution to the study on racism and health disparities.

Empirical researchers listed in the previous section have documented the long history of disparate health treatment rooted in racist and discriminatory practices in the US. These practices and systemic barriers to healthcare are prime examples of social deliriants of health that have been known to result in worsening health outcomes and cultural mistrust within affected communities (Hilliard et al., 2023). Predisposition in healthcare and health inequalities are complex issues however, CRT yields a basis for a better comprehension of the causes that contribute to them (Hilliard et al., 2023). It's widely known that CRT has its genesis opposite scientific research but less widely known is its significant applications in conducting epidemiological research (Roberson, 2022). CRT can help researchers and healthcare providers give meaning to how systemic discrimination rooted in racism shapes research. Scientific research could potentially be greatly enhanced by considering any of the many frameworks offered by CRT (Roberson, 2022).

CRT can be used to highlight the ways discrimination and racism affect mainstream healthcare (Madden, 2015). Systemic barriers that either intentionally or unintentionally reinforce the middle-class White models as the standard by which to judge communities of color, such as AAW, are examples of how structures can maintain racial bias (Madden, 2015). An example of this is Participant P1-NN who felt an extreme level of disrespect when her White OBGYN insisted on repeated conversations about her post-pregnancy weight even though, as the patient, it was not a concern. She explained to her doctor how she planned to lose the weight. Participant P10-DB had a similar experience where she too could not get her OBGYN to focus on the original cause for her visit as opposed to constantly talking about her weight.

Dominant cultural orientation privilege and discrimination is also a tenet of CRT (Mitchell et al., 2022). It suggests that social institutions health care organizations, as an example, operate using customs, values, and principles of the dominant society, that may not be predominant among individuals from other cultural backgrounds, such as AAW. Consequently, AAW must utilize their lived and relevant experiences, knowledge, skills, and other available resources, known as cultural health capital (CHC), to pilot a White-dominated healthcare system to accomplish ideal healthcare results (Mitchell et al., 2022).

For the most part, the obvious evidences of racism exist in the boundaries of our society (Thomas et al., 2011). However, it is still possible for racism to be made detectable to all, as seen in the beating deaths of individuals from protected classes (e.g., racial/ethnic minorities – George Floyd) and the passage of hate crime laws. As it pertains to this study, racism plays out in more subtle ways through what is termed ordinariness, where it is a more indirect part of daily life (Thomas et al., 2011). By integrating CRT’s concept of racism, investigators can better determine the level of influence of routine exposure to racism on health behaviors and status. Additionally, there is a need to implement race consciousness and begin the research process from the perception of racial minorities, which Ford and Airhihenbuwa (2010) called "centering in the margins.” Contrary to the viewpoints of majority White researchers, this could fundamentally alter the complete research course toward a diverse level of engagement around discrimination and racism. The shift could cause a demand for researchers to explore their own lived experiences and the interaction of race, power, and class (Thomas et al., 2011).

Implications

This interpretive phenomenological analysis has implications for theory and research. The researcher has identified the theoretical and empirical implications of this study in the following sections. The implications described below evolved through the analysis of thematic findings and the mapping and coding of each of the data elements that were collected.

Theoretical

The interpretive phenomenological analysis outlined above in Chapter 1 through Chapter Four aligned with Critical Race Theory, which the researcher used as the theoretical framework for the study. CRT blossomed during the 1970s through the early work of the late Derrick Bell who was an African American man and Alan Freeman a White man, who were each deeply concerned over the slow pace of racial reform in the United States (Delgado & Stefancic, 2000). From their perspective along with the added vigor of many others who quickly joined the crusade, the civil rights movement of the 1960s had halted and argued that many of its early societal gains were being repealed or together avoided. They had concluded new and re-designed methods were needed to recognize and come to terms with the more covert, but just as deeply established, variations of racism characterized the current era (Delgado & Stefancic, 2000). They began to witness old approaches yielding smaller and smaller returns. As a result, CRT was born and fifty years later it now consists of a body of several hundred leading law review articles and dozens of books, many of which are noted or excerpted in this volume (Delgado & Stefancic, 2000).

