EXPLORING PERCEPTIONS, BARRIERS, AND FACILITATORS OF ACCESS TO PRIMARY HEALTH SERVICES AMONG AFRICAN IMMIGRANT WOMEN IN THE U.S.: A STUDY OF ETHIOPIAN IMMIGRANT WOMEN

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Doctor of Philosophy

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by

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The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

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presented by Gashaye Melaku Tefera,

a candidate for the degree of Doctor of Philosophy in Social Work,

and hereby certify that, in their opinion, it is worthy of acceptance.

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DEDICATION

I dedicate this dissertation to my mother Asnakech Gissa Jirga. Asne, I miss you every day. You taught me love, kindness, and endurance. I hope you are watching me from above and feeling proud of what your “ጋሻ ጃግሬ” has become.

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ACRONYMS

ACA	Affordable Care Act
BM	Behavioral Model
CVS	Customer Value Stores
CHIP	Children’s Health Insurance Program
COVID-19	Coronavirus Disease of 2019
CSDH	Commission on Social Determinants of Health
DMV	DC-Maryland-Virginia
ECC	Ethiopian Community Center
EAD	Employment Authorization Document
EIW	Ethiopian Immigrant Women
HMO	Health Maintenance Organizations
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IRB	Institutional Review Board
MD	Medical Doctor
ID	Identity Document
OB/GYN	Obstetrics and Gynecology
OPT	Optional Practical Training
RIS	Refugee and Immigration Services
PHC	Primary Health Care
POC	Persons of Color
PRWORA	Personal Responsibility and Work Opportunity Act
TB	Tuberculosis
U.S.	United States
USCIS	United States Citizenship and Immigration Services
WHO	World Health Organization

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ABSTRACT

Access to healthcare services remains a top public health concern in the United States and immigrants are disproportionately affected by low rates of health insurance coverage and poor access to healthcare services. It is reported that 23% of lawfully present immigrants and 45% of undocumented immigrants are uninsured as compared to the 8% of uninsured citizens. Particularly, immigrant women experience multiple barriers in accessing healthcare services and are at higher risk of health problems. Within the immigrant women population, African immigrant women have the lowest access and utilization of healthcare, a high rate of HIV and STDs, high rate of employment in unskilled labor that is hazardous and with no protection. However, African immigrant women remained understudied and underrepresented in the immigrant health literature. This study explored the perceptions, barriers, and facilitators experienced by African immigrant women in accessing primary healthcare (PHC) with a particular focus on Ethiopian immigrant women (EIW).

A qualitative design with a phenomenological approach was conducted to investigate what challenges were experienced by EIW and how they experienced them. Data were collected using in-depth interviews with EIW (N=21) aged 18 and older

(M=36.6) conducted both in-person and virtually via phone and Zoom. Interviews were audio-recorded and transcribed verbatim. Data were analyzed thematically using Nvivo12 software.

Findings showed that the transition and adjustment into a new country and healthcare system delayed EIW’s timely access to PHC services. EIW believe that PHC in the U.S. is of better quality but inaccessible. Compared to their past experiences, EIW started using annual general checks ups in the U.S. but tended to avoid PHC unless they are faced with severe health issues or had maternal care needs. Lack of trust in the PHC system that was underlined by personal barriers including contradictory health beliefs, language and communication, and limited health literacy hindered EIW’s access to PHC. Findings demonstrated that structural barriers, mainly immigration status, unaffordability of PHC, complexity, and discrimination in healthcare impeded EIW’s access to PHC. Social support and having a stable job were the two major facilitators to accessing PHC. The findings suggested that in addition to expanding customized health information, translation, maternal health, and affordable care services; it is imperative to make immigration policy reform, decolonize the PHC system and diversify the health workforce. As the first known study on EIW’s PHC experience, the study highlighted the need to view access through a lens of everyday life struggles of immigrant women, investigate the lack of trust, and move toward a structural approach in understanding and addressing barriers to access among immigrant women.

CHAPTER 1: PROBLEM STATEMENT

The International Organization for Migration (2019) defines an immigrant as a person who moved into a country other than their nationality or usual residence so that the country of destination effectively becomes their new country of usual residence. The term immigrant encompasses a broad range of categories including naturalized citizens, permanent residents, refugees/asylees, twilight, and unauthorized people who live outside their country of origin (Bolter, 2019). Based on this broader definition, the term immigrant refers to people who were born in a foreign country and moved to a new country (the U.S. in this study) to live permanently, and this broader definition is utilized in this study.

In 2019, there were 44.9 million immigrants in the United States making the country the top immigrant-receiving country (Batalova et al., 2021). One-fifth of the world´s immigrants reside in the U.S. and immigrants make up 13.7% of the U.S. population (American Immigration Council, 2020). Despite their significant presence and contribution to the socio-economic advancement of the country, immigrants are affected by growing disparities in many aspects of their lives. One of these is the lack of or disproportionate access to health care services[1] experienced by immigrants (Dedania & Gonzales, 2019; Yao & Hillemeier, 2014).

Access to Health Care Among Immigrants

Access to health care is defined as "the timely use of personal health services to achieve the best possible health outcomes" (Millman, 1993, p. 202). Access to health care

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[1] The terms access to healthcare, access to health care, and access to health services are used interchangeably

services needs three distinct steps. First, one should enter the healthcare system which is usually attained by having health insurance. Secondly, the person should have access to the location of healthcare services that requires transportation and mobility. Thirdly, the person needs to find a healthcare provider that can be trusted and able to build a personal relationship with the provider (Healthy People 2030, n.d.). Hence, access to health care refers to the availability of adequate health services as well as the ability to obtain and utilize them (Gulliford et al., 2002).

Access to healthcare is vital in preventing and managing disease as well as maintaining health. On the contrary, lack of access to healthcare causes unnecessary disability and premature death by impacting one´s overall physical, social, and mental health (Agency for Healthcare Research and Quality, 2020; Healthy People 2030, n.d.). The extent of gaining access depends on one's financial, social, cultural, and personal barriers. It also is determined by the wider political, policy, and healthcare system (Gulliford et al., 2002).

Access to healthcare services remains a top public health concern in the United States. Although around 20 million adults have been covered because of the Patient Protection and Affordable Care Act of 2010, there are still millions of people who have no health insurance. Besides, there are stark disparities in access to healthcare by geography, race, age, gender, education, level of income, and legal or immigration status (Healthy People 2030, n.d.; Uberoi et al., 2010). Even though all Americans are confronted by the growing high cost of health care and erosion of health insurance, immigrants are acutely affected by low rates of health insurance coverage and poor access to health care services (Castañeda et al., 2015; John et al., 2012).

Various studies have uncovered that immigration is one of the strongest determinants of healthcare access and health outcomes. Immigration status includes all categories including being a refugee, asylee, undocumented, permanent resident, or citizen. These immigration statuses have their own positive and negative implications on access to health care (Castañeda et al., 2015; John et al., 2012). Immigrants in the U.S. are more likely to be uninsured than citizens. It is reported that 23% of lawfully present immigrants and 45% of undocumented immigrants are uninsured as compared to the 8% of uninsured citizens (Kaiser Family Foundation, 2019). Immigrants are less likely to have a usual source of health care, private doctors, or use Health Maintenance Organizations (HMOs) compared to native-born citizens. For example, using the 2000 and 2008 data from the National Health Interview Survey, a study (Blewett et al., 2010) compared access among immigrants and native-born individuals. After other socio-economic factors were controlled, immigrants and their children have significantly reduced access to regular ambulatory health care. To see this in numbers, the extent of not having a doctor/nurse or emergency visit among non-citizen adults (41%) and children (38%) is almost double the rate of native adults (21%) and nearly triple that of their children (13%) (Kaiser Family Foundation, 2019).

Precursors of Lack of Access to Health Care Among Immigrants

The precursors to lack of healthcare access among immigrants range from personal to policy level factors that need a coordinated approach in understanding and responding to it. One of these factors is policy barriers that restrict immigrants from enrolling in employer-sponsored coverage, Medicaid, Children’s Health Insurance Program (CHIP), and Affordable Care Act (ACA) marketplace coverages (Kaiser Family

Foundation, 2019). According to the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), although lawfully present immigrants may qualify for Medicaid and CHIP, they are required to wait for five years after obtaining qualified immigration status before they enroll (Edward, 2014; Yao & Hillemeier, 2014). The restriction is even tougher on those who are unlawfully present as they are not eligible to enroll in all three types of coverages: Medicaid, CHIP, or ACA (Kaiser Family Foundation, 2019). Furthermore, the recent changes made to the public charge policy restrict immigrants' eligibility for green card and entry into the U.S. based on the use of certain non-cash programs such as Medicaid (Perreira et al., 2018). Such restrictive policies create fear and confusion in the immigrant community and discourage them from participating in healthcare coverage programs and seeking healthcare services. The restrictive nature of the policies makes it difficult for immigrants to navigate the enrollment process (Kaiser Family Foundation, 2019; Ku & Matani, 2001).

Immigrants' access to private insurance, which is the mainstay of health coverage for most Americans, is limited because they are often not offered protection at work. For example, research showed that job-based insurance is offered to 87% of non-Hispanic White citizens as compared to 50% of Latino immigrant workers (Yao & Hillemeier, 2014). This disparity is partly because of the employment of immigrants in industries that are less likely to offer health insurance such as construction, agriculture, and food processing. Immigrants, even legal immigrants, are often treated differently by employers classifying them as contract and temporary workers so they cannot claim benefits and health insurance (Castañeda et al., 2015; Yao & Hillemeier, 2014).

Lack of public as well as private or employer-sponsored insurance means immigrants are required to pay their health care costs out of pocket. As this is very expensive, many immigrants cannot afford it with their limited income. Most immigrants are often employed in low-wage jobs that fail to provide employer-sponsored coverage, and they often do not afford to pay when coverage is available (Marrow & Joseph, 2015). Low-income immigrant adults are twice as likely as native-born citizens in the same income level to report a lack of regular sources of health care. The problem is even worse among low-income immigrant children who are four times more likely to lack insurance than low-income children of native-born citizens (Armenta & Sarabia, 2020; Tapales et al., 2018).

Language problems are also among the contributing factors to limited access and utilization of health care among immigrants. Immigrants with limited English proficiency find it difficult to understand health care and insurance information. Limited English proficiency creates barriers for navigating the healthcare system, but for those who do manage to navigate some aspects, language barriers still contribute to problems in patient-provider communication (Armenta & Sarabia, 2020; Tapales et al., 2018; Tefera & Yu, 2022). In addition to language proficiency, lack of translation and culturally competent services limit immigrants' access to and use of health care services (Bauer et al., 2000; Yao & Hillemeier, 2014).

Widespread discriminatory practices in the healthcare system also contribute to limited access to health care among immigrants. Discrimination happens based on intersecting identities such as nativity or nationality, gender, religion, and others (Bauer et al., 2000; Hacker et al., 2015). Complex bureaucratic regulations and extensive paperwork requirements also make it difficult to access health care services for immigrants. This creates burden and frustration for most immigrants whose knowledge about how the U.S. healthcare system works is limited (Bauer et al., 2000; Hacker et al., 2015; Yao & Hillemeier, 2014).

Gaps in the Literature

Healthcare access has been one of the central topics in health literature for many years. However, understanding access in its entirety has been challenging and it remains a complex notion represented by a variety of interpretations (Levesque et al., 2013). A systematic review study on healthcare access has reported that access to healthcare is mainly characterized from an availability and adequacy point of view. In most cases, if healthcare services are available and there is an adequate supply of services, it is assumed that the population has access to healthcare (Gulliford et al., 2002). However, the same level of attention is needed in studying important components such as affordability, acceptability, cultural and material settings, and perspectives of diverse groups in society (Fortney et al., 2011; Goldsmith, 2007). Research has also been focused on the traditional conceptualizations of access that are based on provider-patient face-to-face encounters. This traditional conceptualization ignores the highly evolving nature of the interaction between service users and providers and the growing ‘enounterless’ digital dimension of access and telehealth (Fang et al., 2015).

Another gap is that research on access focuses on dimensions or issues that are considered substantial such as insurance and financial challenges but overlooks other structural and individual traits. Individual traits such as gender, race, ethnicity, and others are not paid adequate attention as important dimensions that shape one’s access to healthcare. The interaction between these dimensions and the healthcare system has not been adequately examined (Goldsmith, 2007; Romanelli & Hudson, 2017). In addition, healthcare access research is dominated by deductive approaches that strive to test hypotheses. There is a shortage of inductively developed research that seek to understand the perspectives of individuals and their lived experiences in healthcare access (Bradshaw et al., 2017; Goldsmith, 2007). Mere theory-driven deductive approaches and efforts to quantify access instead of analyzing the actual lived experiences of individuals can lead to treating healthcare access as a static phenomenon. There is a need for qualitative studies that look deep into the individual views, perceptions, and experiences in light of both personal and structural dimensions of accessing healthcare (Bradshaw et al., 2017; Dias et al., 2010).

In addition, healthcare access has mostly been conceptualized only based on the dominant western culture and middle-class population (Goldsmith, 2007). Hence, the existing research body on healthcare access lacks representation of perspectives from non-dominant population groups such as immigrants, indigenous or native communities, and disadvantaged groups (Gopalkrishnan, 2018). As a result, efforts to measure or determine healthcare access to such populations remain incomplete and research outcomes can be misleading. It is vitally important to investigate the perspectives and experiences of these underrepresented populations and push for more inclusive research on healthcare access. Immigrant women in general and African immigrant women in particular fall under these underrepresented populations in the health literature (Gopalkrishnan, 2018; Kantartzis & Molineux, 2011).

This study addressed the above-mentioned gaps by adopting an inductive qualitative approach that looks deep into Ethiopian immigrant women's perspectives and experiences in accessing primary healthcare in the U.S. It investigated the complex realities and attributes of Ethiopian immigrant women that intersect to influence their access and utilization of healthcare. The following sections discuss the disproportionate impact on immigrant women in general and why it is important to focus on African and Ethiopian immigrant women respectively.

The Disproportionate Impact on Immigrant Women

Compared to other immigrant population groups, specifically men, immigrant women experience multiple barriers in accessing healthcare services and are at higher risk of health problems (Goodman et al., 2017; Olukotun et al., 2020). This is partly caused by the historical gender-based discriminatory immigration policies that preferred men immigrants over women for skilled labor that in the long run affected the permanent residency and naturalization of immigrant women (K. Johnson, 2009; Pannell & Altman, 2009). The situation forced immigrant women to be dependent on men, highly vulnerable to exploitation, and unable to access social and healthcare resources (Marshall et al., 2005; Olukotun et al., 2019).

Contrary to their disproportionate access to services, the need for healthcare services among immigrant women is significantly higher than men due to their reproductive health needs (Armenta & Sarabia, 2020; Chavez, 2012). Immigrant women are more likely to report a lower rate of access, receiving sub-optimal care, and discrimination in healthcare settings, and seek care from unlicensed clinics or folk remedies (Castañeda et al., 2015; Cleaveland & Ihara, 2012; John et al., 2012; Olukotun et al., 2020).

Lack of access to health care services leads to short- and long-term health outcomes among immigrant women. Due to a lack of insurance and other means to access health care services, many immigrant women spend years without seeing a physician. Although many immigrant women suffer from occupational illnesses such as hearing loss, fractures, or chronic health conditions, they cannot afford to get medical services (Ku, 2006). A systematic review of 29 studies revealed that immigrants, especially women, suffer from limited or no access to preventive care, screenings, and chronic disease management which leads to higher mortality (Hall & Cuellar, 2016). One of the studies included in the review showed that lack of insurance is associated with a lack of control over hypertension among immigrants. Another study also showed lack of insurance and access to health care is associated with a lack of participation in blood pressure, blood sugar, and cholesterol screenings among immigrants (Salinas et al., 2015; Ursua et al., 2014).

A national-level study also documented the negative consequences of limited access to health care among immigrant women (Yao & Hillemeier, 2014). By using the cross-sectional National Health Interview data, the study reported that immigrant women have disproportionately low mammography rates (65.5%) compared to native-born women (68.9%). The study used the 2000 and 2008 data from which 1,330 and 1,083 immigrants and 8,882 and 6, 321 native-born women were selected respectively as samples. The study revealed that recent immigrants have an even lower rate of screening (39.3% and 64.7% in 2000 and 2008 respectively). Lack of regular mammography screening hinders early detection of breast cancer which is one of the leading causes of cancer death among women in America, and immigrant women could be disproportionately affected by it (Tapales et al., 2018; Yao & Hillemeier, 2014).

Another study analyzed the use of sexual and reproductive health services (SRH) between immigrant and non-immigrant women using the National Survey of Family Growth (NSFG) data with a sample of 23,573 (Tapales et al., 2018). The study uncovered that immigrant women (24%) were less likely to use highly effective contraceptive methods than U.S.-born women (35%). The same study indicated that immigrant women were more likely to be uninsured than U.S.-born women (33% vs. 16%) and this is linked to the low rate of SRH service utilization among immigrant women (Tapales et al., 2018).

Immigrant women also hold the additional burden of serving as the primary intermediaries between their family members and the healthcare system (Chavez, 2012). They play a key role in disseminating health information through their social networks and help the immigrant community stay informed about healthcare services. This unique position of immigrant women as managers of their families' health and informants of the healthcare system makes their perspectives invaluable in improving healthcare access not only to them but also to the general immigrant community (Armenta & Sarabia, 2020; Chavez, 2012; Perez et al., 2009; Pitkin Derose et al., 2009).

Despite the increasing immigrant women population and their unique position, considerably less attention has been given to how the various barriers shape their experiences with the healthcare system (Rodríguez et al., 2009; Schenker et al., 2010). Studies proved that the experiences and perceptions of immigrant women are strongly related to their care-seeking behavior, adherence to treatment, and eventually health conditions. Immigrant women experience healthcare services as a social process and understanding what that experience looks like and its impact is vital in improving access and quality of healthcare services (Bristow et al., 2013; Haywood et al., 2013; Wafula & Snipes, 2014).

