BRK Global Healthcare Journal, 978-1-5323-4858-7

Volume 1, Issue 1, 2017

African American Women Speak: A Phenomenological Study of African American Women's Beliefs and Perceptions about Compliance to the Treatment Regimen in the Healthcare System

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Abstract

African Americans comprise approximately 13% of the U.S. Population; however African American women are in the upper percentile of healthcare diseases that are preventable such as cardiovascular disorders (e.g., heart disease, blood pressure, and strokes), cancer, and diabetes and HIV/AIDS. The purpose of this phenomenological study was to provide a forum for African American women living in a southeastern state of the United States to share their experiences with the healthcare system and health practices. The Health Belief Model was a useful health promotion framework for guiding this study. This study sought to answer the following research question: (a) What do African American women report about their beliefs and perceptions about affecting treatment regimen in the healthcare system. The research study consisted of 50 African American women recruited from various communities in one rural county of a southeastern state in United States. Results of findings consist of nine themes: The nine themes were as follows: (a) distrust of health care providers; (b) difficulties communicating to health provider; (c) poor quality of patient education instructions; (d) lack of knowledge about treatment regimen; (e) Inadequate time management and inability to manage health treatment regimen; (f) inadequate access to care; (f) unaffordable cost; (g) lack of healthy lifestyle practices; and (i) inadequate coping skills. The community /public health nurse is in a key position to advocate and promote health promotion programs for vulnerable groups in communities. Forming partnerships would be useful in developing programs to improve the overall health needs of African American women. Culture competent education for health professionals remains a critical issue in the current health system when improving the compliance to treatment regimen for African American. Future research needs to examine the contributing psychosocial factors of African Americans and compliance to the treatment regime.

Key words: African American women; compliance; treatment regimen; health belief; health disparities; access to care; culture competent

Participant comments regarding health providers:

"When I changed from private insurance to Medicaid I noticed there was a different in the quality of care I received."

"Read about minority's culture-eating habits and ways of life. You have to know me, and about my culture before you can try to help me; where and what I traditionally eat, live, worship, etc. If there seems to be a problem with knowing this then I usually trust my practitioner less. I can always tell."

Introductions

Health disparities continue to plague the lives of many African Americans, especially the poor and undeserved (Kennedy, 2013). Cardiovascular disease is the number one killer of American women (American Heart Association, [AHA, 2013]. African American women are at greater risk for cardiovascular disease than any other ethnic group, yet they are less likely than white women to know that they may have major risk factors (AHA, 2013). Also, African American women have a 48.9% rate of heart disease compared to 32.4% in European American females (AHA, 2013).

African-Americans are at greater risk for heart disease, stroke and other cardiovascular diseases (CVD) than Caucasians (AHA, 2013). The prevalence of CVD in black females is 44.7%, compared to 32.4% in white females (AHA, 2013).The risk of heart disease and stroke increases with physical inactivity (AHA, 2013). Physical inactivity is more prevalent in women, especially, African-Americans and Hispanics (AHA, 2013). For non-Hispanic black females age 18 and older, 33.9 % are inactive, compared to 21.6% of non-Hispanic white females (AHA, 2013).

African Americans comprise approximately 13% of the U.S. population; however African American women are in the upper percentile of healthcare diseases that are preventable such as cardiac disease, breast cancer and an account for 72% of the HIV/AIDS related cases (Centers for Disease Control, 2017). The poverty rate of African American women is twice that of whites (24.3 % versus 10.3%) and the death rate is higher than that of whites for the 8 of the 20 leading causes of death, such as heart disease, breast cancer and stroke. African American women continue to be absent from research (Bell, 2009). As a result of increased prevalence of disease, African American women have the worst health outcomes than other groups.

The purpose of this phenomenological study is to provide a platform for African American women in a southeastern state in the United States to speak about their experiences with the healthcare system and their health practices. The Health Belief Model was a useful health promotion framework for guiding this study. This study sought to answer the following research question: (a) What do African American women report about their beliefs and perceptions about factors affecting treatment regimen in the healthcare system. The sections of this paper are as follows: (a) overview of the Health Belief Model; (b) literature review on the present health status of African American women; (c) methodology; (d) results of findings; (e) discussion; (f) future research; and (d) conclusion.