The foundational basis of CRT is the notion that racism is normal in American society (Ladson-Billings, 2010). Three basic principles guide the understanding and application of CRT (Adebayo et al., 2022). The first underlying premise of CRT is it serves to challenge the idea racism is ordinary or normal. It seeks to dispel the notion of color blindness a White Americans do not see color when they see African Americans. By advancing this notion, AAW are broadly ignored or unaccounted for in social policies, "because an individual (white) person 'does not see race' and therefore 'is not racist" (Adebayo et al., 2022). Furthermore, not only are AAW disregarded in social policies underserving them such as healthcare settings, but they are also discriminated against given the quality of what is "good" only resides in whiteness (Adebayo et al., 2022).

The second premise or staple of CRT is it critiques the material accumulation of wealth as a core manifestation of racism, one that predominantly serves Whites. (Adebayo et al., 2022). Incidentally, as whiteness is cited as a property of interest, CRT contests the hegemonic execution of social institutions (i.e. healthcare settings) that enhance the interests of Whites, materially and otherwise (Adebayo et al., 2022). Lastly, the third premise of CRT is it maintains the fact that race is socially constructed, meaning racial minority populations are only applicable to the extent to which the society "endows them with pseudo-permanent characteristics," subjecting them to social and power hierarchies where they are relegated to the lowest rungs (Adebayo et al., 2022, p. 1138).

To buffer the argument of the validity of CRT in public health settings, the researcher reviewed existent literature on Social Stress Theory (SST) as a very early precursor to CRT. Dohrenwend's 1961 paper documented the early studies on social stress and social stress theory as a contributing factor to mental disparate health outcomes.

Recently, a number of studies begin to lay the groundwork of theory and fact with respect to the relationship between social environmental factors and mental illness (Dohrenwend, 1961). In 1973, the author hypothesized persons in low socioeconomic status (SES) are unreasonably subjected to stressful life events and this type of exposure provides an illuminating connection between low social status and individual psychological distress (Dohrenwend, 1973). These arguments are not much different from CRT.

Critical Race Theory's conceptualizations for leading research and practice are envisioned to assist in interpreting current racial phenomena, broadening the terms with which to discuss complex racial concepts, and challenge the racial pecking order (Ford & Airhihenbuwa, 2010). By introducing the theory into the public health realm, CRT proposes a new standard for examining the root causes of health disparities in the U.S. Based on race equity and social justice philosophies, CRT inspires the expansion of resolutions, which bridge gaps in health outcomes (Ford & Airhihenbuwa, 2010). The CRT lens places race and racial domination at the foreground of social research, allowing scholars to identify kinds of cultural capital that exist in marginalized populations, while criticizing conventions that AAW are at a cultural “deficit” when equated to Whites (Madden, 2015). Drawing upon the early vies of SST and bridging medical sociology with CRT perspectives can foster efforts to counteract the marginalization of AAW when accessing healthcare (Madden, 2015).

Empirical

In the United States, AAW are three to four times more likely to die from childbirth (Hamilton et al., 2021). This reported disparity by Hamilton et al., (2021) is theorized to be related to differences in access to healthcare or socioeconomic status. This statistic highlights the narrative of each of the participants who had serious healthcare scares during their pregnancies, or who sought African American doctors as their OBGY for fear of dying during childbirth. A concern to ensure healthcare resources are mobilized to meet the needs of marginalized groups is a focal point of the concept of access. Gulliford et al. (2002) proposed the notion of fairness or social justice giving way to the tenets of CRT.

Health equity is the condition in which all populations have the prospect of acquiring full health potential, and no one is deprived of reaching this potential due to social position or any other social determinant of health (Weinstein et al., 2007). Health equity and opportunity are intimately correlated. Presently, the weights of disease and poor health and the values of well-being and good health are disproportionately allocated. This inequitable distribution is caused by many social determinants of health that have been shown to have very distinct variations in opportunities for health outcomes (Weinstein et al., 2007).