Significance of the Study: Why Focus on African Immigrant Women?

In addition to the general immigrant status, research shows that nativity or country of birth partially determines one´s access to healthcare and health outcomes (Armenta & Sarabia, 2020; Bristow et al., 2013)**.** Immigrant women from certain countries or regions have lesser access than others and one of these groups is African immigrant women. This is related to the continuous marginalization and discrimination against racial minorities in the U.S. African immigrant women experience fear of discrimination in seeking healthcare services, but their concerns are left unaddressed (Haywood et al., 2013; Menjívar, 2002; Wafula & Snipes, 2014).

Being an immigrant and a person of color at the same time multiplies the vulnerability of African immigrant women to discrimination in accessing healthcare services (Olukotun et al., 2020). The intersecting identities of African immigrant women predispose them to complex challenges in accessing healthcare services. However, little is known about African immigrant women´s experience with the healthcare system and their perspectives are not adequately represented in the immigrant health literature. Addressing these challenges and creating a safe healthcare system requires understanding the lived experiences and perspectives of African immigrant women (Haywood et al., 2013; Olukotun et al., 2020).

Within the fast-growing African immigrant population in the U.S., Ethiopian immigrants are the second largest group next to Nigerian immigrants. In 2018, there were 278, 000 Ethiopian immigrants in the U.S. and this number is increasing (Echeverria-Estrada & Batalova, 2019). Most Ethiopian immigrants reside in the Washington DC metropolitan area which is home to more than 35, 000 Ethiopian immigrants. States including California, Virginia, Maryland, Minnesota, and Texas also host more than 15, 000 Ethiopian immigrants each. It is also reported that female immigrants are increasing faster than their male counterparts (Migration Policy Institute, 2014; Oliphant, 2015). Like other African immigrant women, Ethiopian immigrant women are also highly vulnerable to disparities in healthcare access due to various intersecting factors. Ethiopian immigrant women are employed in low-paying labor jobs and live with significantly lower median household incomes which hinder their ability to afford healthcare (Migration Policy Institute, 2014). Despite few survey/quantitative studies (Chaumba, 2011; Hailemeskel et al., 2017) that reported the low use of health care services and reliance on alternative traditional medicine among Ethiopian immigrants in general, there is no known in-depth investigation of the lived experiences and challenges of Ethiopian immigrant women in accessing health services in the United States.

Although it has been reported that immigrants experience barriers in accessing healthcare services at all levels (Roberts et al., 2021), this study particularly focused on primary care, which is the first point of entry into the healthcare system. Even though primary care is the gatekeeper that most people utilize for illness, injury, referral, regular screenings, and general check-ups; immigrants reported significantly lower use of primary care (Chaumba, 2011; EINSURE, 2017). It was also reported that even insured recent immigrants were equally disadvantaged as the uninsured due to limited knowledge about the health system, language barriers, fear of unknown costs, or complex immigration regulations (Chaumba, 2011). Examining immigrant women's experience with primary care helps to understand the complex barriers they come across from the initial stages of their interaction with the health system. It also gives the opportunity to better understand and identify what is most relevant to immigrant women and expand research on specialized areas of care (Bajgain et al., 2020; Lofters et al., 2011; Turin et al., 2020).

Hence, this study is vitally important for the following reasons: 1) it contributes its share in addressing the existing knowledge gap in the immigrant health literature by exploring Ethiopia immigrant women´s experiences and perspectives, 2) it brings the unique and complex realities of the understudied Ethiopian immigrant women into attention and helps to develop tailored strategies in addressing access to primary healthcare for this particular group of immigrant women, and 3) it paves the way for future studies that intend to investigate and address underserved and minorities in the immigrant population.

Purpose of the Study

The purpose of this study is to gain an in-depth understanding of the lived experiences, perceptions and challenges of Ethiopian immigrant women in accessing primary healthcare services in the United States. The study was guided by the following research question:

- What are the perceptions, barriers, and facilitators of access to primary healthcare services experienced by Ethiopian immigrant women in the United States?

CHAPTER 2: LITERATURE REVIEW

Understanding Access to Healthcare

Health services research shows that there is no single and universally accepted definition of access to healthcare or health services (Penchansky & Thomas, 1981). Etymologically, the word access has been understood as a way of approaching or entering a place or system and having the right to utilize something (Merriam-Webster, n.d.). In the case of healthcare, access has been defined as “access to a service, a provider or an institution thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs” (Levesque et al., 2013, p. 1). Although this is the most direct and simplified definition, access to healthcare has been conceptualized and understood in a variety of ways. These definitions fall under two major categories, narrow and broad definitions. The narrow definitions characterize access to healthcare by entry into the healthcare system. Whereas the broader concept goes beyond entrance into a system to include further components that describe the fit between the client and the healthcare system (Goldsmith, 2007; Levesque et al., 2013; Penchansky & Thomas, 1981). For example, older definitions such as Donabedian’s that stated access as the characteristics of a given health system or service in facilitating or obstructing a person’s ability to use are considered narrow definitions (Donabedian, 1973). Such narrow definitions are focused mostly on the availability of health services and geographic and organizational accessibility of services. Definitions of access later expanded to embrace broader aspects of healthcare. In addition to entry into the healthcare system, definitions started to include continuation of care, access requirements and barriers, health beliefs, and needs of the service user (Goldsmith, 2007). Other definitions also included healthcare outcomes, appropriateness, and quality of services in conceptualizing access to healthcare (Millman, 1993).

One of the most common broader definitions of access to healthcare was developed by Penchansky and Thomas (1981) which incorporates the various dimensions describing the fit between the service user and the health system. They defined access as “a concept representing the degree of fit between the clients and the (healthcare) system” (Penchansky & Thomas, 1981, p. 128). Based on this definition and a synthesis of previous conceptualizations, Levesque et al. (2013) developed a more comprehensive definition that considers both the demand and supply side and conceptualizes access as an opportunity. They defined access “as the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain, or use health care services, and to actually have the need for services fulfilled” (Levesque et al., 2013, p. 8).

Understanding access in terms of these dimensions helps to disaggregate the ambiguous concept into measurable and understandable elements. Although reports on these dimensions are fragmented, three research reports (Gulliford et al., 2002; Levesque et al., 2013; Penchansky & Thomas, 1981) offer a more organized and consistent conceptualization of them. The following section presents the synthesis of the dimensions of access reported in the above three studies.

Availability

Access to healthcare requires the availability of health services in an adequate manner. The availability of adequate supply means that service users will have an opportunity to receive services when they want them (Gulliford et al., 2002). Availability translates to the balance between the volume and type of existing services in contrast to the client’s needs (Penchansky & Thomas, 1981). In most cases, availability is about the physical existence of resources, human and material, to respond to the need of service seekers (Levesque et al., 2013). Availability is usually measured by calculating available resources versus potential users. For example, physicians per head of population. Such operationalizations help to evaluate issues related to the adequacy of supplies and allocation of resources in healthcare (Gulliford et al., 2002). Adequacy of supplies is directly related to the characteristics of facilities, socio-geographic context, provider’s capacity, and modes of provision (Levesque et al., 2013).

Accommodation

Accommodation goes hand in hand with the availability of services. It is mainly about the manner in which services are organized and availed to clients. This includes the schedule of services, distance, walk-in, in-person, virtual services, etc. It also relates to the notion of personal mobility, knowledge, and occupational flexibility of service users (Gulliford et al., 2002; Levesque et al., 2013; Penchansky & Thomas, 1981).

Affordability

The price of insurance, health services, and medications as compared to service users’ ability to pay is a significant dimension of access. The relationship between the two is what is referred to as affordability. Affordability is also about the perception of clients about the worth of service vis a vis the price tag, and the decision to purchase (Gulliford et al., 2002; Penchansky & Thomas, 1981). A broader understanding would include elements such as mode of payment and ability to mobilize financial resources such as cash, loan, and credit arrangements to pay for health expenses (Levesque et al., 2013).

Acceptability

Acceptability is a dimension that is related to the attitudes and perceptions of service users towards the characteristics of service providers, the service provided, or the manner of service delivery. It may also mean service providers' attitudes towards service users and their decision to give or deny services (Gulliford et al., 2002; Penchansky & Thomas, 1981). Acceptability is shaped by one's socio-cultural background and belief systems. What is acceptable varies from person to person or from one group to the other depending on cultural, religious, or personal orientations. Views on certain treatments or having physical contact with an opposite-sex provider might affect a person's decision to access health services (Levesque et al., 2013).

Approachability

Approachability relates to people's ability to identify existing services and the discoverability of services to those in need. People may fail to identify services because some services could be made unapproachable to certain groups by unavailing information or putting limits on transparency (Levesque et al., 2013). Gulliford et al. (2002) refer to this as systematic variations in limiting the approachability of services. Approachability is also about taking into account the location, knowledge, and admissibility of people looking for a healthcare service (Penchansky & Thomas, 1981).

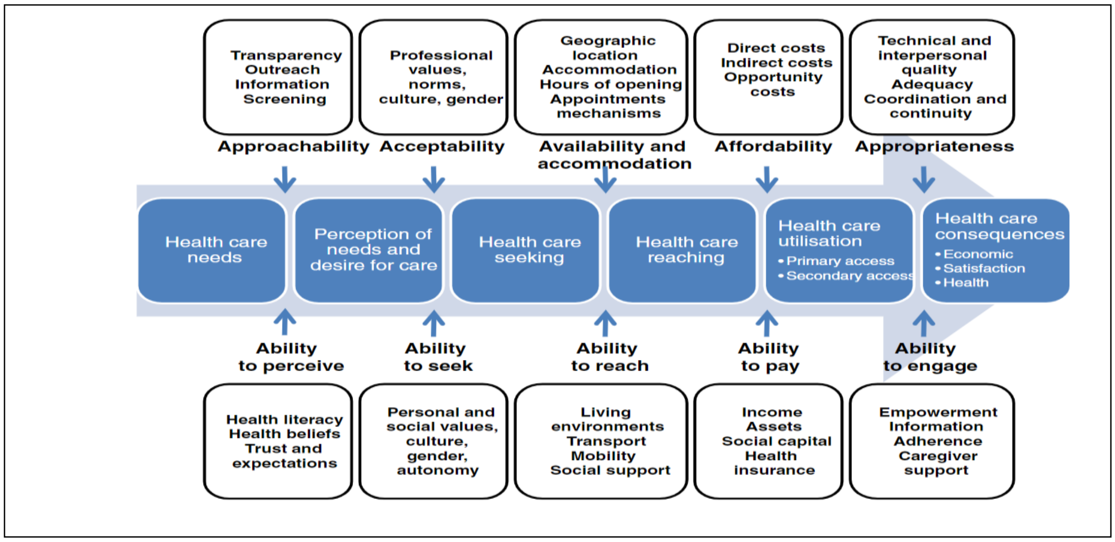
Appropriateness

The relevance, quality, and timeliness of the health service in meeting the service user's need are considered as appropriateness. The time and effort invested in diagnosing the health problem, adequacy, and manner of treatment define the appropriateness of the service. Appropriateness determines health outcomes as well as the service user's decision in pursuing the service in the future or continuation of care (Gulliford et al., 2002; Levesque et al., 2013; Penchansky & Thomas, 1981).

Levesque et al. (2013) developed a comprehensive framework (See Figure 1) to better conceptualize and understand access to healthcare. This framework incorporates all the dimensions discussed above in relation to both service providers' attributes and service users' ability in accessing healthcare services.

Figure 1

Conceptualizing Access to Healthcare



Note. Adapted from Levesque et al. (2013), p.5.

Such broad conceptualization of access to healthcare requires going beyond availability and considering the different levels of barriers individuals experience from personal to financial to organizational levels. The next section presents disparities in access to healthcare with a particular focus on African immigrant women in the United States.

Disparities in Healthcare Access among African Immigrant Women

African immigrant women are one of the immigrant groups with the least access to healthcare services. As much as their limited access, African immigrant women are disproportionately affected by and are vulnerable to various diseases. For example, African immigrants have one of the lowest rates of breast cancer screening in the U.S. (Anuwe, 2020). As another example, a study reported that 41% of HIV diagnoses in eight U.S. states were among African immigrant women. The study also added that this rate is two to three times higher than any other group of women including US-born White and black women, and even black women born in other continents (Sabri, 2018). Another study also reported that African immigrant women are the topmost vulnerable group to sexually transmitted diseases including HIV. The study reported that in Minnesota only, 54% of new HIV infections happen within this group (Okoro & Whitson, 2017).

Although they are very limited in number, studies tried to report factors that contribute to the limited access to healthcare among African immigrant women. African immigrants are less likely to have health insurance than the general population in the U.S. Compared to other population groups, they are more likely to work in jobs that do not provide protection and health insurance benefits. This is despite the higher rates of academic achievements such as high school, college, or graduate-level education they attained. For example, a study from Minnesota reported that 44% of African workers are employed in unskilled labor which is almost double the general population, which is 24%. Lower wages and overall income are contributing factors to the limited rate of insurance among African immigrant women (DeShaw, 2006; Lucas et al., 2011). In addition to the precarious jobs they hold, African immigrant women bear the financial burden of sending remittances back home which limits their capacity to afford healthcare (Venters & Gany, 2011). Traditional gender roles and social structures also put pressure on African immigrant women's help-seeking behavior and accessing healthcare services. For example, Muslim African immigrant women find it difficult to be treated by male healthcare professionals especially in treatments that involve intimate body parts. Despite settling in the U.S., a country with relatively better opportunities for women, African immigrant women continue to bear the burden of raising children and carrying out household activities that hinder their independence in seeking and utilizing healthcare services (DeShaw, 2006; Pavlish et al., 2010; Wolf et al., 2016).

Besides the financial and job-related factors, African immigrant women's access to healthcare is impacted by English proficiency, lower educational levels, and cultural perceptions. Especially, those coming from non-anglophone countries in Africa experience extreme difficulty in navigating the healthcare system (Venters & Gany, 2011). Cultural perceptions toward some types of diseases such as mental health issues and cancer are also part of the barriers to access to healthcare among African immigrant women. Along with the cultural perceptions, trust in the treatments and medications is another factor hindering healthcare access among African immigrant women (Pirie & Gute, 2013; Scharf et al., 2010). Some immigrants are suspicious about the side effects of medications and treatments and might avoid them (Kerani et al., 2019).

African immigrant women are also affected by the political climate that is filled with negativity towards immigrants. In accessing healthcare, immigrant women feel that their personal information could be shared with immigration or government officials which may result in deportation and other consequences. This fear is prevalent despite their documented or undocumented status (Venters & Gany, 2011). It is also important to understand the role of race in serving as an impediment to healthcare among African immigrant women. In addition to being an immigrant, being black in a racially sensitive country increases their vulnerability to discrimination at both personal and system levels. Historic oppression, colonialism, and prolonged past and present traumatic experiences hinder African immigrants' efforts in accessing healthcare (Olukotun et al., 2019; O'Mahony & Donnelly, 2010).

To conclude, despite the disparities highlighted above, research and literature on the challenges and experiences of African immigrant women in accessing healthcare remain shallow and inadequate. The following section presents the discussion of selected theoretical frameworks and the proposed integrated model to guide the study.

CHAPTER 3: THEORETICAL FRAMEWORK

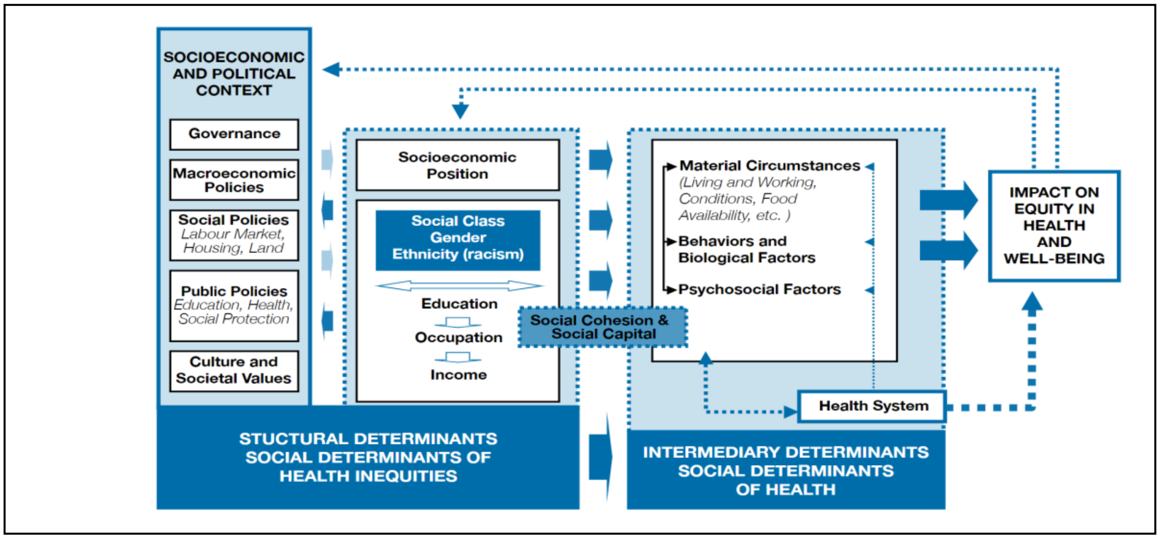
This chapter presents three selected theories -The Commission on Social Determinants of Health (CSDH) framework, the Behavioral Model (BM), and the Postcolonial Feminist Perspective - and concludes with the proposed integrated model that guided this study. The CSDH and BM provided a lens toward the complex factors that are associated with one's ability and experience in accessing healthcare services. The Postcolonial Feminist Perspective added an important perspective on how those factors intersect in hindering Ethiopian immigrant women's experience from a social justice point of view. Relevant constructs were selected from each theory and synthesized to develop an integrated framework that helped to explore and analyze Ethiopian immigrant women's experience in accessing primary healthcare in the U.S.