The Health Belief Model

The Health Belief Model (HBM) is a health protection model developed by Irwin Rosenstock in 1966 provided a framework to explain why some people take specific actions to avoid or treat illness, whereas others fail to protect themselves (Glanz, Rimer, & Lewis, 2002). HBM is the most commonly used theory in health education and health promotion (Glanz et al., 2002). The underlying concepts of the original theory are that behaviors determine by personal beliefs or perceptions about the disease and the strategies available to reduce the occurrence (Glanz et al., 2002). This theory explored the perceived consequences of a disease, perceived vulnerability to disease and beliefs about a potential to reduce severity or susceptibility effects a person to taking preventative measures to lessen the threat of disease which may influence behaviors (Rosenstock & Kazdin, 2000)

There are four components of the HBM: (a) perceived susceptibility, (b) perceived severity, (c) perceived benefits (d) and perceived barriers (Rosenstock & Kazdin, 2000). A primary premise for the HBM for individual susceptibility, the belief of possible severe consequences, potential to reduce severity or susceptibility through action taken could prove beneficial in the minds of those affected by a disease (Rosenstock & Kazdin, 2000). Perceived susceptibility is the subjective perception of an individual regarding their risk of contracting disease (Rosenstock & Kazdin, 2000). Perceived severities are feelings about the seriousness of obtaining the disease or simply the disease being untreated due to neglect where medical, clinical and social evaluations could impact the condition (Rosenstock & Kazdin, 2000). Perceived benefits may or may not be related to health, however, are viewed as the course of effective action taken for a serious threat leading to a behavior change. Perceived barriers are possible negative health actions which may block or detour the prescribed behavior, such as cost, inconvenience, or lack of time; therefore, decreasing the chance of taking any action. Cues to action are triggers which may not be measureable, yet, affect perception on health behavior.

Self-efficacy. In 1988, self-efficacy was added to the original four beliefs of the HBM (Rosenstock, Strecher, & Becker, 1988). Self-efficacy is a central concept in the HBM which is defined as the confidence that one can successfully execute the behavior required to produce the outcomes. The HBM guided this research study in discovering African American women's beliefs and perceptions about factors affecting their compliance to the treatment regimen.

Literature Review

Access to care is a problem in minority populations especially African Americans (Kennedy, 2013; Kennedy, Mattis, Woods, 2007). Furthermore, access to care is far worst in rural minority population in comparison to urban minority population especially African Americans (Carlton, & Simmons, 2011). Access to care and health behavior impact on their health outcomes. Minority groups are less likely to report receiving any care, having regular appointment source of care, or receiving preventive services. For, the rural populations, medical treatments are frequently obtained through hospitals, clinics and emergency rooms (Carlton, & Simmons, 2011). However, public hospitals are the provider of most of the health care of the rural population.

Compliance to healthcare is a critical issue in healthcare (Middleton, 2009; Senteio & Veinot, 2014; Wexler, Elton, Pleister, & Fieldman, 2009). Research reported a lack of knowledge as a barrier to self-care (Bayliss, Steiner, Ferald, Crane, & Main, 2003). African Americans and other minority groups are less likely than whites to receive appropriate medical treatment after they gain access to medical care (Reschovsky & Staiti, 2005). Physicians' recommendations are an important determinant of a patient's decision to undergo treatment (Song et al., 2013). Senteio and Veinot (2014) conducted a grounded study aimed at knowing the adherence among African Americans with chronic diseases. The 37 participants were recruited from various organizations in 3 low socioeconomically cities in the Midwestern area of the United States. Results of findings reported compliance to the treatment for patients were low. In addition, adherence problems are often not known to doctors due to lack of a trusting relationship with them.

Bayliss et al. (2003) in a qualitative study on self-care, participants had a daunting task of keeping up with the medication regimen for multiple conditions.

Many minority Americans do not have a regular doctor, limited choices in where they go for health care and difficulties accessing specialty care (Kennedy, 2013; Kennedy et al., 2007). Segregation is likely to adversely affect access to high-quality medical care (Kennedy, 2013; Kennedy et al., 2007). Healthcare facilities are more likely to be closed in poor and minority communities limiting their access to care (Kennedy, 2013; Kennedy et al., 2007). Even when African Americans access care, quality of care by the health provider and compliance to the treatment regimen are critical issues for overall health outcomes (Kennedy, 2013; Kennedy et al., 2007).

Many of the Black Americans at risk are least likely to afford doctor visits, due to lack of health insurance and lack of access to medical treatment (Middleton, 2009). The lack of health insurance has affects undiagnosed hypertension, stroke, death and elevated cholesterol levels related to poorer access to care. Poverty and low education affect disability as well as unhealthy behaviors, poor social networks, neighborhood influences and other support systems (Louie, & Wald, 2011).

African Americans are less likely to participate in healthy lifestyle practices (Pleis, & Lethbridge-Cejku, 2006). The chronic diseases are also known as poor lifestyle choices that over time cause illness (Kennedy, 2014). Regular physical activity is associated with a decreased risk of developing chronic diseases, such as cardiovascular disorders, diabetes and obesity (CDC, 2017). Despite the known benefits from exercise, in the United States over 66% of women report engaging in no vigorous leisure-time physical activity (Pleis, & Lethbridge-Cejku, 2006). African American women often participate in less leisure-time physical activity than other women (Joseph, Ainsworth, Keller, & Dodgson, 2015; Kennedy, 2014; Luncheon, & Zack, 2011).