For example, AAW are 1.41 times more likely to die from breast cancer (White-Means & Muruako, 2023). In 2011, the research conducted by Thomas et al. detailed the U.S. Census Bureau forecasted the gap in life expectancy will continue to exist and estimated life expectancy for Whites in 2020 to be 80.0 years compared with 76.1 years for Blacks. Another study showed that Black Medicare recipients had a 37% higher readmission rate as compared to Whites (Gillmore et al., 2023). Hypertension rates are (54%) higher among Black adults than among Whites (46%) (Hilliard et al., 2023). Hoffman et al. (2016) conducted a cancer study examining pain management among patients with metastatic or recurrent cancer, which revealed only 35% of African American patients received the appropriate prescriptions as established by the World Health Organization guidelines compared with 50% of nonminority patients. Physicians were more likely to underestimate the pain of Black patients (47%) relative to non-Black patients (33.5%) (Hoffman et al., 2016). Other examples include a study where 57% African Americans and 74% Whites received analgesics, respectively (Green et al., 2003). The researchers cited another study on morphine equivalents where Whites received 22mg/day, African Americans received 16mg/day, and Hispanics received 13mg/day, during the post-operative period. Fertility rates also demonstrate health disparities in AAW. One 1995 study of 10,847 American women of reproductive age conducted by the National Center for Health Statistics suggested infertility affects women of all races but noted the higher rates of AAW; African American (10.5%), Hispanic women (7%), and White women (6.4%) (Missmer et al., 2011).

Practical

As evidenced above, the disparities AAW experience in healthcare are continual and staggering. Findings from health outcomes researchers continue to demonstrate poorer outcomes for African American women compared to women of other race/ethnicity in several conditions (Okoro et al., 2022). The racial and gender health inequalities observed are complicated, immensely nuanced, and multi-factorial (Okoro et al., 2022). The practical implications are focused on the systemic and structural barriers to healthcare access for AAW.

Each of the four emerging themes have practical implications for the treatment of healthcare professionals who contribute to the lived experiences of AAW when accessing healthcare. The findings from Okoro et al. (2022) mimic the findings of this study. While the 2022 study generally focused on the overall healthcare experiences of its participants, the thematic analysis discovered four major themes that are very closely aligned to this study:(a) the perception of not feeling heard, (b) being the expert of their own body, (c)disregard for patient preferences, and (d) the need for self-advocacy.

Okoro et al. (2022) demonstrated healthcare provider implicit racial biases negatively affects the doctor/patient interaction and treatment of AAW. Opportunities exist for primary care providers to improve the effects of social determinants of health through insights into their influences on health outcomes (Ochieng & Crist, 2021). Perceived systematic racism and discrimination place AAW at risk for not receiving preventive care and low-quality healthcare services (Ochieng & Crist, 2021). As a result, it is important for doctors to be as medically astute, as they are culturally astute in treating AAW. This study adds to the existing literature by shedding light on how the promotion of health equity raises questions about the fairness that is associated with the structural conditions, which produce inequities, such as who has access to resources for health and how structural disadvantages limit access (Pauly et al., 2021). Providing healthcare is an intricate progression with substantial political and economic pressures and multiple competing challenges. Although one of the overall goals of public health is to uphold health equity, trying to do so within the confines of a system that does not always prioritize health equity and is wrought with complications and the basis of ethical rigidities that are not well expressed (Pauly et al., 2021). CRT as a theoretical framework for social justice in public health has a great deal of room for growth as it challenges healthcare providers to reconsider how their implicit biases present themselves through judgment, discrimination, condescending tones, dismissiveness, failure to listen, failure to act upon the request, misdiagnosis, overprescribing, and even neglect.