Theory 1: The Commission on Social Determinants of Health framework (CSDH)

The CSDH is a comprehensive framework developed by the World Health Organization (2010) encompassing a wide range of social determinants of health and access to health. Social determinants of health are the conditions in which people are born, grow, live, work, and age that shape health (Galobardes et al., 2006; Krieger, 2001; Krieger et al., 1997).

Figure 2

The CSDH Framework



Note. Adapted from WHO (2010), p. 6.

As presented in Figure 2, the first two groups of social determinants (socioeconomic and political context, and socioeconomic position) represent structural determinants. The second group of social determinants is named intermediary determinants which are mainly made up of individual circumstances and the health system. The structural determinants interact and work together to influence health equity and wellbeing through the intermediary determinants.

The CSDH framework states socioeconomic and political context as the collection of social and political mechanisms such as macroeconomic (social, public, and health) policies and culture, that impact the distribution and effects of social determinants of health across populations (World Health Organization., 2010). Among the variables listed under socioeconomic and political context, public policy, and cultural and societal values have been cited as the two most relevant factors in influencing access to healthcare in the immigrant literature (Doyal, 2000; Krieger, 2001). Socioeconomic position is the second structural determinant that makes up the social determinants of health inequities along with the socio-economic and political context. The socioeconomic position is comprised of important variables that were discussed in the problem statement and literature review chapters as precursors of access to healthcare among immigrants. These include income, education, occupation, gender, race, and ethnicity (Danielle, 2016; Wang, 2018).

According to CSDH, the third group - intermediary determinants work together with the structural determinants, and they accentuate the causal significance of structural factors and shape differences in exposure to health-compromising conditions (Galobardes et al., 2006; Kubzansky et al., 2001; Lenz, 1988). These include material and environmental circumstances such as living amenities, infrastructure, and conditions that affect the ability to access and utilize services. Psychosocial and behavioral determinants are also part of the intermediary determinants along with the healthcare system (World Health Organization., 2010). The fourth group in the CSDH is called intersecting factors that has two variables: social capital and social cohesion. These two factors represent features of social organization or relation between the individual and society through social networks, norms, and social trust. Social cohesion and social capital represent the cultivation of a cooperative relationship between people and institutions in influencing health and health outcomes (Castañeda et al., 2015).

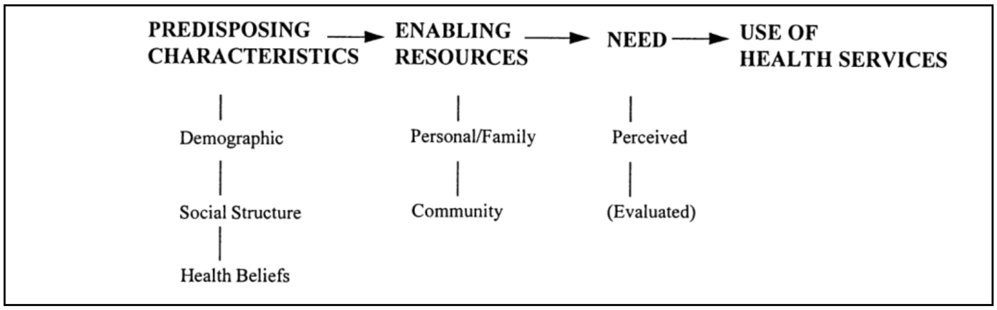
To conclude, the CSDH is a comprehensive framework that tries to encompass several variables from micro to macro-level systems. The framework served as a foundation for the development of the integrated model that is proposed at the end of this chapter. However, as the CSDH framework is developed for the general population, all the variables in the framework could not be utilized to the same degree to understand immigrant women's experiences. In addition, there are a few missing elements that are important in addressing Ethiopian immigrant women's experiences that require looking beyond the CSDH. The organization of some of the variables, for example, the healthcare system could be revisited and there might be a need for adding a few missing elements from other frameworks.

Theory 2: The Behavioural Model of Health Service

The Behavioral Model of health service (BM) was developed by Ronald Anderson in the 1960s (See Figure 3). The model categorized the major population characteristics that predict the use of health services and subsequent outcomes as predisposing, enabling, and need factors Andersen, 1968; Andersen, 1995; Castañeda et al., 2015).

Figure 3

The Behavioural Model of Health Services



Note. Adapted from Andersen (1995), p. 2.

Predisposing Factors

According to the BM, sociodemographic factors including age, and sex together make up a person´s social status and determine the ability to command resources to access and utilize health services or cope with health outcomes. Health beliefs including attitudes, values, and knowledge that people have about the healthcare system also determine access and use of services (Andersen, 1995; Castañeda et al., 2015). Social structures such as education, occupation, social networks, social interactions, ethnicity/race, and culture are also part of the predisposing factors (Andersen, 1968). After revisiting the model, genetic factors were also included as predisposing factors (Andersen, 1995).

Enabling Factors

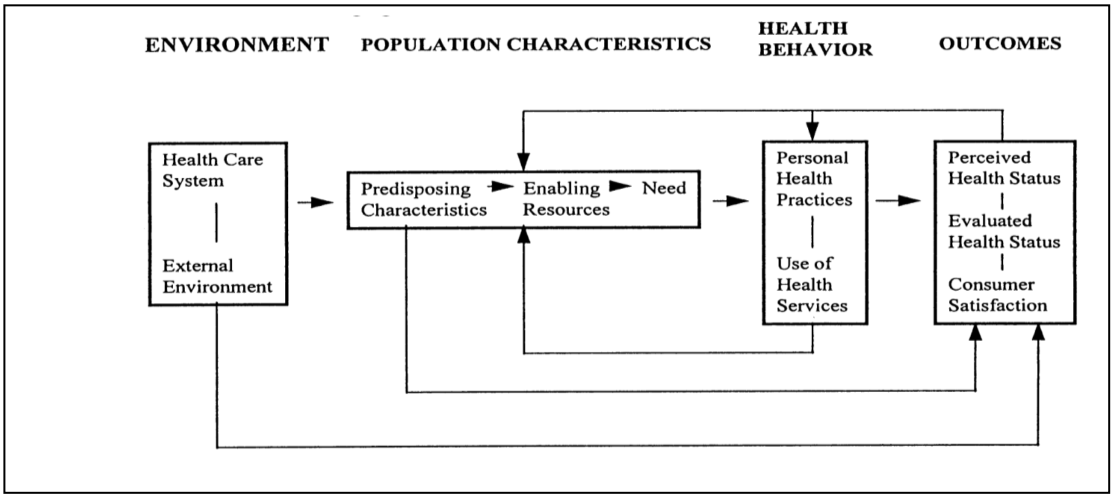
These are resources that hinder or facilitate the use of health care services and are categorized into three parts. The personal and family factors include the means and knowledge to access health services, income, health insurance, and having a regular source of care. The community-level enabling factors include organizational factors, the availability of health personnel, and the facilities where the person lives. The last category is genetic factors and psychological characteristics that work along with the above factors to facilitate or hinder access and utilization of health services (Andersen, 1968; Andersen, 1995).

Need Factors

They include the patient´s perception and the provider´s (professional´s) evaluation of healthcare needs. The perceived needs refer to how people view their own general health and functional state and judgment to seek professional help (Andersen, 1995). However, a professional or health provider’s evaluation is also needed to get the full picture of people´s help-seeking and consumption of health services (Andersen, 1995; Ryvicker, 2018). Later, the BM added the healthcare system, consumer satisfaction, external environment, and personal health practices in recognition of the importance of health policies, resources and organization of service, and health status outcomes. Figure 4 presents the emerging model that incorporated all the elements discussed so far (Andersen, 1995).

Figure 4

An Emerging BM Model



Note. Adapted from Andersen (1995), p. 8.

Compared to the CSDH, the BM is more focused on individual circumstances and behavioral factors in predicting access and utilization of healthcare. The predisposing and enabling factors are more or less a reorganized version of the structural determinants in the CSDH framework. However, the need factors section of the BM is an important addition to the CSDH as it addresses subjective elements such as people's needs and perceptions, decisions, and satisfaction in accessing healthcare services. As discussed in the problem statement and literature review, these factors are important in understanding immigrant women's experience with the healthcare system.

Theory 3: Postcolonial Feminist Theory

As the study aimed to explore the experiences and perspectives of African immigrant women in accessing health care services, the postcolonial feminist perspective added a unique analytical and interpretative lens. Unlike the CSDH and BM, the postcolonial feminist perspective does not provide a visual diagram of constructs or a list of variables. It rather provides critical insights into the positionality of women in the third world vis-a-vis intersecting oppressive social structures (Olukotun et al., 2019, 2020). The following are the major tenets of the postcolonial feminist perspective.

The Positioning of the "Third World Woman"

The postcolonial feminist theory looks at women in light of the historical and socio-political realities that shaped their experiences and left them in disadvantaged positions. Most importantly, the theory intends to counter the hegemonic feminist scholarship that positioned the 'third world woman' in a singular box and identity. This paves the way to explore the ethnically, religiously, racially and culturally diverse African immigrant women who are often mistakenly considered as a single group of black immigrant women. The perspective challenges the representation of women in the developing world as traditional, undedicated, subject to patriarchy, and voiceless (Anderson, 1985; Olukotun et al., 2020).

Multiple Structural Forces: Beyond Gender

The traditional Eurocentric feminism undermines the heterogeneity of women by overemphasizing gender and ignoring the impacts of other relevant forces such as history, colonialism, race, class, and other structures that put women under continued pressure, especially those in the global south (Mohanty, 1984; Olukotun et al., 2020). By taking gender as a basic organizing force shaping women´s lives, the postcolonial feminist perspective proceeds to analyze how gender, race, and class relations simultaneously affect women (Anderson & McCann, 2002; O'Mahony & Donnelly, 2010). These forces are also very important in understanding African immigrant women´s experiences and how these social constructs shape their access to health care services (Olukotun et al., 2020).

Women as Experts of their Experience

The post-colonial feminist theory acknowledges women´s role as experts of their own stories. Women´s participation should be understood in a way that positions them at the center and promotes their active engagement in shaping research outcomes and discourses (Khan et al., 2007; Olukotun et al., 2020). The theory aims to realize social change by exploring the real experiences of women and echoing their unique and emancipatory perspectives. By adopting this theory, this study was able to contextualize and analyze African immigrant women's detailed accounts of their experiences with the goal of helping their voices be heard in the healthcare system (Khan et al., 2007; Olukotun et al., 2020; O'Mahony & Donnelly, 2010; Racine, 2003).

Critical Approach and Social Justice

The postcolonial feminist theory follows a critical inquiry towards issues related to power inequities, structural forces that limit women from realizing their potential and promote oppression (Olukotun et al., 2020; O’Mahony & Donnelly, 2010). By challenging the status quo, postcolonial feminist theory offers new ways of approaches to address women´s problems including access to health services (Allen, 1985).

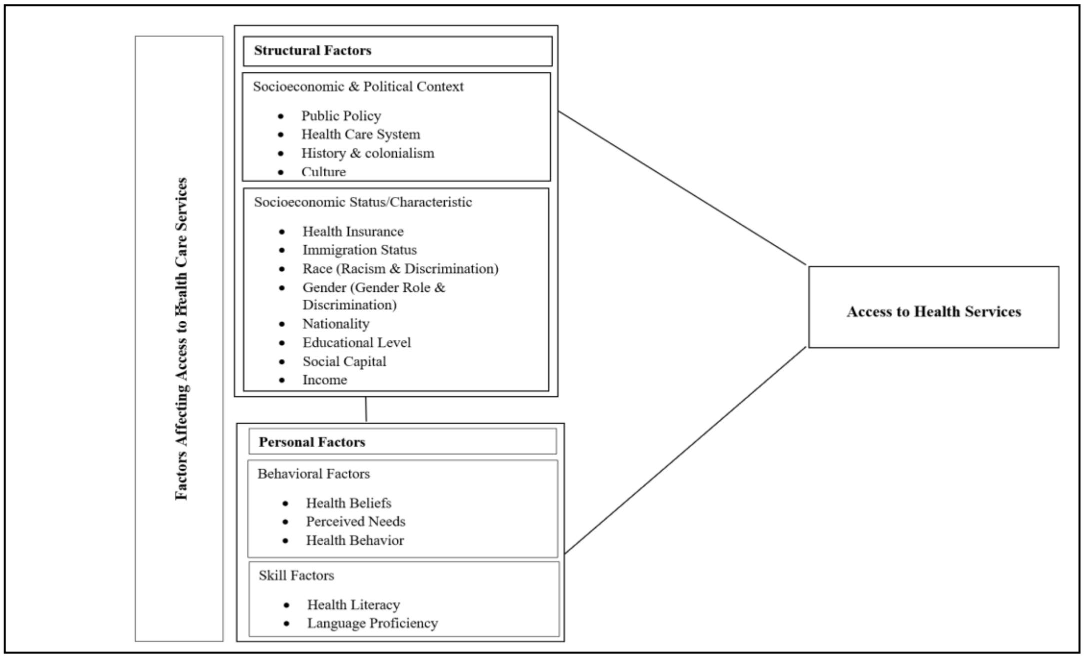
To conclude, using the postcolonial feminist perspective helped to deeply analyze the experience of African immigrant women, unbalanced power relations, and examine the extent of stereotypes and discrimination experienced while seeking health services (Anderson, 2000; O’Mahony & Donnelly, 2010).

Integrated Model to Understand Access to Health Care

This section presents the integrated model that incorporates relevant constructs from the three theoretical frameworks that helped to explore Ethiopian immigrant women’s experience in accessing primary health care services. As shown in Figure 5, most of the constructs are present across the three frameworks, mainly the CSDH and BM, and they are reorganized under the proposed integrated model.

Figure 5

Integrated Model of Access to Health Services



The following are the constructs and components of the integrated model.

Structural Factors

The structural factors construct is adopted directly from the CSDH framework to represent a collection of various structural variables that determine access to health care services. The construct is divided further into two groups of variables: 1) socio-economic and political context and 2) socioeconomic status (position). The structural factors, according to the CSDH framework, are those "socioeconomic and political mechanisms that generate stratification and social class divisions in society and define individual socioeconomic position within hierarchies of power, prestige, and access to health resources" (World Health Organization, 2010, p. 5).

Sociocultural and Political Context. Sociocultural and policy context refers to variables external to the individual that shape the individual's capacity to access health care services.

Public Policy. Public policy is present in both the CSDH and BM models to refer to both health policy and social protection policies that hinder immigrants´ access to health care services. Research showed that anti-immigration policies in the U.S. hinder immigrants' access to health care services and health outcomes. Improving access to healthcare among immigrants should start by reforming these restrictive policies at both national and local levels (Martinez et al., 2011; Wilson & Stimpson, 2020).

Health Care System. The level of openness, bureaucracy, complexity, and regulations in the health care system plays a vital role in determining access to health care among immigrants (Hacker et al., 2015). Easing bureaucratic obstacles, creating an inclusive and culturally competent service environment are needed to improve healthcare access among immigrants (O'mahony & Donnelly, 2010).

History and Colonialism. As indicated in the postcolonial feminist framework, exploring immigrant women's experiences within the historical context of their life provides an analytic lens to generate transformative knowledge and increase the understanding of their unique needs in accessing health care services (Clough et al., 2013).

Culture. Cultural values influence one's access to health resources and shape people´s attitudes and beliefs about access and utilization of health services. Understanding the culture of immigrant women helps to accommodate cultural needs, reduce stigma, create a balance with the American medical culture, and help access and utilization of services (Choi, 2009).

Socioeconomic Status. Socioeconomic status refers to a position held by individuals in the social hierarchy. This social position includes variables that predispose individuals to inequitable access to health care resources. Although these characteristics are often considered as defining individual identities, the CSDH framework presents them as socially constructed structural factors that determine individuals' positions that determine their ability to access and utilize resources. As indicated in the CSDH framework, socioeconomic status will be expanded to include a wide range of characteristics beyond the commonly used variables such as education and income (Shafiei et al., 2019).

Health Insurance. Having health insurance is the key to accessing health care that is determined by one's financial capacity as well as legal status. Improving access to health care requires the expansion of insurance and reforming eligibility requirements for immigrants (Olukotun et al., 2019; Wafula & Snipes, 2014).

Immigration Status. This is the missing variable in all three frameworks but added from the immigrant literature due to its importance for the purpose of this study. Like other statuses, immigration status is a significant determinant of access to health in its own right and needs to be examined (Castañeda et al., 2015). Health care policies that operate based on assumptions of deservingness should be revisited to realize equitable access to health care services among immigrants (Boulware, 2003; Richardson & Norris, 2010).

Race (Racism and Discrimination). Race may serve as the basis of social division and discrimination and affect access and utilization of health services. This is important when studying African immigrant women in the U.S. where discrimination against racial minorities and immigrants has been repeatedly reported in the immigrant health literature (Betancourt, 2003; Williams & Rucker, 2000). Improving data systems, exercising regulatory vigilance, and promoting cultural competence can help reduce racial disparities in the health system (Socías et al., 2016).

Gender (Gender Role and Discrimination). Gender comes with socially constructed roles, behavioral expectations, and discrimination that puts women in a disadvantaged position to access health care resources and services (Marshall et al., 2005; Phillips, 2005). Understanding the role of gender in determining access is the first step in the effort to bridge the existing gender disparity among immigrants (Mohseni & Lindstrom, 2007; Montazer & Wheaton, 2011).

Educational Level. Education determines people´s ability to read and understand health information. It is also related to one´s occupation and financial capacity to have health insurance. Helping immigrant women to improve their education, in turn, builds their capacity for better decision-making regarding health and increased social and personal resources that are vital for accessing health care services (DeVoe et al., 2007; Howell, 1988).