Although, African American women have the worst health status in the United States; limited research has been conducted on this group (Bell, 2009). Few studies have explored their beliefs and perceptions about health care (Baffour & Chonody, 2009; Bell, 2009). This study attempted to explore the lived experience of African American women's beliefs and perceptions about factors affecting their compliance to the treatment regimen in the healthcare system. However, this study takes it to another level in exploring their beliefs and perceptions about recommended strategies to improve their compliance to health regimen.

Methodology

Purpose of the Study

The purpose of this phenomenological study was to capture the lived experience of African American women in a rural region in a southeastern state in United States about their beliefs and perceptions of the healthcare system. The key to understanding phenomenology lies in the lived experience of persons who are going through the phenomenon to be understood. This study was intended to acquire additional knowledge in an area of research that had been understudied. The researcher sought to examine the reports of African Americans women regarding the healthcare system, in addition to their health behavior practices.

Sample and Population

The purposive sample comprised of 50 African American women between the age of 18 to 65 in a southeastern state of the United States. Participants were recruited via flyers

from various organizations such as church groups, colleges, universities and other organizations throughout the community. The contact information and the purpose of the study were provided on the flyer. If women chose to participate and met the selection criteria, an interview was scheduled and informed consent provided before the interview.

Interview Guidelines

The semi-structure interview guided the research questions were open ended. The questions focused on (a) quality of health care; (b) attendance of routine medical appointments; (c)compliance to prescribed treatment regimen, treatment appoinments, doctor visits, test appointments and (d) suggestions for improving compliance to the health care system. If participants agreed to participate in the study, a consent form was signed. The participant completed a demographic sheet with the following items: (a) age; (b) education level; (c) marital status; (d) employment; (e) income; (f) religious affiliation; (f) common health problems; (h) medical insurance and benefits; (i) health care providers; (k) information on attendance and compliance to the treatment regimen ; and (k) health promotion activities (i.e., exercise; nutritional diet).

Research Questions

The primary research question was centered on capturing the essence of the experiences of these African American women who used the healthcare system. The guiding question for this study is as follows: What are African American women's beliefs and perceptions about factors affecting their compliance with the treatment regimen in the healthcare systems. All the questions were constructed so that women were allowed to fully express their beliefs and perceptions. The sub-questions are as follows:

1. What are African American women's beliefs and perceptions about the quality of healthcare received?
2. What perceptions African American women have about accessing health care and utilization of health services?
3. What perceptions African American women have about their recommended treatment regimen?
4. What perceptions African American women have about their greatest challenges with accessing health care and utilization of health services?
5. What are African Americans women's beliefs about strategies that would improve their compliance to the health care system

Results of Findings and Discussion

Results of Findings

Demographic Background

Participants. Partcipants who met the critieria completed the consent form and demographic sheet. The participants comprised of 50 African Americans who agreed to participate in a semi-structured interview. Participants' ages ranged from 18 to 65. The participants' education level ranged from less than a high school education and college education. Only, 10 participants had a college education. Participants' marital statuses consist of married, separate, sin**gle** and divorce. Thirty-five of the participants were separated, single or divorce. Most of participants were employed in non-professional jobs. However, 20 participants were unemployed to include 2 students. Participants' incomes ranged from the middle class to low income status. Thirty participants were in low income status.

All participants reported religion affiliation to include church attendance. The major health problems of participants were cardiovascular disorders (e.g., heart disease, blood pressure, strokes, cancer and diabetes. Most of the participants had health insurance and benefits which included workplace insurance, Medicaid and Medicare. However, the majority of participants had health insurance from jobs, 20 of the participants had Medicaid as their primary source of funding for health care. Only 10 participants had Medicare. The majority of their health providers were Caucasian physicians for this group. Only, 10 participants reported nurse practitioners were in their healthcare organization. Most of participants reported that they did not attend medical appointments on a consistent basis and comply with the recommended treatment regimen. Most of the participants reported that they did not attend medical appointments on a consistent basis and comply with the recommended treatment regimen. Forty participants reported they never exercise and ate a well balance meal on a weekly basis.

Major Themes

The interviews were audiotape and transcribed. The transcript was compared to the audiotape data to confirmed accuracy. Using the research questions guided by the semi-structure interview guidelines, 9 themes emerged**.** Current status of evidence-based literature was used to support the main 9 themes

The major theme were as follows:

Theme 1: Distrust in Health Providers

African Americans reported that health professionals treat them unfairly or disrespectful because of their race (McNeil, Campinha-Bacote, Tapscott, & Vample, 2002). Medical mistrust was negatively correlated with adherence to screening recommendations with minority ethnic groups which seem to have less belief in the healthcare system than do Caucasian women (Cronan et al., 2008). In addition, adherence problems are often not known to doctors due to lack of a trusting relationship with them (Senteio & Veinot, 2014).

Participants reported: (a) mistrust of health providers outside of race; (b) health provider would not display direct eye contact; and (c) hesitant about touching during physical exams.