Delimitations and Limitations

The researcher placed certain delimitations on the study to narrow the scope, which facilitates discovering unique themes through the shared experiences of AAW access to healthcare. AAW who currently work in healthcare careers were excluded from the study to eliminate any professional bias. Although the Midwest has one of the highest infant mortality and pregnancy-related deaths in the country AAW who did not live in the Midwest were excluded from the study to set the groundwork for future studies in other geographical locations. Men were also excluded from the study for twofold reasons. The first rested on how AAW are seen as a double minority, enabling the researcher to consider the intersectionality of race and gender. The second focused on women having unique, gender specific healthcare needs. The researcher used a random sampling from a Google form Screening Questionnaire. As a result, the age of each participant could not be controlled outside of the general 18-75 age range that was preset. The research was limited to only AAW.

Recommendations for Future Research

This study explored the lived experiences of AAW and access to healthcare from an interpretive phenomenological analysis. Recommendations for future research include examining men and other racial and ethnic minorities with respect to access to healthcare. Additionally, this study should be repeated in other geographical locations, especially the South. Most studies on disparate health outcomes are quantitative in nature. By increasing the number of qualitative studies, researchers give deeper meaning to the lived experiences of marginalized populations in this country. Another thought to consider is to conduct the study with White women and cross-examine the results.

Summary

The purpose of this interpretive phenomenological study was to explore the lived experiences of AAW and their access to healthcare in the Midwest. To get a better understanding of each of those experiences, this study posited the following Central Research Question: What do the experiences associated with healthcare access mean to African American Women? In addition, one Guiding Research Question was asked to further understand the phenomenon; How do African American Women (AAW) describe the impact of race and racism in relation to healthcare access? The literature review demonstrated that while there is a plethora of empirical data revealing quantitative results of the health disparities between AAW and White women in this country, much less exists or even sought to understand the lived experiences of African American Women through qualitative measures. By connecting theoretical frameworks such as Critical Race Theory (CRT) the researcher was able to detail the human side of the analysis through personal narratives by highlighting the impact of each participant's experiences on their mental and physical health due to the systemic social injustices in this country which have risen to the level of a public health concern (Ford & Airhihenbuwa, 2010; Roberson, 2022).

CRT was born out of the social justice school of thought but has strong implications in medical sciences as this research has demonstrated the many social injustices AAW face when accessing healthcare in the United States (Ford & Airhihenbuwa, 2010). Participants explained that the treatment and quality of care from White doctors led to neglect and increased stress levels.

All the data elements used in this study were collected through semi-structured interviews with 11 research participants as outlined in Chapter Three. The data elements were analyzed and validated through member checks. The researcher was careful to disregard personal beliefs and preconceived notions and by following a hermeneutical approach, four themes and seven sub-codes organically emerged. The researcher used Chapter Four to outline a detailed presentation of those themes and sub-codes. As a result, the questions the researcher explored were answered. Each of the four thematic discoveries aligned well with existing research (Adebayo et al., 2022; Allen et al, 2014; Anderson et al., 2002; Assari, 2018; Blair et al., 2013; Butler et al., 2-18; Dahlem et al., 2015; Ford Airhihenbuwa, 2010; Gulliford et al., 2002; Jones, 2021; Hilliard & Pearson, 2023; Homan et al. 2021; Kirksey, 2021; Lundeberg et al., 2023; Mitchell et al., 2022; Molina et al., 2014; Okoro et al., 2022; Okara et al., 2020; Roberson, 2022; Wright et al., 2023) and more, in addition to adding to each of the above studies and theories. I found t participants' perceptions of their lived experiences accessing healthcare contributed to the health disparities. The researcher's findings of a lack of respect, lack of confidence in the level of care, experiences of discrimination and racism, and increased stress levels when accessing healthcare are a social injustice as well as a public health concern. One participant summed up each participant's experiences by saying:

> You often hear the phrase; we live in the greatest country on earth. But that's not true if your skin is Black. If am Jewish, Muslim, Christian, or even gay, you would never know it unless I told you. But I cannot walk out my front door without you knowing that I am a Black woman. So, when I do, it's not fair that I will be judged, and judged unfairly I might add.
>
> I was diagnosed with a chronic condition before I could even spell diagnosis, chronic, or diabetes that I will have to live with unless a cure is found, for the rest

of my life. I need to be able to trust the routine and regular care that I receive in addition to any emergency care that I might receive. But how can I do that if the first thing you see and judge me by is the color of my skin? And that judgment leads you to falsely believe that I am poor or on Medicaid and can't pay you. Let's take it a step further, let's say I am a poor AAW. Does that mean I do not deserve to be treated with respect? Does that mean I do not know my own body and I don't deserve to be listened to? Does it mean that I only receive the bare minimum of care just so I can leave your emergency department and you can run off to treat your next patient as fast as you can? Does my treatment deserve to be rushed because I am an African American Woman? Do I deserve to be misdiagnosed and over-prescribed narcotics because you don't want to listen to me? So instead of dealing with microaggressions or any of these other behaviors, I have to go out of my way to try to find Black a doctor. It’s just stressful thinking about everything I have to do and consider, just to live. And we call that justice? Fairness? Freedom? Or liberty in this country? Not for us.” Not for African American women just trying to access quality healthcare in this country.

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Appendix A

Screening Questionnaire

Doctoral Study Screening Questionnaire

Online Recruits

Required

Section

1.Full name

2.Phone number

3.Do you consent to receiving text messages regarding your participation in this research study?

Yes

No

4.Email

5.Home address

6.City

7.State

8.ZIP code

9.Are you aged 18-75?

Yes

No

10.Do you self-identify as an African American Woman (AAW) (Born this way at birth?)

Yes

No

11.Have you sought out medical care (physical or mental) within the last 15 years in Northeast Ohio?

Yes

No

12.Please Enter the year you were born.

Appendix B

Recruitment Letter

11/16/2022

Dear [Recipient]:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to explore the lived experiences of African American Women (AAW) perceptions of access to healthcare in Midwestern towns, and I am writing to invite eligible participants to join my study.

Participants must be 18 years of age or older and self-identify as a racial and gender minority, specifically African American Woman. Participants, if willing, will be asked to complete a 30-minute semi-structured interview questionnaire. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please click here https://forms.office.com/r/jZhnZjR489 to complete the attached screening questionnaire. If you qualify for the study, you will be contacted by E-mail or text message, at which point you will be asked to sign a consent letter detailing all of the procedures for the study. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of your interview.

Sincerely,

RaMona D. Benson
Doctoral Candidate
[redacted]

Appendix C

Recruitment Letter Social Media

ATTENTION Facebook members! I am conducting research as part of the requirements for a doctorate in Community Care and Counseling at Liberty University. The purpose of my research is to explore the lived experiences of African American Women (AAW) perceptions of access to healthcare in Midwestern towns, and I am writing to invite eligible participants to join my study. To participate, you must be 18-75 years of age, self-identify as a racial (Black) and gender (female) minority, and have sought medical care (physical or mental) in the Midwest United States AND do not work in a professional healthcare setting.

Participants will be asked to participate in a video-recorded interview that will last no longer than one hour. Please click here https://forms.office.com/r/jZhnZjR489 to complete the attached screening questionnaire. If you qualify for the study, you will be contacted by E-mail or text message, at which point you will be asked to sign a consent letter detailing all of the procedures for the study. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of your interview. A consent document will be given to you at the time of the interview.

Facebook

ATTENTION FACEBOOK FRIENDS: I am conducting research as part of the requirements for a Doctor of Education degree at Liberty University. The purpose of my research is to explore the lived experiences of African American Women (AAW) perceptions of access to healthcare in Midwestern towns. To participate, you must be 18-75 years of age, self-identify as a racial (Black) and gender (female) minority, and have sought medical care (physical or mental) in the Midwest United States.