Income. Income determines people´s capacity to access health resources and afford health care services including health insurance. Expanding job and skills training, and employment opportunities for immigrant women can help improve access to health services (Leclere et al., 1994; Mantwill & Schulz, 2017).

Social Capital. Social capital provides people with information, material, and emotional support to access health care services. Immigrant women rely on their social networks to get support in navigating the health care system. Mobilizing these networks and facilitating community partnerships would help improve access to health care (Ku & Matani, 2001).

Personal Factors

The second section of the integrated model presents the personal level factors: behavioral and skill factors.

Behavioral Factors. Behavioral factors investigate more personal values and perceptions of a person seeking healthcare services. Apart from the structural factors, immigrant women’s held beliefs, perceptions, and practices are crucial in analyzing their experience with the healthcare system.

Health Beliefs. The BM model states that one’s health beliefs affect the diagnosis of a disease, trust, and utilization of services. This is very important in understanding immigrants’ experiences as they come from a different belief and cultural system (Yosef, 2008). The health beliefs and perceptions of immigrant women should be examined to best serve their interests and improve the utilization of services (O’Mahony & Donnelly, 2007).

Perceived Needs. According to the BM, people’s view of their state of health and perception about the appropriateness of health services determines their decision in seeking care (Andersen, 1995). Immigrant women come from different countries and have varied healthcare experiences and expectations. Hence, understanding the perceived needs of immigrant women is important in meeting their health demands (O'Mahony & Donnelly, 2007).

Health Behavior. As discussed in both the BM and CSDH frameworks, health behavior refers to both negative and positive practices of the individual that affect health outcomes (Suka et al., 2015). Educational strategies that promote positive health practices such as physical activity and regular check-ups among immigrant women are recommended (Millman, 1993).

Skill Factors. Skill factors are related to one's ability to acquire knowledge and understand it through thought and experience. As discussed in the literature review, the two most relevant skill-related aspects that affect immigrant women's ability to access healthcare are health literacy and language proficiency.

Health Literacy. As highlighted in the BM, health literacy is the ability to obtain, understand and utilize health information as an important variable in determining access to health services (Andersen, 1995). Immigrant women are highly affected by the lack of health literacy as they are unfamiliar with the U.S. health system. Expanding customized educational resources and supportive networks reduces the problem (Jenkins et al., 1996; Yosef, 2008).

Language Proficiency. Limited language proficiency has been vastly discussed as a major barrier to access health services among immigrants (Ponce et al., 2006).

Providing language assistance services, recruiting multilingual staff, and English language training for immigrant women would be helpful (Johnson et al., 2008).

Access to Health Services

The third and final section of the integrated model presents the dependent variable which is access to health services. Access to health services refers to "the timely use of personal health services to achieve the best possible health outcomes" (Healthy People 2020, 2017; Millman, 1993, p. 202). As demonstrated in the integrated model, all the social and personal determinants work together to impact immigrants' access to health care services.

The above chapter presented the discussion of the three theoretical frameworks: the CSDH, BM, and the postcolonial feminist perspective to develop an integrated framework to understand access to healthcare. The integrated model was used to guide this study, particularly to develop the interview guide and inform the discussion of the study findings. The next chapter presents the methods used in the study.

CHAPTER 4: METHODS

Research Design

This study used a qualitative design to explore Ethiopian women's experiences, perceptions and challenges in accessing primary healthcare services in the U.S. The use of a qualitative design was deemed appropriate for this study due to 1) the unavailability of adequate information on the healthcare experiences of Ethiopian immigrant women; and 2) the need for an in-depth examination of the complex realities involved in Ethiopian immigrant women's health care seeking attempts and utilization (Creswell & Clark, 2018). The study followed a descriptive phenomenological approach which is suitable to develop a synthesized description and common meaning of a given phenomenon or concept (access to health care, in this case) based on the lived experiences of individuals (Creswell & Creswell, 2017). The approach attempts to understand and explain a given situation or the social world from the perspectives of people who directly experienced it (Annansingh & Howell, 2016).

Compared to other qualitative approaches such as narrative or grounded theory, phenomenology fitted the purpose of this study which was to gain a deeper understanding of the unique lived experiences and perceptions, and inductively develop a common meaning of EIW's healthcare experience through the identified themes (Creswell & Creswell, 2017). In the phenomenological approach, the researcher generates themes from the analysis of significant quotes and statements and develops textural (e.g., what participants experienced) and structural (e.g., how they experienced) descriptions. This procedure is suitable to examine what the challenges of EIW are in accessing PHC, and how they experience, view, and respond to those challenges and situations.

Another methodological advantage of using the phenomenological approach was the application of its core processes; epoche, phenomenological reduction, and bracketing. As the study was conducted by an Ethiopian researcher to investigate Ethiopian immigrant women's experiences, it was important to be conscious of potential researcher biases and assumptions that might impact the research process and outputs. Applying the three core processes of phenomenology helped achieve this goal. The researcher refrained from judgment (epoche) and purposefully remained open (phenomenological reduction) to learn from the experiences of Ethiopian immigrant women (Morley, 2010). The researcher also set aside his experience and assumptions (bracketing) to gain a fresh perspective on participants' experiences and realities in accessing health services (Chan et al., 2013). The combination of its aligning purpose and procedural advantages made phenomenology the most suitable approach to be used in this qualitative study (Creswell & Creswell, 2017; Groenewald, 2004; Khan, 2014).

Sampling and Recruitment

A combination of purposive and snowball sampling was used to recruit participants for the study. Purposive sampling helped to strategically select participants relevant to the objectives of the study and gain a broader understanding of the issue under investigation (Creswell & Creswell, 2017). Accordingly, Ethiopian immigrant women who were believed to best inform the study and offer detailed accounts and perspectives on the subject matter were recruited for the study. Inclusion criteria for participating in the study included: 1) identify as an Ethiopian immigrant; 2) identify as a female; 3) be 18 years old and older; 4) arrived in the U.S. within the last five years; and 5) speak Amharic or English. Although the majority of Ethiopian immigrants speak Amharic, which is the national language, English was included to give an option for potential participants who have been in a third country before they arrived in the U.S. and commonly use English. Given the hard-to-reach nature of the study group, snowball sampling was also used to support the selection process (Royse, 2020). According to Creswell and Poth (2017), a sample size of 5-25 participants can help to reach saturation in phenomenological qualitative inquiry. First, two Ethiopian immigrant women were recruited to pilot the interview guide and test the appropriateness and clarity of the questions. Then, 21 participants were selected to undertake in-depth interviews until the saturation level was reached in the data collection process. Participation in the study was voluntary.

To recruit and engage participants for data collection, the researcher established contact and built rapport with organizations working with immigrants and refugees in the U.S. As part of the recruitment effort, the researcher volunteered at the Refugee and Immigration Services (RIS) to establish rapport with the staff members and gain experience in the work related to immigrants and refugees. Participants accessed through RIS provided recommendations of other potential participants that significantly helped to recruit more EIW. For additional participants, the researcher also contacted the Ethiopian Community Center. The researcher briefed the staff members of the organizations about the goal and nature of the research. In addition to these organizations, social media platforms such as Facebook and WhatsApp groups were utilized to disseminate the information. Flyers were prepared in Amharic and English and dispatched through the contacted organizations and social media. In addition, snowball sampling and word of mouth were used to recruit participants who cannot be accessed directly (Royse, 2020).

Participants verbally agreed to the informed consent (See Appendix 2) before taking part in the interviews.

Data Collection

Data collection took place right after the approval of the study proposal by the Institutional Review Board (IRB) of the University of Missouri. Data were collected through one-on-one, in-depth interviews to dig deeper into the rich and unique experiences of Ethiopian immigrant women. Interviews lasted between 45-90 minutes. The one-on-one nature helped to create open and free interaction with the participants on issues relevant to answering the research questions. It also helped to build trust with participants so they can share their stories and feelings about their encounters with the health system freely. In-depth interviews also created the opportunity to thoroughly explore and represent the missing voices of Ethiopian immigrant women in the immigrant health literature (Kvale & Brinkmann, 2009). They also permitted the researcher to explore factors that underpin immigrant women´s responses: reasons, feelings, opinions, and beliefs around accessing health services (Ritchie et al., 2013).

A carefully developed interview guide (See Appendix 1) with open-ended questions was used to extract the necessary information. The interview guide was informed by the integrated model of access to health services (See Figure 5) and an in-depth review of the immigrant health literature. The interview guide was also designed as per phenomenological inquiry to emphasize what challenges immigrant women encountered in accessing health services and how they experienced them through the main and probing questions. The interview guide had a section for demographic information that was collected using close-ended questions. Based on the two pilot interviews, a few questions were re-phrased to improve clarity and questions of similar nature were merged during the interviews. The in-depth interviews were audio recorded using a voice recorder based on the consent of the participants and stored on a password-protected computer. The interviews took place both in-person (*n*=5) as well as in virtual (phone, Zoom, or Skype) (*n*=16) formats depending on participants' preference and convenience. During the interview sessions, the researcher took field notes to capture important gestures, body language, and expressions relevant to the analysis and interpretation process.

Ethical Considerations of Study

The research followed various approaches to meet ethical expectations in every stage of the study. Approval was gained from the IRB of the University of Missouri to conduct the study. In addition, the organizations (RIS and ECC) involved in recruiting participants were consulted on how to approach and recruit participants in an ethically and culturally sound way. The purpose and objectives of the study were made clear to the participants and informed consent was verbally agreed upon. This helped to make sure their decision to participate was based on knowledge and was totally voluntary. Sensitive and identifiable information was removed from transcripts and fictitious names were used while analyzing data and presenting the findings (Creswell & Poth, 2017; Edmonds & Kennedy, 2020).

Data Analysis

The data analysis followed an inductive analytical process where the researcher read through the raw data and alloed findings to emerge from the dominant and frequent themes from the raw data. The inductive process involved a bottom-up strategy of organizing and immersing in the raw textual data, rigorous coding, and theme building to develop a condensed summary or composite description (Thomas, 2016). To achieve this, the data analysis followed the five steps of inductive qualitative data analysis (Creswell & Poth, 2017).

Step 1: Data Organizing, Transcribing, and Cleaning

A file naming system was created by the researcher to store the interview recordings, transcripts, filed notes, code reports, demographic information, spreadsheet with participant information, and related files in an organized and searchable manner. After making this arrangement, the data analysis process started with the verbatim transcription of the audio-recorded data by the researcher. The researcher listened through each recording to correct them for accuracy. The researcher de-identifyed names, addresses, and any sensitive information from the transcripts.

Step 2: Reading and Memoing

De-identified transcripts were individually reviewed to identify important bits of information that stand out in each interview and across interviews. During the review process, memos were taken to capture emergent ideas and sketch reflective thoughts around potential codes. These memos were combined and synthesized with the field notes taken during the interviews. This marked the start of the iterative process of developing the codebook.

Step 3: Theme Building and Coding

Using the reviewed data and memos, the researcher sought themes, patterns, and categories throughout the transcripts to form initial codes (Frost, 2011). After the themes were organized into different levels representing greater and lesser levels of specificity, the codebook was finalized. Memos were used to help arrange and categorize codes during the development of the codebook (Creswell & Poth, 2017; Kreuger & Neuman, 2006). Once the codebook was developed, transcripts were entered into Nvivo 12 software to begin the thematic analysis process. Each interview was reviewed again, using the codebook to highlight sections of text in which individual nodes apply. During this process, updates were made to the codebook and retroactively applied to sections of text already coded (Medelyan, 2021).

Step 4: Developing and Assessing Interpretations

After coding was finished, code reports were generated to review the sections of text for each node. This allowed the researcher to explore the themes within and across each individual node. Significant statements that summarized the personal experiences of participants across the nodes were developed. Memoing was used to mark, select, and create links among the developed statements. These developed statements were grouped into meaningful units that portray the essence of participants' experience in accessing health services (Creswell & Poth, 2017).

Step 5: Representing and Visualizing Data

The final analysis included rich textual and structural descriptions, organized by major categories and themes. Based on these descriptions, a composite description of the essence of participants' experiences in accessing primary healthcare services was presented, and implications for policy and practice were discussed.

Rigor and Trustworthiness

To ensure scientific rigor and establish trustworthiness, the researcher applied various strategies. A clear description of the study and rationale of the sampling, recruitment, and data collection process was transparently presented. And interviews were conducted until a saturation level was reached. The researcher applied prolonged and persistent engagement to ensure an in-depth understanding of the data and accurately captured emerging ideas. Field notes and memos helped ensure participants' experiences and themes were equally valued and represented in the analysis. Thick and thorough descriptions of participants' accounts regarding their primary healthcare experience were presented. A large number of direct quotes from participants were used to support the themes and descriptions (Creswell & Poth, 2017).

The researcher engaged in reflexivity to reduce the influence of his own positions such as gender, academic, linguistic, nationality, and subjective biases in the research process and outputs. As an Ethiopian living in the U.S., the researcher tried to reduce the impact of potential insider biases by applying the core processes of the phenomenological approach discussed in the research design above (epoche, bracketing, and phenomenological reduction). Peer debriefing (with the research advisor and colleagues) was sought to increase validity throughout the process. Member checking or participant validation was done to ensure the credibility of results and check for accuracy and resonance of the data with participants` views and experiences. Two participants expressed willingness to undertake member checking with the researcher. The researcher virtually met with them to review the initial codes and themes. The two participants provided feedback that informed the analysis and presentation of the findings (Birt et al., 2016). The following chapter presents the findings of the study.

CHAPTER FIVE: FINDINGS

This chapter presents the demographic information of participants followed by the findings of the study. The findings are categorized into four parts based on the major categories of themes that emerged from the analytical process. These are 1) transition and overall perceptions, 2) personal barriers of access to PHC, 3) structural barriers of access to PHC and 4) facilitators of access to PHC. Under each major category, Figures are presented to demonstrate the emergent themes and subthemes.

Demographics of Participants

Twenty-one female Ethiopian immigrants living in six states (MO, KS, MD, VA, MI, VA) and Washington DC, with most of the participants living in Missouri (n=9, 42.9%), took part in this study. Participants were between 24-53 years old (M= 36.5), most of them married (n=12, 57.1%), and lived in the U.S. for 2.6 to 5 years (M=4.43). Most of the participants were with the immigration status of asylee (n=5, 23.8%), and refugees (n=5, 23.8%). See Table 1 for more details.

Table 1

Demographic Information

Characteristics	**Number/Percentage**
Age	
18-25	1 (4.8 %)
26-32	6 (28.6 %
33-40	9 (42.9 %)

41-47	1 (4.8 %)
48-55	4 (19.05 %)
Relationship Status	
Married	12 (57.1 %)
Single or never married	5 (23.8 %)
Divorced or separated	3 (14.3 %)
Widowed	1 (4.8 %)
Live with partner	
Yes	11 (52.4 %)
No	10 (47.6 %)
Children	
Yes	13 (61.9 %)
No	8 (38.09 %)
Number of Children	
1	5 (23.8 %)
2	6 (28.6 %)
3	1 (4.8 %)
4	1 (4.8 %)
Household size	
1	4 (19.05 %)
2	3 (14.3 %)
3	5 (23.8 %)
4	5 (23.8 %)

5	4 (19.05 %)
Length of stay in the U.S.	
1-2 yrs	1 (4.8 %)
3-4 yrs	9 (42.9 %)
5 yrs	11 (52.4 %)
Immigration Status	
US Citizen	4 (19.05 %)
Permanent Resident (Green Card Holder)	3 (14.3 %)
Asylee	5 (23.8 %)
Refugee	5 (23.8 %)
Asylum Seeker	3 (14.3%)
Pending (Transition from J1 to O1[2])	1 (4.8 %)
Level of Education	
Elementary	1 (4.8 %)
Highschool graduate or GED	5 (23.8 %)
Some college	1 (4.8 %)
Graduated college	8 (38.09 %)
Postgraduate study	6 (28.6%)
English Proficiency	
Full professional proficiency (advanced)	2 (9.5 %)
Professional working proficiency (intermediate)	12 (57.1 %)
Elementary proficiency	6 (28.6 %)

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[2] J1 visa is an exchange visitor visa and O1 is a via category for individuals with extraordinary ability or acheivement

No proficiency	1 (4.8 %)
Other Languages	
Amahric	21 (100%)
Oromiffaa	3 (14.3%)
Tigrigna	1 (4.8 %)
Somali	1 (4.8 %)
Dawrogna	1 (4.8 %)
Hadiyigna	1 (4.8 %)
Kembatigna	2 (9.5%)
Swahili	1 (4.8 %)
Arabic	3 14.3%)
Turkish	1 (4.8 %)
Employment status	
Employed fulltime	17 (81 %)
Employed parttime	3 (14.3 %)
Not employed, looking for work	1 (4.8 %)
Not employed, not looking for work	1 (4.8 %)
Annual Household Income	
Less than 19,999	1 (4.8 %)
20, 000 - 39, 999	8 (38.09 %)
40, 000 - 59, 999	3 (14.3 %)
60, 000 – 79, 999	3 (14.3 %)
80, 000 – 99, 999	2 (9.5 %)

100, 000 – more	4 (19.04 %)
Residence	
MO	9 (42.9 %)
MD	3 (14.3 %)
VA	3 (14.3 %)
Washington DC	3 (14.3 %)
KS	1 (4.8 %)
MI	1 (4.8 %)
IN	1 (4.8 %)
Health Insurance	
Yes	18 (85.7%)
Private	15 (71.4%)
Public	3 (14.3%)
No	3 (14.3%)
Frequency of PHC use per year (non-pregnancy-related)	
1-2	14 (66.7 %)
3-4	5 (23.8 %)
5-6	2 (9.5 %)
Common reasons for PHC visit	
General regular checkups	15 (71.4 %)
Pregnancy (pre- and post-natal)	13 (61.9 %)
Dental regular checkups	5 (23.8 %)
Backpain	3 (14.3 %)

Diabetes	2 (9.5 %)
Vision	2 (9.5 %)
Thyroid	1 (4.8 %)
Tonsilitis	1 (4.8 %)
Mental health service	1 (4.8%)
Overall Health Self-Rated	
Excellent	5 (23.8 %)
Very good	8 (38.1 %)
Good	6 (28.6 %)
Fair	2 (9.5 %)

Table 2 presents each participant with selected demographic information. The aim is to help readers connect the individual quotes with the participants' background information easily and avoid repeated statements of demographic information in every quote.