Theme 2: Difficulties Communicating with Health Provider

Communication was considered a key factor in the distrust by participants. (Davis, Williams, Marin, Parker, & Glass, 2002; Jones, Synder, & Wu, 2007). Because of conscious or unconscious patient racial bias or lack of communication skills, doctors and other healthcare clinicians do not always communicate consistently and effectively with ethnic minority patients (Jones, Synder, & Wu, 2007). Ineffective communication impacts patient satisfaction and adherence to health provider recommendations. Many healthcare clinicians are unaware of how good communication during a patient's visit can result in disease outcomes (Davis et al., 2002). Research has also shown that poor communication between the health provider and patient can adversely affect the delivery of health care services (Song et al., 2012). Many healthcare clinicians are unaware of how good communication during a patient's visit can result in disease outcomes (Davis et al., 2002).

Participants reported (a) difficulties communicating with health providers; (b) communication of health provider was not culture and gender sensitive; (c)

difficulties understanding the providers; ***and*** *(e)* ***stereotypical*** *racial bias comments were made during their interaction.*

Theme 3: Poor Quality of Patient Education Instructions

Education is perceived to affect the uncertainty of illnesses among African-Americans (Clayton, Mischel, & Belyea, 2006). Lack of higher education and little interaction with health professionals can obscure understanding and perception. When physicians communicate to African American women using excessive medical terminology, it may confuse and intimidate patients, which results in a lack of urgency for medical treatment and/or decision-making (Clayton et al., 2006). Low literacy impacts how African Americans comprehend information pertaining to their illness and contributes to the difficulty in finding resources to assist in the management of symptoms (Davis et al., 2002). Low health literacy has a negative impact on health outcomes of African Americans.

Participants reported (a) lack of understanding of specific patient education instructions; (b) information provided was too complex with many medical terms;(c) the patient information such as pamphlets were not understandable ; and (d) patient educational materials were provided without additional instructions .

Theme 4: Lack of knowledge about Treatment Regimen

Research reported a lack of knowledge as a barrier to self-care (Bayliss et al., 2003). Often, African Americans tend to ignore certain conditions such as blood pressure because of the generational circle (Wexler et al., 2009).

Participants reported (a) discontinuing the treatment regimen when there was lack of improvement in condition; (b) condition was worse before they would seek treatment;(c) discontinuing the treatment regimen and prescribed medication when they were feeling better or side effects from medication or lack of improvement in condition; and(e) and lack of follow-up with health provider.

Theme 5: Inadequate Time Management and Inability to Manage Treatment Regimen

The role of caregiver of African American women poses a problem in complying with the treatment regimen and medical appointments (Abrums, 2004; Baker et al., 2006; Belin, Washington & Greene, 2006; Joseph et al., 2015: Kennedy, 2014). Within the social system of African Americans' lives, particularly for women, everyday family relationships and caregiving roles influence their health (Abrum, 2004). The role of caregiving presents a barrier of African American women in seeking preventive care (Belin et al., 2006). African American women reported struggling with meeting the daily needs of their children (Abrums, 2004).

Participants reported (a) attended medical appointments but did not comply with the recommended treatment regimen; (b) unable to comply with health regimen because of difficulties keeping up with treatment schedule and scheduling time (e.g., juggling, school, care of children and parents, work, busy schedule); (c) juggling of the time contributes to their inability to follow-up on treatment regimen, in addition, to health lifestyle practice; (d) not complying with treatment

regimen because of difficulties keeping up with complex treatment regimen; and (e) treatment regimen would interfere with their routine activities.

Theme 6: Inadequate Access to Care

Access to care is a problem in minority populations especially African Americans (Kennedy, 2013; Kennedy et al., 2007). Access is far worst in rural minority population in comparison to urban minority population (Carlton , & Simmons, 2011). Furthermore access to care and utilization of health services impacted on health outcomes for minority groups. Minority groups are less likely to report receiving any care, having regular appointment source of care or receiving preventive services. Many minority Americans do not have a regular doctor, limited choices in where they go for health care and difficulties accessing specialty care (Kennedy, 2013). Irrespective of residence, African Americans and members of other minority groups are less likely than whites to receive appropriate medical treatment after they gain access to medical care (Reschovsky, & Staiti, 2005). For, the rural populations, medical treatments are frequently obtained through hospitals, clinics and emergency rooms. Often African Americans have either unreliable or no transportation to get to and from medical appointments, screenings, and follow-up care (Kennedy, 2013). This problem is more critical in rural than in urban areas. Rural communities provide fewer preventative and health promotion programs than urban areas (Coughlin, Leadbetter, Richards, & Sabatino, 2008).

Participants reported (a) accessing most of the care in the local emergency room because of lack of insurance; (b) lack of transportation for medical appointments especially in the rural areas due to lack of automobile and public transportation; (c) workplace would not allow them to take off for sick and; (c) some participants who were temporary employees would not be paid when absence from work.