Participants will be asked to complete an anonymous online survey, which should take about 3 minutes. If you would like to participate and meet the study criteria, please click the link provided at the end of this post.

Link to Screening questionnaire: https://forms.office.com/r/jZhnZjR489

Appendix D

Permission Request

11-22-2022
The Light Church
980 Rhodes Ave
Akron, OH 44307

Dear [Recipient],

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to explore the lived experiences of African American Women (AAW) perceptions of access to healthcare in Midwestern towns, and I am writing to invite eligible participants to join my study.

Participants must be 18 years of age or older and self-identify as racial (Black) and gender (female) minority. Participants, if willing, will be asked to complete a 30-minute semi-structured interview questionnaire. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

I am writing to request your permission to conduct my research at First Congregational Church of Akron by utilizing your membership list to recruit participants for my research.

Participants will be asked to complete this screening questionnaire.

Thank you for considering my request. If you choose to grant permission, respond by email to [redacted]. A permission letter document is attached for your convenience.

Sincerely,

RaMona D. Benson
Doctoral Candidate, Liberty University

Appendix E

Permission Response

[Please provide this document on official letterhead or copy and paste it into an email. Permission response letters/emails should be returned to you, the researcher, and not the IRB. Upon receipt of documentation of permission, please attach it to your Cayuse application and return your application to the IRB.]

[Date]

[Recipient]
[Title]
[Company]
[Address 1]
[Address 2]
[Address 3]

Dear RaMona D. Benson

After careful review of your research proposal entitled ***Exploring African American Women's Perceptions of Access to Healthcare in the Midwest***, [I/we] have decided to grant you permission to [Select the appropriate phrase:] [access our membership list/contact our faculty/staff/other and invite them to participate in your study]—OR—[conduct your study at [name of district/school/church/etc.

Check the following boxes, as applicable:

☐ [[I/We] will provide our membership list to [your name], and [your name] may use the list to contact our members to invite them to participate in [his/her] research study.

☐ [[I/We] grant permission for [your name] to contact [description of potential participants] to invite them to participate in [his/her] research study.]

☐ [[I/We] will not provide potential participant information to [your name], but we agree to [[send/provide] [his/her] study information to [description of potential participants] on [his/her] behalf.]

Sincerely,

[Official's Name]
[Official's Title]
[Official's Company/Organization]

Appendix F

Consent Form

Title of the Project: *Exploring African American Women's Perceptions of Access to Healthcare in the Midwest*

Principal Investigator: RaMona D. Benson, Doctoral Candidate, School of Behavioral Sciences, Liberty University

Co-investigator: Dr. Todd Schultz, Professor – Dissertation Chair, Liberty University

You are invited to participate in African American Woman between the ages of 18-85 living in the Midwestern section of the United States have sought medical care (mental or physical within the last 15 years), AND do not work in a professional healthcare setting. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to explore the lived experiences and perceptions of access to healthcare of African American Women in midwestern towns. Access to healthcare will be generally defined as satisfaction of healthcare providers with respect to the needs of African American Women (AAW).

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. First task: Complete and online screening and demographics questionnaire (https://forms.office.com/r/jZhnZjR489).
2. Second task: Participate in an in-person, video-recorded interview that will take no more than 1 hour.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

What risks might you experience from being in this study?

Minimal risk, but the possibility of psychological stress exists.] The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include the possibility of psychological stress from being asked to recall and discuss prior trauma. To reduce risk, will monitor participants, discontinue the interview if need, and provide referral information for counseling services.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer. After three years, all electronic records will be deleted and or all hardcopy records will be shredded.
- Recordings will be stored on a password locked computer/etc. for three years and then deleted/erased. The researcher and members of her doctoral committee will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is RaMona D. Benson. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her [redacted] [redacted] You may also contact the researcher's faculty sponsor, Dr. Todd Schultz at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher[s], **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and *faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.*

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher[s] will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to video-record me as part of my participation in this study.

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Printed Subject Name

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Signature & Date