Table 2

Participant Reference Information

No.	Participant Pseudonyms	Age	Level of Education	Immigration Status	Relationship
1	Halima	33	Postgraduate	Asylum seeker	Single or never married

2	Saba	35	Postgraduate	Green card holder	Widowed
3	Senayit	27	Highschool graduate	Refugee	Married
4	Ametsash	52	Elementary education	Refugee	Divorced or separated
5	Seble	36	Graduated college	Asylee	Married
6	Maya	38	Postgraduate study	Asylum seeker	Married
7	Sishat	41	Graduated college	US citizen	Married
8	Terefech	24	Highschool graduate	Asylee	Single or never married
9	Gelila	53	Some college	US citizen	Divorced or separated
10	Haben	36	Graduated college	US citizen	Married
11	Tirsit	37	Highschool graduate	Refugee	Married
12	Ruth	32	Graduated college	Green card holder	Married

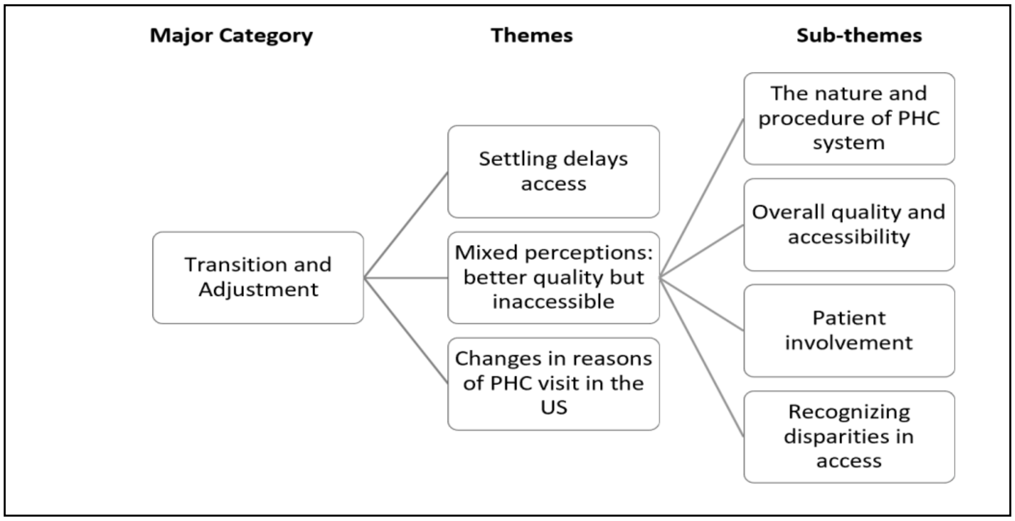
13	Tina	48	Highschool graduate	Refugee	Divorced or separated
14	Etalem	48	Highschool graduate	Refugee	Married
15	Meba	32	Postgraduate study	Asylee	Single or never married
16	Yetim	32	Graduated college	US citizen	Married
17	Salem	37	Graduated college	Asylee	Single or never married
18	Marda	35	Postgraduate study	Pending status (J1 to O1 transition)	Married
19	Samiya	34	Graduated college	Asylee	Married
20	Hager	30	Postgraduate study	Green card holder	Married
21	Chaltu	28	Graduated college	Asylum seeker	Single or never married

Part One: Transition and Overall Perceptions: Moving from Universal Primary Healthcare to a Non-Universal Primary Healthcare System

This section presents the overall perceptions of EIW in relation to their transition from Ethiopia and the Ethiopian PHC system to the U.S. and U.S. PHC system. Three major themes emerged under this category: 1) Settling into the new life in the U.S. delays EIWs' ability to access PHC, 2) Mixed perceptions: PHC in the U.S. is of better quality but inaccessible, and 3) EIW's reasons for PHC visits changed in the U.S. (See Figure 6).

Figure 6

Transition and overall perceptions: Themes and subthemes



Settling into the New Life in the U.S. Delays EIWs' Ability to Access PHC

Participants stated that the overwhelming experience of settling into a new country could not let them prioritize their healthcare needs. Familiarizing themselves with the new environment, findings a place to live, and understanding how things work in the U.S. took them time. Hence, most EIWs were not paying attention to their PHC needs for the first couple of years. Haben shared:

> It was tough, I didn’t know anyone, and it took me almost two years to adapt and connect with people, and learn about how to have and use insurance and healthcare. And this is in the DC-Maryland-Virginia (DMV) area where there are many Ethiopians. I can’t imagine how it will be difficult for those living in other areas with no Ethiopian community. (Haben)

Settling into life in the U.S. was not a straightforward path for participants. EIW had to continually change their legal status and residential addresses. These changes in legal status and residence disrupted EIW’s ability to get connected to PHC services. For example, Saba changed her legal status four times and lived in three different states within her first couple of years in the U.S. She said,

> I was on a student visa in a small town in Iowa. Then moved to California on OPT visa and then changed to H1B and moved out of California on a different visa. As a student, I had access through my school and could ask for guidance. Moving to California exposed me to the other face of life. I was on my own. Let alone healthcare, figuring out how to move around was tough because I didn’t drive. I used to use uber which cost me a lot. The project ended and I was suddenly at risk. I had to change my status immediately and had to move out of California, and I stayed without insurance. (Saba)

Most participants agreed that the first two years are the most challenging years in terms of adjustment and the ability to pursue PHC services. Haben said, “The first year I moved to the US, I fell and got injured. I didn’t know where to go and suffered a lot.” Maya also said, “The first year and a half, I lived without any insurance, health service, or check-ups at all. I had so many health issues, but I had to wait until my documents were processed and got employed.”

Leaving their families (support system) behind and navigating the individualistic lifestyle in the U.S. affected EIW’s ability to seek and utilize PHC services. Participants who gave birth in the U.S. were especially affected by the limited social support system. Salem said:

> I was pregnant with no one around. My husband is still in Ethiopia. It was the toughest time of my life to be a single mother in a new country, with no job and healthcare for a while until I process documents and learn the language. (Salem)

The hassle of adjusting to the weather, homesickness, poor work conditions (including standing long hours), communication challenges, and the lonely lifestyle in the U.S. could not help EIW think about their well-being or healthcare needs. The emotional burden of adjustment and limited knowledge constrained EIW’s capacity to effectively navigate the PHC system. Etalem said, “If it wasn’t for my husband, I would be miserable and lost, let alone getting medical help.” The struggle to adjust to their new lives affected EIW’s ability to prioritize their healthcare needs and pursue PHC.

Mixed Perceptions: PHC in the U.S. is of Better Quality but Inaccessible

Participants shared their overall perceptions of PHC services in the U.S. as compared to their experiences of PHC in Ethiopia. Before presenting participants’ responses, it is important to give the context of PHC in Ethiopia. In Ethiopia, PHC is free in public health centers, clinics, and hospitals. There is no health insurance system in general and most people are not familiar with the concept. Instead, patients are expected to pay a few Ethiopian Birr just for the “card” number (patient identification card) and get examined and treated at no cost in public health hospitals/centers/clinics. However, they have to pay for the prescribed medicine, which can be bought from public pharmacies (at a lower price) or private pharmacies. In some cases, they might be referred to do tests at advanced private laboratories that are costly. Although the majority of the population uses public PHC services, there is a growing tendency to go to private healthcare, in the major cities of the country. This is mainly because of the overburdened public healthcare centers, and the relatively fast and better health services in private healthcare centers. In both public and private health centers, all payments are made in cash and upfront. Except for a few employers who have medical allowances (mostly international organizations and non-profits) for their employees, there is no health insurance system (Assefa et al., 2020; Debie et al., 2022). The flowing subthemes demonstrate the mixed perceptions of EIW about PHC services in the U.S.

The Nature and Procedure of Primary Healthcare System

Coming from a developing nation with relatively universal healthcare, participants expressed that it is difficult to comprehend why basic primary healthcare is not universally available in a wealthy country like the U.S. Most participants expressed their shock when they realized they can not access services without insurance and healthcare is very expensive. Hager said:

> I was shocked to learn about healthcare expenses. In Ethiopia, if I don’t have money, I would go to a public health center to get my treatment and contraceptive

> pills for free. I lived in the anxiety of getting pregnant here because I couldn't afford it as a student. It is insane given the wealth and advancement of the US that you have to struggle to meet basic PHC needs. (Hager)

Familiarizing themselves with the healthcare and insurance system was a big challenge for EIW. As Gelila put it “It is a whole new world.” Participants stated that it took them some time to realize the healthcare system works totally differently. Most of the participants admitted they still do not completely understand the complexity of the insurance and PHC system. Hager said, “I still rely on my husband. It is a lot to figure out.”

For participants who have been enjoying the freedom of going to any nearby health center when they feel sick, meeting the expectations of insurance companies, identifying the in-network providers, understanding copayments and deductibles, covered and uncovered conditions, and making appointments has been overwhelmingly difficult. Having the requirement to see a general doctor before a specialist in some circumstances is hard to abide by for EIW. “There are so many requirements and expectations that overburden you as a patient. In Ethiopia, if I get sick, I will just get up and go to the nearest hospital. Not anymore”, said Hager.

The standard and procedure of care in the U.S. is also a huge learning curve for EIW. Participants stated that making regular check-ups, screening, and highly specialized practice that involves multiple referrals are new to them. Below is what Marda had to say:

> I came from a country where healthcare system is financed out of pocket and there is also no standard procedure on when to get what screening or tests unless you are someone who read about it and doing stuff on your own, or you have friends and families in health care who will recommend you. When I arrived in the U.S. my doctor asked, ‘when was your last pap test?’ and I was like ‘Ummm….no provider in Ethiopia ever told me that I needed a pap smear’. Finally, in my case, I was one of those people who were at high risk for some of those diseases, the screening could have identified it but in Ethiopia, no one told me I needed this care. Coming here and getting asked these questions like wow I’m ashamed why the provider back home didn’t tell me about this. (Marda)

The interviews demonstrated that EIW were expected to unlearn the healthcare procedures in Ethiopia and struggled to familiarize themselves with the U.S. PHC system.

Overall Quality and Accessibility

Compared to their experience in Ethiopia, participants agreed that the quality of PHC services in the U.S. is better. Participants appreciated the advanced technology, treatment process, and regular follow-ups in PHC in the U.S. However, they also expressed that its inaccessibility left them frustrated. As Ametsash expressed it using an Amharic poetic proverb “ላም አለኝ በሰማይ ወተትዋንም አላይ”, a saying used to refer to an empty hope. Saba added, “As to me, the PHC service is very good; the treatment and follow-up are good. But the cost is unspeakable. If you don’t have a well-paying job, you are left out.” For most participants, the inaccessible nature of PHC in the U.S. is stressful. Maya said, “Leaving my job with medical allowance and all the privileges back home and struggling here to process immigration and get affordable insurance for my children has been emotionally draining." Most of the participants repeatedly stated they believe that PHC in the U.S. is primarily driven by money (profit making) than saving lives. Hence, they have mixed feelings and most of them approach the PHC services with suspicion and extra care.

Although participants appreciate the universal nature of PHC and its relative affordability in Ethiopia, they also acknowledged the imbalance between demand and supply that overburdened healthcare centers. The long lines, waiting hours, limited human resources, inadequate medical supply and equipment, and unavailability of treatment beds and rooms for admission are some of the problems participants identified in PHC in Ethiopia. Gelila said, "In Ethiopia, if you need to be admitted, it would be very hard to find a spot as the number of patients outnumbers the available places and physicians." A midwife nurse herself, Samiya offered a contrast of PHC in Ethiopia and the U.S.; "My second baby was born here (the U.S.) before the due date and had to stay in ICU for weeks. I didn't have to worry about infections, which are the main cause of health complications back in Ethiopia." For participants, PHC in the U.S. is characterized by its two opposite features, better quality but inaccessible. As Sishat said,

> I have both positive and negative feelings about my experience. I received good treatment and follow-up for my problem. But it took me more than 2 years to get treated because it was hard for me to navigate the system, get coverage and have the financial capacity. Sishat, 41.

Patient Involvement

Compared to their experience in Ethiopia, participants stated that PHC professionals in the U.S. try to engage their patients in the care process. According to participants, professionals in the U.S. try to find every piece of information and involve them in the decision-making process during diagnostic/treatments. Although they appreciate the efforts, for some of the participants, this is a difficult experience. First, EIW came from a culture where they mostly rely on the physician to examine, identify the problem and tell them what to do. As Halima said, “Sometimes I feel confused when they ask me too many questions and explain too much information. Sometimes, I don’t even understand what they are saying as it is too technical for me.” Second, most EIW have limited English language skills which makes communication stressful. But for a few with a better command of English and technical understanding, this experience is positive. Referring to her prenatal care, Hager said, “The doctor explained the three options I have, and I liked the way she engaged me in the decision-making process.” A few of the participants also noted that their experience with the PMC in the U.S. taught them an important lesson about the need to advocate for themselves in situations they think are unfair. Meba said, “After they misdiagnosed me, I learned that I have to advocate for myself and express my thoughts and feelings. I no longer stay too humble and quiet as I used to be back in Ethiopia.”

Recognizing Disparities in Access

Beyond their perception of overall inaccessibility, participants also recognized that there are disparities in accessing PHC in the U.S. They believe that PHC is not accessible, especially for immigrants in the U.S. Halima said:

> When you are an immigrant in the US, having the courage to go to the health center is very difficult, even to enter the system. When I first came, I didn’t have a job, proper documents, or even to get government-sponsored insurance programs. Because of that requirement, I had to pay a lot of money, even my brothers had to send me money from home (Ethiopia) to get treated. (Halima)

Participants also stated that PHC is not accessible for people of color, particularly black immigrants. During the interviews, participants expressed directly and indirectly that their PHC experience has been influenced by their immigration status and racial identity (this will be presented in Part Three in detail). Marda said, “So, I would say my experience is pretty much shaped by my understanding of the race relation in this country and how entire the medical industrial complex is racist and unfair to some people, and how it took me a while to understand that.” The interviews also showed that participants understand the residential and economic segregation in the PHC services in the U.S. Meba shared her experience as follows:

> Living in low-income communities means the healthcare facilities are poorly resourced. I was in Maryland, and I went to a hospital. The hygiene was so poor and packed with people waiting for services. I went to another hospital in an affluent neighborhood to visit a friend and it felt like I was in a different country. It was of high quality in everything. (Meba)

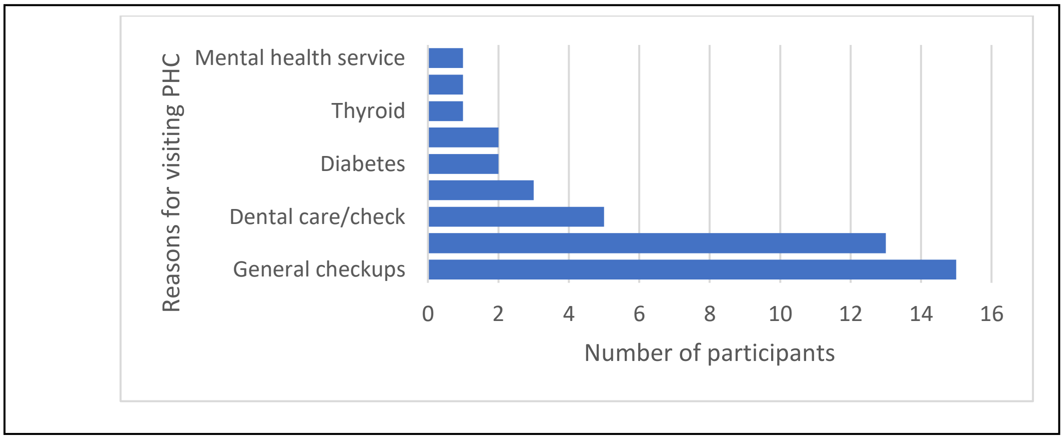
Participants also recognized that there is a difference between private and public health insurance. They stated that although public programs offer lower-cost options, they are under-resourced and the waiting time to get appointments and treatments is longer. Sishat, who used the Washington DC public insurance said, “You should be lucky to get an appointment when using public programs. I had to wait for long hours for treatment which was very challenging given my work schedule".

EIW's Reasons for PHC Visits Changed in the U.S.

The interviews revealed that EIW's reasons for seeking PHC have changed since moving to the U.S. Participants agreed that they developed a new habit of doing annual regular check-ups and screening in the U.S. Haben said, "here you don't have to be sick to go to health centers. You can go for checkups and examinations as a preventive measure. That is good". Next to check-ups, maternity/pregnancy-related/child-birth services are the most common reasons among participants for visiting PHC in the U.S. (See Figure 7). Thirteen out of the twenty-one participants stated they used PHC mainly during their pregnancy. Ruth said, "I would say my top reason is pregnancy and pre- and post-maternal follow-ups. This is not something I can avoid but for other illnesses, I prefer not to go".

Figure 7

Reasons for Visiting PHC



However, most of the participants stated that they do not pursue PHC for issues like headaches, stomach problems, or illnesses that are not chronic as they used to do back in Ethiopia. They try to avoid going to PHC if the issue is not serious or life-threatening. For example, only four of the participants said they regularly use primary healthcare services due to diabetes (two), thyroid (one), and back pain issues (three). The other participants would seek primary healthcare only if they are severely ill or if the pain couldn’t let them work.