Theme 7: Unaffortable cost

Many of the African Americans who are at risk for health conditions are least likely able to afford doctor visits, due to lack of health insurance and access to medical treatment (Middleton, 2009). Especially, African Americans in lower socioeconomic status may not be able to obtain and afford the needed healthcare services (Kennedy, 2013; Kennedy et al., 2007). Poverty and low education affects disability as well as unhealthy behaviors, poor social networks, neighborhood influences and other support systems (Louie, & Wald, 2011)

Many African-American women do not have the financial ability to pay for healthcare (Ward et al., 2008). African-American women with health insurance encountered innumerable costs for treatment options which exceeded their insurance plans. Having access to healthcare insurance through private and government subsidiaries still presented financial obstacles to their healthcare needs(Ward et al., 2008). Excessive cost for treatments, and diagnostic procedures have exhausted many healthcare plans (Ward et al., 2008).

Participants reported (a) insurance plan did not cover the entire cost of medication and medical appoitnment; (b) not able to afford the out-of-pocket cost of insurance difference; (c) without insurance they were not able to afford the entire cost of health care, medication and medical appointments.

Theme 8: Lack of Health lifestyle Practices

African Americans are less likely to participate in healthy lifestyle practices (Joseph et al., 2015; Kennedy, 2014; Pleis, & Lethbridge-Cejku, 2006). The chronic diseases are also known as poor lifestyle choices that over time cause illness (Arcury et al., 2006). African Americans who resided in predominately low income neighborhood have limited food choices (Baker et al., 2006; Kennedy et al., 2007). African Americans are less likely to use preventive care such as breast screening (Spurlock, & Cullens, 2006). Rural communities where African Americans reside provide fewer preventative and health promotion programs than urban areas (Coughlin, Leadbetter, Richards, & Sabatino, 2008).

Participants reported (a) not complying with health lifestyle practices such as exercising and eating a balanced meal during the week.

Theme 9: Inadequate Coping Skills

Ineffective coping has been an issue related to addressing racism in health services (Benkert, & Peters, 2005; Kennedy et al., 2007). African American women reported strategies used to cope with racism to include angry, learning to unlearn, being assertive, and walking way (Benkert, & Peters, 2005).

Participants identified some of the psychosocial issues related to their reasons for non-compliance as :(a) lack of motivation (e.g., no consistency when condition improves, too time consuming, (b) inability to cope (e.g., denial about illness, fear of the unknown); and (c) inability to cope with racism in the health care system (e.g. became very anger when they experience racism instead of empowered to be assertive).

Discussion

The Health Belief Model was a useful model in conceptualizing this study. As mentioned, a perceived barrier is a person's mindset as to what will keep him or her from implementing the new behavior. The results of findings were as followings: (a) distrust of health providers; (b) difficulties communicating to health provider; (c) poor quality of patient education instructions; (d) lack of knowledge about treatment regimen; (e) Inadequate time management and inability to manage health treatment regimen ; (f) inadequate access to care; (f) unaffordable cost; (g) lack of health lifestyle practices; (h) and (i) inadequate coping skills.

Cultural factors need to be considered when developing a treatment regimen for African Americans (Joseph et al., 2015; Kennedy, 2013; Kennedy, 2014). Often, health professionals have not effectively addressed cultural factors when providing treatment for this group. One barrier to consider in healthcare is the lack of culture competent treatment (Kennedy, 2013; Kennedy, 2014; Kennedy et al., 2007). Cultural factors need to be considered and health providers need more cultural competency training. The importance of cultural competency needs to be incorporated in healthcare organizations which are the underlying foundation that aims to make a difference for the patient compliance.

In summary, treatment provided by health providers may not be culturally relevant for their environment. Research suggests that little initiatives have transpired over the most recent twenty years to improve communication between African-Americans, healthcare organizations, and providers (Kalauokalni, Franks, Oliver, Meyers, & Kravitz,

2007). Disparities continue to exist in the quality of care and poor communication amongst physician and African American patients (Smith, Davis, & Krakauer, 2007).

Healthcare disparity is a concept that many physicians have yet to grasp; thus they do not understand its impact. The ability to identify and address healthcare disparities is becoming more challenging for healthcare organizations and private practices. To address and improve disparities, culture competency training should be mandatory among physicians and other health professionals in the healthcare system. Smith et al., (2007) suggested that healthcare organization guidelines need to teach disparities and periodically evaluate communication training to ensure its effectiveness within the organization. In addition, culture competency training needs to be a part of the curriculum for all health professionals in schools, colleges and universities.