Participants shared a broad range of factors that contribute to the changes in reasons and avoidance of PHC that will be presented in the next sections (Parts Two and Three) of the findings chapter. Some of the factors included difficulty in navigating the healthcare system, lack of satisfactory results, legal status, illegibility issues, lack of insurance, and financial limitations. Ametsash said, “I wish I could find a solution for the number of health problems I have. I don’t feel well but I also don’t want to go as it is too expensive for me, and not satisfying results”.

Although participants shared the overwhelming and stressful experience of adjusting to the new environment and healthcare system, only one of them stated using mental health services. Marda shared why she started seeing a therapist as follows:

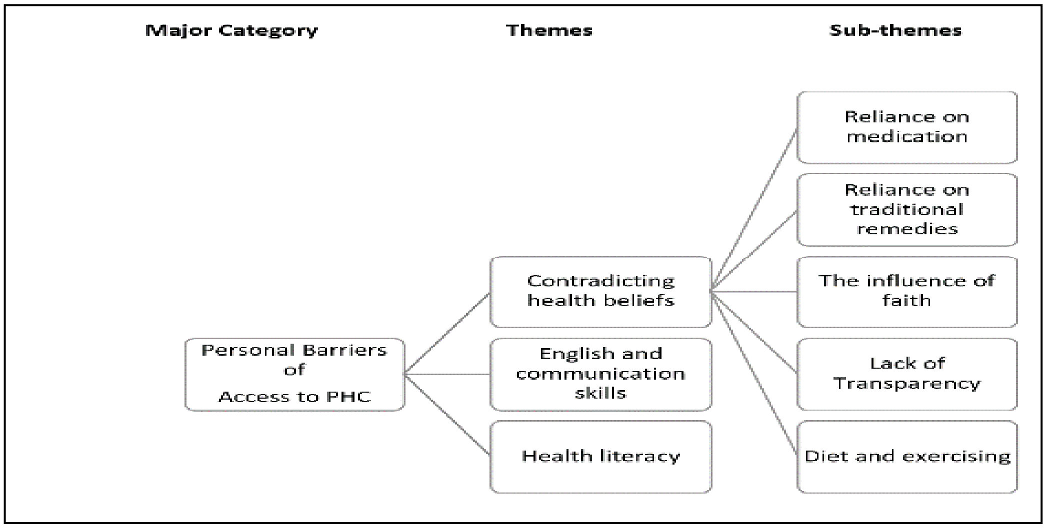
> I started seeing a mental health provider since I came here which is new in part because I wouldn’t say I never need it while in Ethiopia, but I would say this life puts you through so much and you need to make sense of it, and you need to process it. Therapy offers you a space where you can talk about your experiences and make sense of what happened to you. As I said when you go through workplace racism and racism in other spaces including healthcare. (Marda)

Part Two: Personal Barriers of Access to PHC

This section presents the personal barriers experienced by EIW in accessing PHC in the U.S. Under the personal barriers, three important themes emerged: 1) contradicting health beliefs hindered access to PHC among EIW, 2) English language and communication challenges constrained EIW's utilization of PHC 3) limited health literacy impacted EIW's PHC decisions. The themes and subthemes are presented in Figure 8 below.

Figure 8

Personal Barriers: Themes and Subthemes



Contradicting Health Beliefs Hindered Access to PHC among EIW

Reliance on Medication

Coming from a less-medication-intensive cultural and healthcare environment, most participants stated that they are hesitant to fully accept the healing power of medicine/drugs. Most believed that PHC in the U.S. is heavily dependent on medication as compared to PHC in Ethiopia where providers tend to suggest fewer prescription drugs. Some participants stated that they avoided taking all prescribed medications. For example, Ametsash said “My blood test showed diabetes and I don’t take all the prescribed medicine. I wanted to control it through a healthy diet” Hager added, “I don’t take prescribed drugs immediately. I will come home and prefer my body to heal by its own natural process and mostly I hesitate to take medicine”. Participants agreed that the over-emphasis on medication in the U.S. PHC is a red flag. Meba said, “Whatever the issue is, they tend to rush into prescribing medicine. I believe there are a lot of issues that can be addressed through diet, exercise, or something natural”. For participants like Seble, prescribed drugs that were ineffective increased their distrust of modern medicine. She said:

> When you take a medicine you expect that it will cure you. That is not the case here. Medicine here (in the U.S.) is a way to hook you up with the never-ending system that keeps you jumping from one drug to another. I usually have a headache. But I prefer to get enough sleep than to take medicine. I am afraid of going to healthcare places. (Seble)

Such a belief is also held by participants who work in the healthcare system. Haben, a nurse, shared the view held by other participants.

> Here (in the U.S.) there is this culture that portrays everything can be treated by taking medicine/drugs. Society here seems to accept this drug culture. I can’t understand it. I am a nurse and I don’t see often recommendations to address issues through natural and dietary mechanisms. (Haben)

Most of the participants believed that reliance on modern medicine in the U.S. is associated with profit making of the pharmaceutical industry. The influence of such a belief in EIW’s health-related decision-making was clear in the interviews. Gelila stated, “The healthcare system here is a business and I don’t trust it". Some participants shared, when they have a chance, they will try to consult with Ethiopian professionals before taking medications. Hager said, “During my pregnancy, I had a lot of pain, and the physician prescribed me medicine. I didn’t trust the judgment and consulted friends with a medical background, they said ‘no’ and I didn’t take it”.

Reliance on Traditional Homemade Remedies

Most participants stated they would prefer to try traditional homemade remedies first and delay healthcare services if it is not serious. They have more trust in the healing effects of traditional medicine. As Maya said, “Homemade remedies like black oil, lemon, ginger, and others are my shields. To be honest, I prefer them over drugs” Maya said. Ruth also added “My children don’t take the flu shot, no. I treat them with some Ethiopian honey and ginger, that is it” Ametsash also shares the same view “I use fenugreek (አብሽ), garden cress (ፌጦ), Ruta chalepensis (ጤና አዳም) and black seed then I mix them all together and take it daily”.

The Influence of Faith in PHC Decisions

Although most participants were hesitant to admit their faith impacted their access and utilization of PHC when asked directly, most opened up about it during the in-depth conversations. The influence of faith was mainly evident during their pregnancy; when they were asked to undertake tests for potential deformity of the fetus and declined the tests. Except for Marda, all other mothers shared that they were told that there might be a risk of deformity on the fetus and a test is needed to decide whether to give birth or terminate. Participants, those with a nursing background, expressed they were not familiar with the recommended tests. Samiya, who was a mid-wife nurse in Ethiopia, said this:

> They told me I might give birth to a deformed baby because my protein level is high, and they need to get a sample from me and the fetus' spine. They threatened me and I was very anxious. Imagine how devastating this could be. I didn't agree and I said I will accept what Allah will give me. If I weren't a midwife myself, the stress would have killed me. (Samiya)

The participants said that the experience left them very uncomfortable and suspicious of the healthcare system. They all said it was against their faith, and they cannot question God's/Allah's decision but accept what they will be given. Participants also stated that they exchanged this information and consulted with other EIW who gave birth in the U.S. to make decisions. Maya said:

> When the nurse told me that, I said 'I need to ask the doctor'. I asked the doctor 'is this mandatory or is this for research?' She said it is not mandatory and I said 'well I don't need it. I am a Christian and I take what God gives me. It still feels weird. (Maya)

For participants like Gelila, the PHC in the U.S. cannot be trusted in general. She said, "My belief is in God, not in the healthcare system. I don't want to go for every health issue unless it is serious". Some participants discussed COVID-19 as an example to demonstrate the central role of their faith in making healthcare decisions. For example, Meba strongly believed that the COVID-19 pandemic is not real and had spiritual and political motives behind it, so she avoided getting vaccinated. She said, “I don’t trust the vaccine and what it is made from. It has a connection with human fetus and abortion, which is forbidden in my religion”. Halima, although she has been vaccinated for COVID-19, said “I don’t totally believe in it, and I took the vaccine endorsed by the Catholic church. I rather trust God, and my future decisions to use reproductive health services will depend on what my church says”.

Although most participants expressed allegiance to their religious values and reliance on their faith in making healthcare decisions, there was one exceptional participant who said she was able to revisit her religious values since moving to the U.S. Marda said,

> I was one of those naïve Ethiopians who thinks abortion is bad, republicans are good, children are good, the unborn matter. I came here and saw how politicized health care itself is. I had an eye-opening experience as I went through two miscarriages, the care I received with my miscarriage was abortion so if your body couldn’t naturally completely expel the miscarriage. I know that abortion is a wonderful thing for those women instead of putting them through that pain and then the eventual death of the baby and putting their body through that trauma of caring for this non-viable pregnancy….My views, my religious perspective on abortion got significantly challenged since I came here due to my own personal experience as well as the health literacy I have right now compared to when I was back home. (Marda)

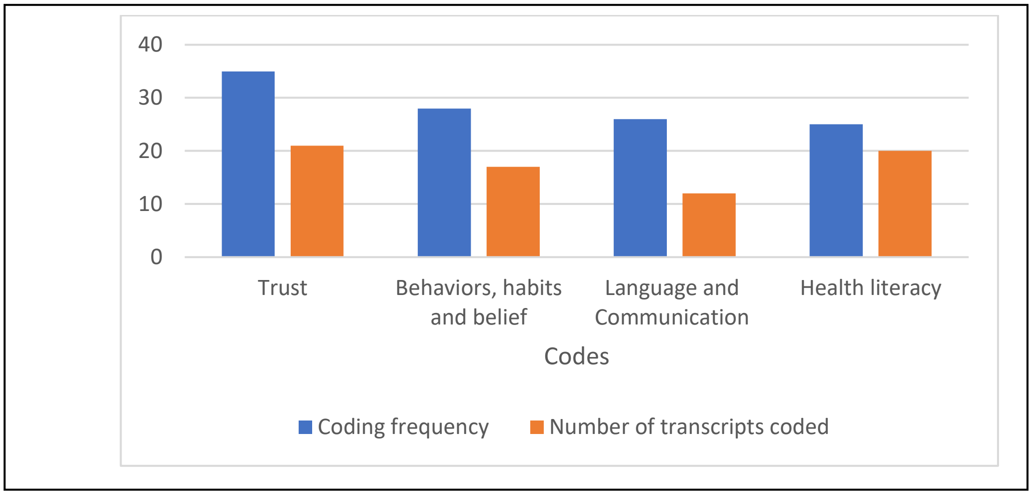
Belief about Lack of Transparency in PHC

Participants believe that there is a lack of transparency on vaccine preparation and dissemination. For example, Samiya said "In Ethiopia, vaccines are open and prepared in front of parents. Here you don't see the nurses when they prepare the vaccine. You will wait outside and when they are ready, they will call you in. It makes me suspicious". Part of the distrust is related to participants' belief that the healthcare system treats immigrants differently or discriminates against immigrants. Some clearly stated that they do not feel comfortable taking drugs, as they suspect that immigrants and people of color could be subjected to drug trials or experiments without their knowledge. Etalem said, "I am afraid they would test new drugs on immigrants/foreigners because we don't have the privilege of asking why or resisting because of our legal status and the fear of avoiding deportation". Hager also said, "Pregnancy and childbirth-related death is higher among Blacks, and it makes me question the integrity of the system. I feel anxious whenever I go to healthcare".

For some participants, getting treated and having a diagnostic history makes them anxious. They believe that having a medical history that can be accessed by authorities or any other unknown party can make them vulnerable, and they feel afraid of that. For example, Meba said, "The medical history is very centralized and accessible even after years. I sometimes feel afraid the information can be used at some point to harm me medically, or employment or even immigration-related eligibilities". Throughout the theme (and subthemes) presented above, it is evident that EIW struggled with mistrust of the healthcare system in the U.S. As demonstrated in Figure 8, trust (lack of trust) was the most coded (mostly double-coded) element along with behaviors, beliefs, and habits.

Figure 8

Personal Barriers Coding



Controlling Diet and Exercising

Participants also shared their challenges in following health recommendations that demand a selective diet or exercise. Participants struggled with maintaining a healthy diet for various reasons. First, EIW came from a culture rooted in a traditional agricultural system where most of the food is not processed or organic. Shifting from the traditional Ethiopian diet to the U.S. where they should differentiate between organic and non-organic food is difficult to understand and deal with. Developing the habit of controlling their diet is difficult for EIW. As Meba said, “We eat what we get in Ethiopia. It is difficult to worry about every food we eat. We are not used to that”. Second, a selective diet comes with a financial burden. Affording to buy organic and selected food in the U.S. is challenging for participants, especially those with limited incomes.

In addition to dietary habits, EIW also struggled to develop exercise habits in the U.S. The shift from a physically active lifestyle where they walk long distances to work, school, or social activities in Ethiopia to a more sedentary lifestyle in the U.S. where they have to drive or use transportation services is challenging. Most participants had no planned exercise habits because of the already active nature of life in Ethiopia. After moving to the U.S., developing a habit of going to the gym or exercising is very difficult due to the lack of prior exercising habits, lack of time and stressful work conditions, and affordability. Especially for those who work multiple jobs or over-demanding jobs, it is unthinkable to have time for self-care and exercise. Marda said:

> In times when we are not working, we are parenting. If I want to go to the gym with my husband, we need childcare. If I want to go for a run early in the morning it means my son is home so one of us must be home. (Marda)

English Language and Communication Challenges Constrained EIW's Utilization of PHC

Most participants expressed that their limited skills in the English language hindered their communication with providers and negatively affected their healthcare experience. Most EIW learn English from school meant participants with lower levels of education have the lowest English language skills. Particularly, most EIW struggle with spoken English when communicating with providers, insurance companies, and customer service. Where interpreters are available, participants stated that they used interpreters. Otherwise, they try to rely on friends and families, or they have to struggle on their own. For example, Ametsash said "I don't speak English and that is a huge problem. Rarely, they offer translators over the phone and the translators are not good." Seble also shared the concern about the quality of the translation:

> First, their translation is confusing because I can listen to what they are saying and catch them talking about something I didn’t say. Secondly, they (the interpreters) tend to be judgmental. When I ask for something, they would reply to me saying ‘isn’t what you are getting enough? Why don’t you accept and go’. They try to intimidate you”. (Seble)

Participants stated that they feel discouraged from asking a question or seeking help due to their linguistic limitations. Compared to participants in other areas, EIWs in DC, Maryland, and Virginia (DMV) reported having translational support in PHCs. Public health programs in DC especially try to provide health documents and forms in the Amharic language. Haben said “With the heavy accent we have and our limited vocabulary, it is also hard for providers to understand us. That creates misunderstanding” Hager added,

> The problem was worse during COVID-19 because I was wearing my mask, I naturally cannot speak loudly, and have an accent. It was bad because they couldn’t get what I said and yelled at me thinking I was doing it intentionally. (Hager)

Particularly, EIW who live outside the DMV area, are refugees, and have a lower educational background suffered the most. Limitations in language and communication created anxiety and fear of being misunderstood and misdiagnosed. Maya said, “Sometimes, they completely miss what I am trying to say due to my grammatical mistakes. I am afraid they might misdiagnose me or prescribe an unrelated drug”. Because of this fear, some participants avoid seeking care. Tina said, “I sometimes prefer not going to healthcare centers just to avoid the stress of communication”.

Limited Health Literacy Impacted EIW's PHC Decisions

The interviews showed that most participants struggled with a low level of health literacy, which is "the obtaining, reading, understanding and using healthcare information to make appropriate health decisions." (CDC, n.d.). Most participants, with both lower and better levels of education, expressed difficulties in understanding, appraising, processing, and using health information to make the best possible decisions. For example, Ametsash, who has only an Elementary level education stated "I am not well educated, I don't read and understand English, and I don't use emails either. So, I rely on my daughter or friends to help me handle healthcare-related communications". Hager shared a similar concern, "To be honest, I am not confident I have adequate knowledge. My husband steps in and handles healthcare-related things always."

All participants, except for Marda and Haben, repeatedly mentioned that they have limited knowledge of the PHC system in the U.S., and they feel insecure and lack confidence about making healthcare decisions. Etalem said, "I don't have adequate knowledge about the system, and I can't defend myself if I run into some debt or financial crisis with the healthcare providers or insurance companies". Haben, a nurse, understands well the challenges faced by EIW. She gave an example from her own experience; "The providers sent me an inaccurate bill that included unnecessary tests. I argued with them, and they corrected it because I had the knowledge. Most EIW wouldn't understand and pay what they are asked to pay." Most participants agreed that information about PHC is complex, very technical, and not immigrant-friendly. Meba shared her concen as follows:

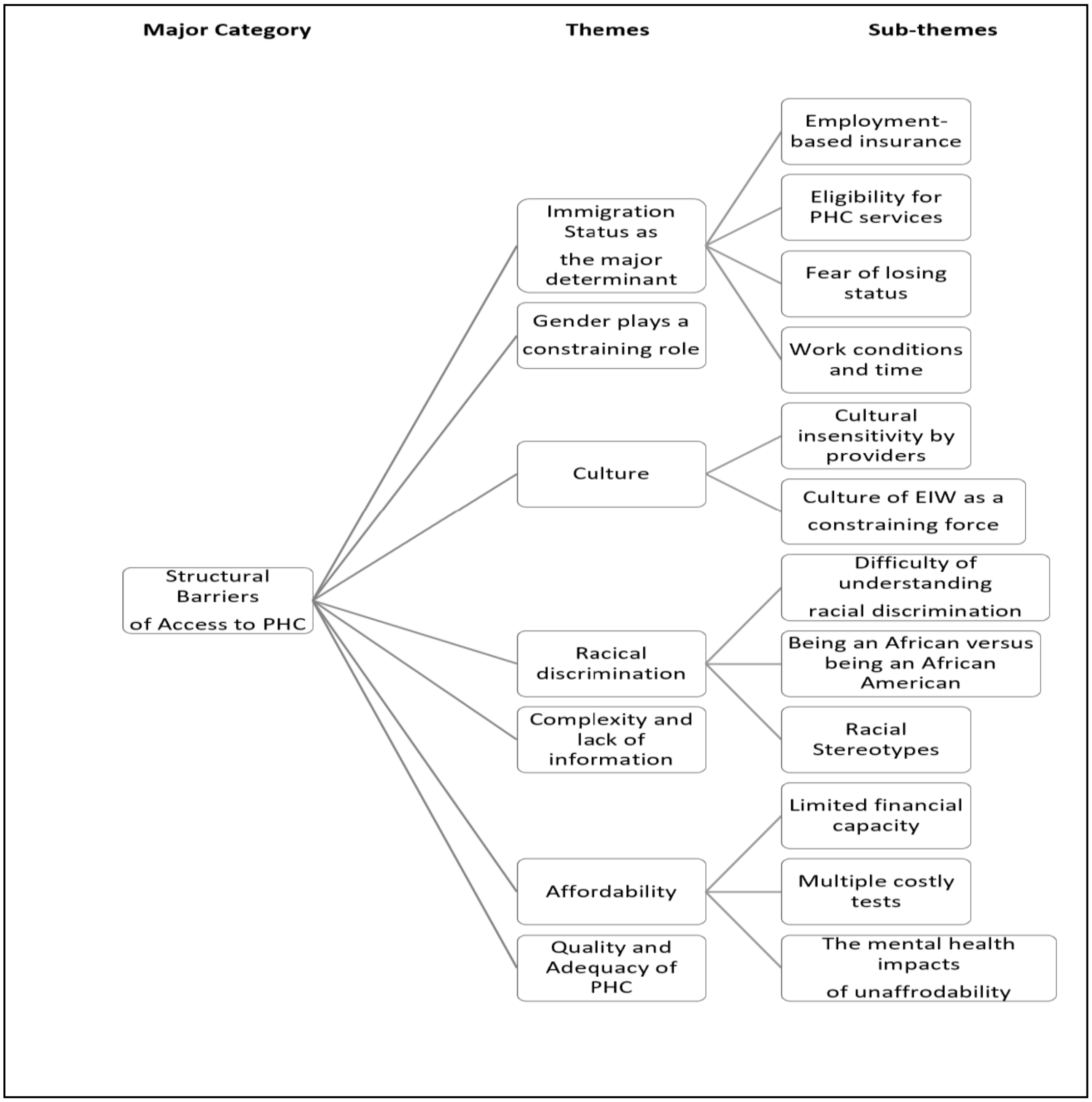
> Sometimes I go with whatever they say. But honestly, I also think that they don't care that much when they know you are a foreigner. It is hard to ask many questions because some of them don't show readiness to listen. Meba

Part Three: Structural Barriers of Access to PHC

This section presents the structural barriers experienced by EIW in accessing PHC. Under the major category of structural barriers, seven themes emerged: 1) immigration status as a major determinant of access 2) gender played a constraining role 3) the two directional impact of culture 4) racial discrimination and the burden of blackness 5) complexity and lack of information 6) unaffordability of PHC and 7) doubt on the quality and adequacy of PHC. Each of these themes has several subthemes that will be presented in detail below (See Figure 9).

Figure 9

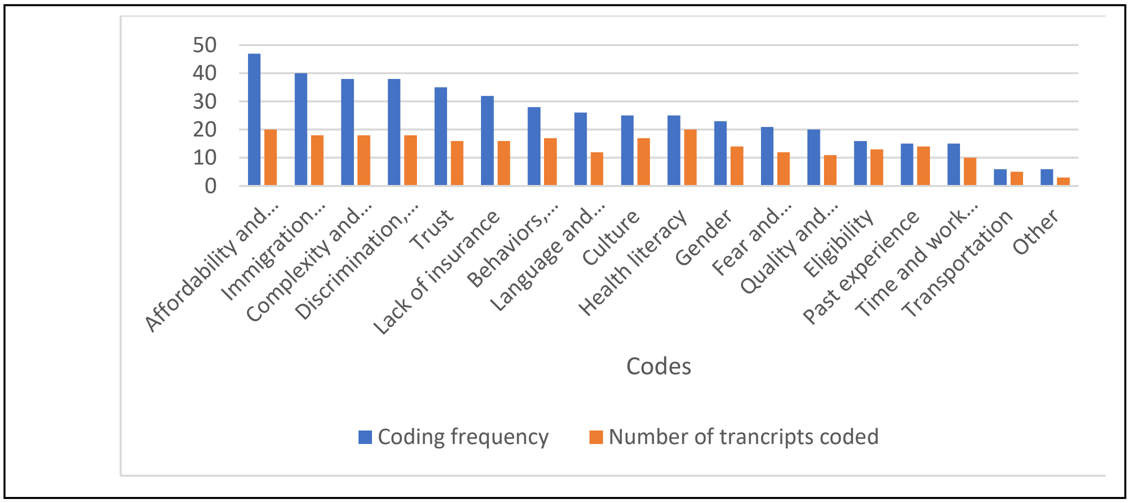
Structural Barriers: Themes and Subthemes



It is important to note that structural barriers dominate over personal barriers in hindering EIW's access and utilization of PHC. As demonstrated in Figure 10, affordability, immigration status, discrimination, and complexity were the top barriers to access to PHC. The following section presents the subthemes under structural barriers of access to PHC.

Figure 10

Comparing Structural and Personal Barriers to Access to PHC Coding



Immigration Status is the Major Determinant of Access to PHC

The interviews revealed that immigration status is one of the major structural determinants of access to PHC among EIW. The following subthemes demonstrate how it affected EIW's ability to utilize PHC.

Employment-Based Insurance

According to participants, except for those who are citizens, public healthcare programs are not accessible to immigrants of various legal statuses. Even after getting a green card, participants are expected to wait for five years to start using public programs such as Medicaid, CHIP, and others. Hence, the only gateway to PHC for most participants is employment-based insurance. Getting employment-based insurance is dependent on EIW's eligibility to legally work in the U.S. or to have an Employment Authorization Document (EAD). All participants were not eligible to get EAD, and those who were eligible should apply and wait for approval which took (and still takes) a year or more. The EAD is given for a year or two and should be renewed. According to participants, EAD renewal process is taking more than a year currently. Without an up-to-date EAD, EIW cannot be eligible for employment, hence for employment-based health insurance. Gelila said, “I couldn't get a work permit and I was unemployed. I stayed without any insurance coverage for a year”. For participants with no green card or U.S. citizenship, EAD serves as their only legal identifying document, and they cannot renew their driver's license or ID without it, fly, or undertake any activity that needs legal ID. Seble said, “Our life is in the hands of USCIS. When they delay our EAD, we can't do anything, no work, no healthcare”.

Eligibility for PHC Services

To be enrolled in public or private insurance, EIW are required to present several types of documents. However, this is very unrealistic given the continuous transitions participants make in terms of legal status, employment, and residence. For example, participants said, even producing residential addresses is challenging unless they find friends with permanent residential addresses who are willing to help them use their addresses. Sishat said, “All my stays were temporary, and I had to change my address multiple times. Enrolling in healthcare programs [public] and maintaining access was unthinkable for me”. Saba also shared her struggle as follows:

> I was a student, unemployed in-between, and part-time worker, and later a full-time employee. Every time my immigration status changes and affects my

> eligibility for different healthcare programs. Then it always becomes a new challenge to navigate the health system on each status. (Saba)

Participants shared that, in most cases, they were asked for social security numbers to be enrolled for healthcare insurance or any PHC programs. They are subject to extensive background checks frequently because of their immigrant background. In some cases, getting a social security number is difficult for EIW women, especially in the first year of their arrival. Halima said, “The background check takes a long time when you are an immigrant, and something may happen in between, and you will be out of health coverage”. Participants also reported that they are also asked to present additional documents such as tax reports. Due to the inconsistent nature of their jobs, participants struggled to produce all required documents and meet eligibility criteria.

Work Conditions and Time

The interviews also revealed that immigration status affects EIW’s access to PHC by exposing them to stressful employment conditions. Participants shared that because they were new to the country and mostly had restricted employment authorizations, they tend to take any job opportunity that helps them survive. This, according to most participants, is true despite their educational levels or qualifications. According to participants, most of these jobs are temporary, low paying, and do not provide adequate healthcare benefits. Participants also shared that they work for extended hours and may work multiple jobs with little or no protection. For example, all participants who are refugees reported that they work in factories and getting adequate time to seek healthcare is difficult for them. Especially, single mother participants were affected by the extended working hours and the caregiving role that restricts their ability to pursue healthcare.

Senayit said, “My work schedule is very difficult and the times available at the health center don’t match my schedule. I have canceled healthcare appointments many times”.

Most participants had to start a new life in the U.S. from scratch, despite their career or professional background back home. Most of the participants had to give up on their previous qualifications as employers in the U.S. prefer US-based training. Hence, they have to put extra effort to get employment opportunities and maintain their immigration status in the U.S. Sishat said,

> I was studying nursing and was pregnant at the same time. I had to drive 40 miles to go to classes. After studying for three years, I failed the research course because I was giving birth to my baby. The instructor couldn’t understand my situation and all my efforts were in vain. I gave up and started driving uber. (Sishat)

According to participants, it is very common for them to prioritize maintaining their legal status over their mental and physical well-being. Marda provided the following account:

> I had to accept unpaid tasks because I have to in order to qualify for that visa which is an added pressure. I was reviewing manuscripts for journals, and I would be signing up for more journal editing and leadership opportunities, and I was volunteering for some global initiatives which are nice, but I understood that I took on more than I should have because I was also trying to check some boxes for my immigration in addition to my day job. It was a lot in the sense that you have to be extra successful to be granted the legal status to just exist in this place.

> I remember… I was working from home even at the hospital when I was waiting for my C – section, approving some manuscripts on my phone and I was going to work until the last minute. (Marda)

Fear of Losing Status and the Unknown

The interviews revealed that participants refrained from using some PHC services because they are afraid of the legal consequences including losing status and potential inadmissibility. Most participants expressed a lack of certainty around the ever-changing legal, immigration, and political ramifications in relation to immigrants' eligibility for public services. Hence, most of them try to avoid health care services. Etalem said,

> I am afraid of things related to healthcare and insurance. I am afraid of unexpected debts, financial burdens, and legal consequences. I can't be sure I have the right to use certain health programs because there is a lot of rumor about the deportation of immigrants. (Etalem)

According to participants, irregularities in the policies and proclamations by different administrations and the anti-immigrant political rhetoric contribute to their growing fear. Participants agreed that there are no clear guidelines communicated to them, and the rules are very different from one place to another. Halima said, "We work and pay taxes but we can't access and use healthcare and other services. It is unreasonable and confusing. The rules are very different from place to place so I simply stay away to be safe". Hager added, "I was scared even to go to planned parenthood because of my status, and I was trying to reinstate my visa and I couldn't risk any legal complications." Sometimes, because of the changing rules, participants may not be clearly told if they are eligible or ineligible for certain healthcare services upon their application. Instead, they might be asked if they used the services during their interviews for adjustment of status or a green card. This creates a risk of getting rejected for a service they used some time ago. Halima shared, “The waiting period for becoming a citizen is very long and you might use healthcare services at some point. But they will come after you when you apply for a change of status. Very unfair and discriminatory”. Saba added “My uncle, a diabetic older adult, and a green card holder was denied citizenship because he was using public healthcare. Nobody told him not to use it. There were pressures on immigrants during Trump’s time.”

Participants also shared that their immigration status puts them in a vulnerable situation to be easily exploited or disregarded in workplaces as well as healthcare settings. Because of the fear related to their immigration status, participants prefer not to speak up against mistreatment or unjust situations in healthcare settings. They stated that they try to conform to what the insurance companies and providers ask them to do. Haben said, “There is fear of losing immigration status, lack of knowledge, financial problems, time, and all that silences us”. Even if they have legal documents, submitting such information is sometimes risky for them and may jeopardize their immigration process. They have insecurities about sharing sensitive information that may compromise their safety and future in the U.S. Maya said, “Mostly, the formats we are asked to fill in are not easy and clear. I am always afraid not to fill out wrong information that would put me and my family at risk of deportation or any legal consequences”. It is not only the legal implications, but participants are also afraid of any negative implication of having a medical history that might affect their future employability or eligibility when changing immigration status. Meba said, “I wish I don’t go to healthcare often because they will record everything, and I am not sure about the implication that medical history will have on my future life and employability."

The fear and anxiety around maintaining their immigration status has mental-health implications for EIW. Participants shared that maintaining their legal status, changing legal status, and the expectations attached to each status and restriction are mentally draining. Most participants shared that the experience is stressful. Marda said,

> I couldn't sleep at night because this immigration thing was weighing down on me a lot. I remember waking up at 4:00 AM looking up immigration permits and trying to figure out ways I could transition to a stable visa that could allow me to continue the work I had already started here. (Marda)

For most participants, accessing PHC is not only an issue of eligibility and financial capacity but also a mental health challenge as it is surrounded by the fear and anxiety of the unknown.

Gender Plays a Constraining Role in EIW's Ability to Access and Utilizing PHC

The role of gender in affecting EIW's ability to access PHC is multifaceted. The first aspect is the participants' preference in relation to the provider's gender. Most of the participants stated that they feel more comfortable having a female provider than a male provider. "If I am given a chance, I deliberately choose female physicians, especially for reproductive health treatments. I am not comfortable revealing my private parts to a male provider," said Halima. Etalem also said, "My first physician was a female and my current OB/GYN is a male and I wish I have a female because I still get worried when my exam time approaches. I feel more comfortable with a female physician."

Secondly, participants shared that being a female comes with additional healthcare needs and examinations, especially related to reproductive health needs, which require both time and financial capacity to afford care. “There is indeed an extra need for us, women. Affording family planning itself is difficult, something we are used to using for free in Ethiopia” Hager said. She added, “Being pregnant and giving birth is insanely expensive here. Women’s healthcare burden is stressful. I couldn’t imagine a modern country like the US couldn’t provide your basic healthcare rights”. Being a reproductive-age woman requires more interaction with the PHC system, and with all the personal and structural barriers involved, it can be extremely difficult for EIW to navigate and utilize PHC services.

As indicated in the demographic information, the main reason for EIW’s interaction with PHC is pregnancy and birth. Participants stated that the lack of adequate maternity leave has been one of the barriers for EIW in accessing PHC. Yetim said,

> I am anxious about the health of my baby and myself because I don’t have enough maternity leave. The US is so different from Ethiopia. In Ethiopia, you have months of leave and social support. Not here, and I can’t even think of doing proper follow-ups and treatments because I am a working mother. (Yetim)

The third aspect is related to motherhood and the responsibilities participants bear as women. Participants stated that being a woman limits their ability to pay attention to their healthcare needs and seek treatment as they are mostly preoccupied with family responsibilities. The impact is more severe on single mothers and those whose spouses/partners are not in the U.S. Seble shared an extremely emotional story of being an immigrant woman with no adequate support or maternity leave and affording healthcare. She said, “I sent my son to Ethiopia to my family. I couldn’t raise him here because I cannot take care of him. I was worried about how I would pay for health expenses if he or I got sick”. The burden of maintaining legal immigration status, providing for families, and affording healthcare weighs massively on EIW. Marda’s words demonstrate this.

> I have a meeting scheduled today, my son is sick and he is home. My husband is not around (her *husband currently traveled home because his visa restricts him from working in the U.S.*) and I must be available for our son… the lack of social support and being the only avenue of care for your own child support while trying to navigate a very demanding career…and utilize healthcare as I want to. (Marda)

The fourth factor is the historic disadvantage and gender disparity in education that affected participants’ present ability to access and utilize healthcare services. Especially participants who are refugees, come from disadvantaged academic and socioeconomic backgrounds that continue to affect their ability to navigate and afford PHC in the U.S. Maya said, “Navigating the system, looking for the right provider, making appointments and the cost is heavy on immigrant women who mostly don’t have the academic and professional preparation”. Ametsash added, “Have I had the opportunity for education, I could have at least learned English and solved half of my problems in accessing healthcare”.

The Two Directional Impacts of Culture on Access to PHC among EIW

Cultural Insensitivity and Mistreatment: EIW Felt Ignored by Providers

Contrary to some providers who try to actively engage EIW in the PHC provision process (as presented in Part One), participants also experienced mistreatment in the

PHC. From mild aggression to high-level discrimination, participants expressed that they experienced mistreatment by providers including nurses, physicians, receptionists, and other medical personnel. Participants expressed that there is widespread cultural misunderstanding and insensitivity in the PHC settings. Lack of patience and interest to listen to the concerns of EIW, who mostly have limited English language skills and a different cultural orientation, is prevalent, according to the interviewees. For example, Ametsash said, “The drug was affecting my body, and the nurse wouldn’t listen to me. Another time the receptionist threw the paper at me, and I was so heartbroken. I never went back there, and I transferred to another hospital.”

Participants also stated that there is a tendency from providers to assume that immigrants have limited knowledge and they will accept anything without questioning. Maya said “When I start talking to them and they realize I have an accent, I could feel that they immediately start assuming like I know nothing, and they become ignorant in their responses. Not a good feeling.” The feeling of being ignored is shared by most participants. Ruth added,

> They don’t care to explain why they are doing tests. I took my infant, just a few days old, and they took a lot of blood samples from his heel and the procedure was uncomfortable. When I asked why they simply replied it is for DNA purposes. I didn’t know what they meant by it because they were not open to explaining more. (Ruth)

Participants also shared incidences where providers asked them stereotypical questions that made them feel unwelcome. Instead of relying on documents submitted, some providers asked participants further background questions that have no relation to care provision (the care they are supposed to provide). Below is Marda's experience.