Strategies for Program Development

The Community/Public health nurses are in a key position to advocate and promote health promotion programs for vulnerable groups in communities. African Americans have the highest morbidity and mortality rates of all American race and ethnic groups (Kennedy, 2013). Often, they have limited resources, lack of access to health care and health utilization (Kennedy, 2013; Kennedy et al., 2007). The Health Belief Model was utilized in identifying participants' beliefs and perceptions of the problems with their health practices and the compliance to treatment regimen. A mentioned, the HBM is based on the premise that an individual will utilize a health-related task if they feel that a negative health condition can be evaded. Also, there will be a positive outcome by following specific behaviors, therefore preventing a negative health condition or preventing the complications that are seen with a negative health condition; resulting in successfully accomplishing the suggested health action. Therefore, a perceived barrier is a person's mindset as to what will keep him or her from implementing the new behavior. Social, political and socio-economic factors predispose African American women to health disparities (Kennedy, 2013). Therefore, people who are deprived of economic, social and political power are often marginalized in all aspect in society (Rogers, & Kelly, 2011). Women who experience a lack of control, low-self-worth and negative beliefs or perceptions may impact on compliance to health regimen. Research reported a relationship between women beliefs, knowledge, attitudes, behavior and perceived lack of control over health behaviors (Landry, & Solmon, 2002). Therefore lack of positive-self-worth and negative beliefs and perceptions thus will become a barrier to compliance to health regimen impacting overall health outcome. Women of all cultures internalize their social roles and personal relationships. Caretaking roles, such as mothering, being a wife, raising grandchildren and caring for elderly parents have great demands that may result in role overload (King, Atienza, Castro, & Collins, 2000;Landry, & Solmon, 2002). Other barriers include the lack of social support (Joseph et al., 2015; Kennedy et al., 2007). African American women need to be empowered to be assertive when communicating health needs to health professionals. A woman's perceived lack of control over autonomy and time may result in the lack of motivation to consistently comply with health regimen.

The results of findings were as follows: (a) distrust of health providers; (b) difficulties communicating to health provider; (c) poor quality of patient education instructions; (d) lack of knowledge about treatment regimen; (e) Inadequate time management and inability to manage health treatment regimen (f) inadequate access to

care; (f) unaffordable cost ; (g) lack of health lifestyle; and (i) inadequate coping skills. The participants voiced their recommendations for improving their overall health and healthcare systems in their communities located on **Table 1: Participants' Recommendations of Strategies for Improvement.**

Table 1: Participants' Recommendations of Strategies for Improvement
More Cultural Competence Care
▪ More patient involvement in care
▪ More minority health providers
▪ More research on minorities
▪ Culture specific treatment (e.g., diagnosis, interventions)
▪ Increase physicians-patient communications
▪ Establish a trusting relationship with health providers
Quality Patient Education Instructions
▪ Thorough patient instructions
▪ Specific patient education information
▪ Attentively listening to patients
▪ Culture and gender specific instructions
More Health Care Resources
▪ Free clinics, walk in clinics
▪ Free screening (e.g., cholesterol/AIDS/AIDS)
▪ Free medications/lower cost program/generic medications
Flexibility and Accessibility in Healthcare Appointments and Scheduling
▪ Evening and week-appointments for working with patients
▪ Home health services provided if needed
▪ Workplaces need to provide on-site clinics and health screening
▪ Transportation to healthcare appointments
Health Promotion/Prevention Prevention Activities
▪ Free health seminars/conferences/health prevention
▪ Community-based education (e.g., church groups, schools, sororities, fraternities)

Their recommendations were as follows: (a) more cultural competence care; (b) quality patient education instructions; (c) more health care resources; (c) flexible and accessibility in healthcare appointments and scheduling; and (d) health promotion/disease prevention activities These suggestions are useful in improving their overall health in communities that will be useful when designing health programs.

Likewise, public health professionals such as community/public health nurses are in a key position to serve as advocates for change in diverse communities. Culture competent treatment is essential for improvement in overall health outcomes. The community members need to be empowered to bring about positive social change (Kennedy, 2013). The community/public health nurses need to assist the community's members with forming partnerships with politicians, health providers, community leaders, academicians, and researchers in addressing the health needs of the community.

Future Research

The Health Belief Model focused on self-efficacy which is one's personal belief in their ability to carry out a task. Often, African American women are viewed in the *Superwoman role* contributing to their poor health outcomes (Woods- Giscombé, 2011).

In addition, African American women are often viewed in the role of *Superwomen* which might contribute to underutilization of mental health services in compared to the general population. For example, they may suppress their emotions when dealing with a diversity of adversities in life. As mentioned, the participants identified some of the psychosocial issues related to their reasons for non-compliance as follows: (a) lack of motivation (e.g., no consistency when condition improves; too time consuming; (b) inability to cope (e.g., denial about illness, fear of the unknown); and (c) inability to cope with racism in the healthcare system (e.g., became very anger when they experienced racism instead of being empowered to be assertive). However, participants did not identify specific recommendations for improving these inadequate coping skills in dealing with health issues. Even when access to care was not a problem, they do not adhere/comply with the recommended treatment regimen resulting in poor health outcomes (Kennedy, 2013). In addition, to inadequate coping with health problems, African Americans experience numerous stressors related to their overall environment and institutional racism in our society (Kennedy, 2013; Kennedy, 2014; Kennedy et al., 2007). These stressors in their environment may have numerous psychosocial issues impacting on their health outcomes especially compliance to the treatment regimen. Future research needs to focus on psychosocial factors of African Americans and health outcomes in identifying strategies for improving coping skills.

Conclusion

In conclusion, numerous barriers exist for African Americans resulting in challenges in improving their overall health outcomes .These barriers are multifaceted which consist of biopsychosocial factors in their environment. Culture competent treatment is imperative by their health provider especially when African American women do access the healthcare system. Also, when they do access the healthcare system, they don't comply with the treatment regimen bringing about more challenges for health providers. Empowerment skills are needed for this group when communicating with their health needs.

References

Abrums, M. (2004). Faith and feminism: How African American women from a *27*(3), 187-201.

American Heart Association. (2013). Statistical Fact Sheet 2013 Update African Americans & Cardiovascular Diseases. retrieved from http://www.heart.org /idc/groups/heart- public/@wcm/@sop/@smd/documents/downloadable /ucm_319568.pdf

Arcury, T., Snively, B., Bell, R., Smith, S., Stafford, J., Wetmore-Arkader, L., & Quandt, S. (2006, Spring). Physical activity among rural older adults with diabetes. *The Journal of Rural Health*, 22(2), 164-168.

Baffour, T.D., & Chonody, J.M. (2009). African American women's conceptualizations of health disparities: A community-based participatory research approach. *American Journal of Community Psychology*, (44), 374-381.

Baker, E.A., Kelly, C., Barnidge, E., Strayhorn, J., Schootman, M., Struthers, J., & Griffith, D. (2006). The Garden of Eden: Acknowledging the impact of race and class in efforts to decrease obesity rates. *American Journal of Public Health, 96*(7), 1170-1174.

Bayliss, E., Steiner, J. F., Fernald, D. H. Crane, L. A., & Main, D. (2003). Descriptions of barriers to self-care by persons with co-morbid chronic disease. *Annals of Family Medicine, 1* (1), 15-20.

Belin, P.L., Washington, T.A., & Greene, Y. (2006). Saving grace: A breast cancer prevention program in the African American community. *Health and Social Work*, 31(1), 73-76.

Bell, B. (2009). African American women's perceptions of race, gender, socioeconomics, and stress on health outcomes. *Saybrook Graduate School and Research Center.* San Francisco, CA, 1-120.

Benkert, R., & Peters, R. M. (2005). African American women's coping with health care prejudice. *Western Journal of Medicine, 27,* (7), 863-889.

Carlton, E. L., & Simmons, L., A. (2011). Health decision-making among rural women: physician access and prescription adherence. *Rural and Remote Health, 11 (1599)*1-16.

Centers for Disease Control and Prevention (2017). Developing healthy people 2020. Retrieved from http://www.cdc.gov/nchs/healthy_people.htm

Clayton, M. F., Mishel, M., & Belyea, M. (2006). Testing a model of symptoms, uncertainty, and well-being, in older breast cancer communication, survivors. *Research in Nursing & Health, 29,* 18-39.

Coughlin, S.S., Leadbetter, S., Richards, T., & Sabatino S.A. (2008). Contextual analysis of breast and cervical cancer screening and factors associated with health care access among United States women. *Social Science Medicine*, 66, (2) 260-275.

Cronan, T.A., Villalta, I., Gottfried, E., Vaden, V., Ribas, M. & Conway, T. (2008). Predictors of mammography screening among ethnically diverse low-income women. *Journal of Women's Health*, 17 (4) 527-537.

Davis, T., Williams, M., Marin, E., Parker, R., & Glass, J. (2002). Health literacy and cancer communication. *CA A Cancer Journal for Clinicians*, 52,134-149.

Glanz, K., Rimer, B.K., & Lewis, F.M. (eds) (2002). Health behavior and health education: Theory, research and practice, (3rd ed.) Jossey-Bass, San Francisco, CA.

Hargreaves, M.K., Signorellat, L.B., & Blot, W. J. (2010). The southern community cohort study: Investigating disparities. *Journal of the Health Care for the Poor and Underserved*, 21 (1), 26-37.

Joseph, R.P., Ainsworth, B.E., Keller, C., & Dodgson, J.E. (2015). Barriers to physical activity among African American women: An integrative review of the literature. *Women Health*, 55 (6), 679-699.

Johnson, R.L. & Nies, M.A. (2005). A qualitative perspective of barriers to health-promoting behaviors of African Americans. *ABNF Journal*, 16 (2), 39-41.

Jones, J.B., Snyder, C.F., & Wu, A.W. (2007). Issues in the design of Internet-based systems for collecting patient-reported outcomes. *Quality Life Research Journal*, 16(8), 1407-17.

Kalauokalni, D., Franks, P., Oliver, J.W., Meyers, J.J. & Kravitz, R.L.L. (2007). Can patient coaching reduce racial/ethnic disparities in cancer control? Secondary analysis of randomized controlled trail. *Pain Medicine,* 18, 17-24.

Kennedy, B. R. (2013).Health inequalities: Promoting policy changes in utilizing transformation development by empowering African Americans' communities

in reducing health disparities. *Journal of Cultural Diversity: An Interdisciplinary Journal.* 20 (4) 155- 161.

Kennedy, B. R. (2014). African American women and obesity: Promoting culture competent weight management program. *Current Nursing Issue Journal,* 1 (1) retrieved from http://www.intermedcentral.hk/index.php?journal =Nursing&page =article&op=view&path%5B%5D=169

Kennedy, B.R., Mathis, CC. & Woods, A. (2007). African Americans and their distrust of the health care system: Healthcare for diverse populations. *Journal of Cultural diversity: An Interdisciplinary Journal,* 14, (2), 56-60.

King, A. C., Atienza, A., Castro, C., & Collins, R. (2002). Physiological and affective responses to family caregiving in the natural setting in wives versus daughters. *International Journal of Behavioral Medicine, 9*(3), 176–194.

Landry, J. B. & Solomon, M. A. (2004). African American women's self-determination across the stages of change for exercise. *Journal of Sport & Exercise Psychology, 26*, 457–469.

Louie, G., & Ward, M. (2011, July). Socioeconomic and ethnic differences in disease burden and disparities in physical function in older adults. *American Journal of Public Health*, 101(7), 1322-1329.

Luncheon, C. & Zack, M. (2011). High-related quality of life and physical activity levels of middle-aged women, California Health Interview. *Preventive Chronic Conditions*, 8 (2), retrieved from http:// www.cdc.gov/pcd/issues/2011/mar/10_ 0033.ht

McNeil, J., Campinha-Bacote, J., Tapscott, E., & Vample, G. (2005). *BeSafe: National Minority AIDS Education and Training Center Cultural Competency Model*. Washington, DC: Howard University Medical School.

Middleton, J. (2009). A proposed new model of hypertensive treatment behavior in African Americans. *Journal of National Medical Association*, 101 (1), 12-17.

Owens, P.L., Hoagwood, K., Horwitz, S., Leaf, P., Poduska, J., Kellam, S.G., & Ialongo, N.S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 731-738.

Pleis, J. R. & Lethbridge-Cejku, M. (2006). Summary of health statistics for U.S. adults: National health interview survey. *National Center of Health Statistics*

Reschovsky, J.D., & Staiti, A.B. (2005). Access and quality: Does rural American lag behind? *Health Affairs Project Hope (Millwood),* 24 (4), 1128-1139.

Rogers, J, & Kelly, U.A. (2011). Feminist intersectionality: Bringing social justice to health disparities research. *Nursing Ethics*, 18(3), 397-407.

Rosenstock, I. M., & Kazdin, A.E. (2000). Encyclopedia of psychology, Vol. 4. , (pp. 78-80). Washington, DC, US: American Psychological Association; New York, NY, US: Oxford University Press.

Rosenstock, I.M., Strecher, V.J., & Becker, M.H. (1988). Social Learning Theory and the Health Belief Model. *Health Education Quarterly, 15* (2), 175–183.

Senteio, C. & Veinot, T. (2014). Trying to make things right: Adherence work in high-poverty, African American neighbors. *Qualitative Health Research*, 24 (12), 1745-1756.

Smith A.K., Davis, R.B., & Krakauer, E.L. (2007). Differences in the quality of the patient-physician relationship among terminally ill African-American and white

patients: Impact on advance care planning and treatment preferences. *JGIM,* 22(11):1579–1582.

Song, M.K., Lin, F.C., Gilet, C., A, Arnold, R.M., Bridgman, J.C., & Ward, S.E. (2013). Patient perspective on informed decision-making surrounding dialysis initiation. *Nephrology Dialysis Transplant*, 28 (11), 2815-2823.

Spurlock, W. & Cullins, L.S. (2006). Cancer fatalism and breast cancer screening in African American Women. *The ABNF Journal*, 17 (1), 38-43.

Ward, E., Halpern, M. Schrag, N., Cokkinides, V., DeSantis, C., Bandi, P., Siegel, R., Steward, A., & Jemal, A. (2008). Association of insurance with cancer utilization and health outcomes. *Cancer Journal for Clinicians*, 58 (1) 9-31.

Weir, E. & Lipscombe, L. (2004). Metabolic syndrome: Waist not want not. *CMAJ*, 170 (9), 1390-1391.

Wexler, R. Elton, T. Pleister, A. & Feldman, D. (2009). Barriers to blood pressure control as reported by African American patients. *Journals of National Medical Association*, 101 (6), 597-603.

Woods- Giscombé, C.L. (2011). Superwoman Schema: African American women's view of stress, strength, and health. *Qualitative Health Research*, 20 (5) 668-683.

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