> The biggest reason behind my giving birth in this country was related to my job but to them, it doesn't matter. I'm just another black mother with a weird accent from a foreign country giving birth to take advantage of the system and give her son U.S. Citizenship. When we were filling out that social security form, they were like "you guys have a beautiful accent where is this accent from?" that is the way to confirm their biases against you and "what brought you to the United States?" You literally have my Employers information, what I do, and who I am, and you still ask me what brought me to the U.S.? (Marda)

The interviews showed that some providers lack cultural competence and inclusivity while providing PHC services. Incidents that undermine participants' beliefs or cultural values forced some of them to be anxious about pursuing PHC services. Below is one such moment shared by Ruth:

> I had my prayer book with a spiritual painting next to me at the hospital. When changing my bed, the nurse was aggressive and threw it carelessly on the table. I was so upset, and she said 'it will not save you'. (Ruth)

One of the biggest venues of discrimination is the process of calling for appointments. Participants said they experience mistreatment during calls. Samiya said, "Sometimes, they don't show any patience to listen to you and understand what you say. Once they know you have an accent, they develop an attitude, and they lose interest in talking to you".

EIW's Culture as a Constraining Force to Access PHC

Participants shared that culture played a role in holding them back from being expressive and standing for their rights in the PHC system. Most participants said that because of their culture, they tend to speak less and more softly when interacting with providers. First, this is often misunderstood by providers as being unsure and untruthful about what they are saying. Second, it limits their ability to present their issues in detail and advocate for themselves. Saba shared her experience as follows:

> I went for my first dental care and my responses were very short, yes or no, and the physician asked me if I had other problems. But I was just being myself, you know we (Ethiopian women) don't talk too much, especially when interacting with new people until we feel very comfortable. (Saba)

Hager also said, "I was talking to the receptionist, and she yelled at me to raise my voice, I can't. She thought I was doing that intentionally. It is not how we were raised, and I don't talk like that". Participants agreed that this has been very challenging, especially during phone calls to make appointments. Besides creating a communication barrier, it limited EIW's ability to explain their issues and engage in productive conversations for better health outcomes. The cultural pressure is too high on some participants, and they sometimes avoid healthcare. Saba said,

> Growing up, I was always told to speak less, and not to raise my voice because that is disrespectful. That even affected my career here. Having solid work experience, educational preparation, and a postgraduate degree, I still struggle doing interviews. When you are silent people assume you don't know the work. I went through depression and migraine a lot of times. It is a struggle for me to be

> successful in a place where words are more powerful than work…since I moved to the US, I never did reproductive health screening because I am afraid. (Saba)

Participants said that their culture didn’t prepare them to stand up for their rights, say ‘no’ when appropriate, or defend themselves in the healthcare setting. Saba added, “Being an Ethiopian woman and an immigrant puts you in a more vulnerable position. I mostly say ok to whatever the providers and insurance companies say”.

Racial Discrimination and the Burden of Blackness in Healthcare Settings: EIW Experienced Racial Discrimination in PHC

The Difficulty of Understanding Racial Discrimination and the Role of History

The conversation on race and racial discrimination with participants yielded interesting results. When asked directly whether they experienced any sort of racial discrimination or if they think their race had an influence on their PHC experience, most participants struggled to respond directly or gave hesitant responses. Some automatically answered ‘no’ to the question. However, as the interview advanced, they would start telling stories that imply an experience of racial discrimination. During the interviews, the researcher could recognize and note facial expressions and voices that depict confusion, uncertainty, and discomfort in responding to the question. For example, when Ametsash was asked if she thinks she experienced discrimination, she replied “no”. However, deep into the interview, she said “As you know there are people who hate Blacks” when referring to the incident the receptionist threw the paperwork at her. Like Ametsash, most participants tended to be hesitant to point out the discrimination they experienced as ‘racial’ discrimination. After sharing a discriminatory experience that they feel is ‘racial’, some tried to backtrack and provide excuses. For example, Etalem said, "Mistakes (racial discrimination) happen anywhere, and you may experience them wherever country you are in".

However, those with relatively higher level of education (For example, Marda and Hager) and who work in healthcare (Haben, Yetim, and Samiya) demonstrated better racial consciousness and criticality about their PHC experience and the systemic racism in the healthcare system in general. Hence, it was relevant to have further conversations with participants on their understanding, hesitance, and mixed responses about racial discrimination in PHC. Based on the participants' initial responses, the researcher tried to carry out a deeper conversation on why most of them provided mixed responses when it comes to questions around discrimination, especially of racial nature. Most of the participants agreed that their understanding of race and racial relations is limited because of different factors. Participants admitted that their knowledge of race and racial relations in the U.S. is very limited. They considered themselves as people with low racial consciousness and shared that it is often difficult for them to tell if an act is racially motivated discrimination or not. For example, Marda said, "I was naive to the reality of racialized care and how a lot of factors get in my way when it comes to being treated fairly, and then I was also presumptuous like I believe that my training (academic preparation) will protect me".

When explaining their limited understanding of race, most of the participants referred to the history of Ethiopia as a country that was never colonized and their lack of exposure to racial oppression. Participants expressed that historical background limited their racial consciousness and knowledge of race relations. Hence, they found it difficult to identify, recognize or even respond to racially motivated discrimination in healthcare. For example, Ruth said,

> I think as a layperson, I may not critically look at what is happening to me. I don't have such an experience back home and I may not notice things from that angle. But others with a better knowledge of the system could understand. (Ruth)

Meba also added "As an Ethiopian, for me to tell someone is racially discriminating against me, it must be very obvious. As we lived in our own world, we lack the awareness and skill to identify and handle racial discrimination often". According to these participants, being raised as Ethiopian has multiple implications for their understanding of race. Yetim responded,

> I grew up being told that we defeated the Italian colonialists and remained free and independent. Although we have other problems as a country, we lived as very proud people and that is my mentality. Race was never an issue for us back home. So, when I encounter some discrimination in the healthcare settings here, race doesn't come into my mind. (Yetim)

Although most participants shared the above explanatory perspectives, few of the participants attributed it to naivety and ignorance among Ethiopians. Particularly, Marda, who uniquely stood out from participants for her deep critical reflection on the systemic racism in the U.S. healthcare system, believes most Ethiopians, including EIW, stay in the mythical 'Ethiopianness' that prohibits them to open their eyes to the experience of Black people in the U.S. including the healthcare system. Marda said,

> The Ethiopian immigrant community is naïve towards conceptualizing racism, and how it would affect them. In most places they are just not aware, I'm talking about the immigrants who came here like as an adult a lot of them even when I share my own experience with racism, they don't understand it….when I said they are naïve, even when racist experiences happened to them in part some of them don't think they are Black… like am not an African American this is not happening to me because I'm Black, I'm an Ethiopian, am Habesha. So, it is hard to break it down to them they are Black and this is racism, it's happening to them. (Marda)

Being an African-Black Immigrant versus Being an African American: EWI Struggle Between the Two Identities

Participants shared that they sometimes feel trapped between two identities: being an African-Black woman and an African American Black woman, and that affected their healthcare experience. According to some participants, their interaction with healthcare providers is shaped by their skin color, and providers see them instantly as Black African Americans until they hear their accents. Participants shared the realization of their accents sends a message that they are foreigners or immigrants. The situations, according to the participants, add another layer of potential discrimination or stereotypes. They also shared that, although they are first seen as Black African American women, they lack the knowledge and lived experience of African American women and do not know how to handle discriminatory situations. Marda said

> When I first came to this country my understanding was that I will have the best care and this is a great place, a part of me felt like my years of training and my

> position as a professor, my stable carrier and my employer-provided insurance will afford me that kind of care and quality I deserve. But I have moments that were eye-opening and red flags that raise my concerns, I dismiss them. For people who were born and raised in this country as Black, they have some level of exposure to the health care system and they have the tools to deal with them and they know when things happen to them. In my case, I didn’t take those red flags seriously and it played out very badly, especially in my postpartum care. (Marda)

The interviews demonstrated that there is a knowledge and awareness gap among EIW about race and its influence on accessing healthcare services. As Hager said,

> Mostly, the receptionists are not kind to me. I see anger on their faces. I am not sure if it is because I am Black or have an accent or they thought I am a foreigner. I think the racial tension between Black and White America has a double impact on us, I don’t know how to handle it. (Hager)

Racial Stereotypes: EIW Suffered from Racial Discrimination in the Healthcare System

Black as Pain Resistant. As mentioned above, participants with higher educational levels and those who work in healthcare were more open to sharing their lived experiences of racial discrimination and their critical insights on systemic racism in healthcare. They particularly called out the biased assumptions of providers toward Black patients as pain resistant or resilient to pain/suffering hence they need less attention or pain management. Yetim said, “I work in healthcare, and I am aware that professionals with the assumption that we (Blacks) resist pain, so they don’t give painkillers, even after giving birth.” The bias towards Blacks as pain resistant is also associated with another bias towards Blacks as drug abusers who tend to take advantage of medical diagnoses to get painkillers/drugs to satisfy their addiction. Marda said, “They (providers) associate the need for painkillers with drug addiction in the Black community, and do not believe the patient’s pain is valid. It is sad.” The fact that some providers did not hold back from communicating their misconception of ‘Black pian resilience’ created more distrust and anxiety among participants. Marda’s experience during her pregnancy visit confirms this:

> On one of my final visits, I asked my provider how hard/painful labor/birthing a child is and then he told me Black women have better pain resistance than White women, so I don’t have to worry much. When he said that to me, I was visibly shocked, and then when we walked out with my husband I told him I’m scared because if they think Black women have better pain resilience, they will never take my pain seriously. (Marda)

Being Black and the “Deficit of Credibility” in Healthcare. Participants shared that they often feel a burden of validity or believability when interacting with health providers. As Marda stated it, a “deficit of credibility” (Anderson, 2021). Some providers would not believe participants, value their words, or take them seriously. Participants believed that the inherent systemic racism and culture in U.S. institutions that discredit Blacks is also prevalent in the healthcare system, and affected their ability to access and utilize PHC services. Haben, a nurse, shared her experience in her work environment that awakened her to the reality of racial discrimination in the healthcare system. She shared her encounter as follows:

> There was a Black patient going through severe pain and screaming to get help. And there was a White patient with drug addiction problems who was

> inappropriately shouting all over the workers to give him a drug/medicine. No one said anything to the White patient, but the hospital administrator came to me and ordered me to walk the Black patient out. They discharged him with all his pain because he needs an immense volume of medicine and they want me, a Black nurse, to take him out. They didn't care at all. It broke my heart and made me realize how I am working in a structurally racist system. I lost my trust in professionalism and the system. I am even afraid for myself. What will happen if I am in the patient's position someday? (Haben)

According to the participants, the biased attitude toward Black patients could lead to misdiagnosis and further erosion of trust in the healthcare system. Meba shared the time when the providers could not listen to her concerns and forced her to take a pregnancy test.

> I was sleepless, had a fever and my heartbeat was high. They took samples and even did a CT scan, and the result didn't show any problem. They asked me if I was pregnant and I said no, and there was no possibility at all. The physician didn't believe me and still forced me to take a pregnancy test, which obviously came as negative. Their bias towards Black women was clear. They prefer to listen to their stereotypes than what the patient tells them. I was disappointed and started avoiding healthcare. (Meba)

Marda's Case. One of the most captivating experiences of racial discrimination was shared by Marda. For the purpose of capturing the whole phenomenon (experience) and help readers feel the depth of the story, the following long excerpt from the interview is presented.

I was close to my due date. I have an unplanned cesarean section birth. Right after my son was born, I ended up with major medical complications from the anesthesia. No one told me what was going on and I was going through a lot of pain, I was complaining, and no one was taking my complaints seriously. This was exactly about 8-10 hours after my son was born, I was going through so much pain and I was trying to tell them I was through this excruciating headache, I couldn't sit, couldn't feed the baby, I couldn't hold the baby…The entire staff didn't take my pain seriously…and no one was explaining to me…I was in debilitating pain that I can't sit, and no one is trying to help me. It was like a Friday and finally, the nurse, a very compassionate older White woman saw me and said something is off, I think you have a spinal headache from the anesthesia, and she called them. The anesthesia people were mad, on the way she advocated for me. They must draw a Blood patch that helps the headache. I had that procedure and I have instant relief from the pain. After the blood patch, unfortunately, I ended up with a spinal headache again. When my headache came back again it is another round of battle for people to take my pain seriously.

As my husband was going through that process of trying to have someone listen to us, the hospital staff apparently felt like, we were trying to extend staying at the hospital because we didn't have money to go home or baby supplies or food at home because to them what they see is this Black woman with a baby complaining about pain and likely needing may be some drugs. No one was taking me seriously and eventually I was going partially deaf from the headache. My husband tried hard to find someone to help me…when I request to speak with the doctor, they said, 'oh you gave birth on Thursday so today is Sunday and you are no longer a priority patient, and no one is coming and talking to you.

And I requested repeatedly … and no one is going to take my complaint seriously. Another doctor came and said, 'when you guys are going to home?' She is asking me if I'm willing to discharge. Then I told her 'Listen; I like everything in my life right now, and all I want is to be able to be in my own space, on my bed, in my house but I cannot go home unless this headache is addressed. I can't sit in a stroller or wheelchair to the car, how do you expect me to sit on my way home, I can't'. I was that debilitated. That person seems to understand at least how I felt, but nothing was done.

The next morning the social worker showed up on my hospital bed and she said, 'the doctor referred you guys to me because apparently, you have anxiety about going home'. She asked, 'you guys have food in the house, baby supplies in the house?' and at the time, I was deaf like 75% deaf from the headache. My husband told me, he had tried to explain to me that this person is saying that we are here because we don't have food or baby supplies and he pulled out his phone and showed her 'listen, we planned this baby, look at the nursery we decorated for a month ago, look at the supplies on our shelf'. He went that extra mile and eventually he said 'my wife is a professor at [University Name], we planned this baby' we had to explain ourselves to that level. It was like the whole new level of vulnerability, and he mentioned to them that 'there is nothing we want more than being in our space but we cannot go to our space because she is in this pain'.

> I cried for two straight hours. An older nurse saw me…and called another older anesthesiologist who gave me another blood patch then I had that relief for a moment. Now I can sit, and they said, 'we will monitor you for two more hours, you just had the blood patch' and when we are doing that the nurse escalated my case, the hospital's employee patient relation office came to document what happened to me, where the break on the care happened, etc. When they interviewed me now, they know that am a doctor at [University Name] and that I'm not the stereotypical Black immigrant woman. I'm the cool one, the educated one, and deserved some attention. We had our case documented and they told us they will follow up, and we got discharged.
>
> Two or three days later, I received a call from the department chair of anesthesia, and he was like 'Hi Doctor [ANONYMIZED] I am really sorry about what happened, we are going to take a few administrative steps to address this in the future'. You know he said those political disaster management languages and he asked if I will be willing to hear the outcome of the administrative meeting that he is going to have with his staff, and I told him 'I have no interest in being part of any effort they are going to take but I do hope they take some action because I don't want another mother to go through this experience'. The hospital had its own investigative process, and they initially dismissed my case because it was a 'misunderstanding'. I did not have any energy left in me to fight this case, I had my hands full with a newborn and I was still recovering from those anesthesia complications. It was so traumatic for the subsequent several months that I bring that up, I used to cry, it took me a while to come back to my sense and to be able

> to talk about that experience without shedding some tears. That experience shaped my understanding of healthcare, especially the staff I thought would protect me, will never protect me. It’s not about my insurance, training, pain, or the way what I am going through is explained. It ultimately comes down to their understanding of me, racial stereotypes against me, and biases against me. So, no amount of education or other variables can protect you from getting racially discriminated against if you are Black or a person of color.

Marda’s case is a clear demonstration of racial discrimination and lack of accountability in the healthcare system. It sums up the inherent systemic injustice that puts the burden of credibility, pain, and suffering on Black women. Marda’s case also made it visible that discriminatory experiences have a disempowering and silencing effect on victims. In addition to being a Black woman, being an immigrant multiplies the burden and forbids immigrant women from speaking up against the injustice in PHC. Hager said,

> I read a lot about discrimination against and poor health treatment among Black women. I had anxiety when I was pregnant because there are high rates of death among Blacks related to pregnancy or childbirth because of the quality of care. But I also knew I couldn’t do anything about it but hope for the best. (Hager)

Complexity and Lack of Information: EIW Experienced Difficulties in Navigating the PHC System

Participants stated that navigating the PHC system and understanding how the insurance system works was one of the most challenging experiences. Transitioning from a relatively universal healthcare system where they are not expected to have ‘insurance’ to access PHC to a non-universal system in the U.S. put them in a vulnerable position. Participants agreed they lack the right knowledge and information to navigate healthcare. “I am a Ph.D. holder with a better position to understand health information. But I still rely on my husband who has a medical education to understand how things work. It is still hard for me to understand everything,” said Hager. Participants repeatedly mentioned that they were left in the dark regarding access to PHC and insurance information. No participant reported having a proper orientation or accessing organized information on healthcare prior to or on their arrival in the US. Participants struggled to find adequate, understandable, and readily available information about how the healthcare system works in the US. Halima said “I had no clue most of the time. No one guided me except some friends who would suggest I go here and there when I ask them. The first two years were very difficult to get healthcare”. Haben also said,

> My first year was horrible. I fell and got injured and I didn’t know what to do or where to go. I had to stay home with a lot of pain for weeks because I had no insurance, and I didn’t know if there was any mechanism that would allow people like me to get treatment. Later, I was also confused about choosing physicians. I had no idea about the inside/outside-network provider issue. I ended up getting treated by an outside-network provider which left me with a huge amount of bills. It was unbearable as a new person, and a student working some tiny jobs here and there. (Haben)

Since they came from a different healthcare culture and system, participants struggled in unlearning what they have been practicing back in Ethiopia. For example, they struggled with differentiating between prescribed versus over-the-counter drugs.

Most of the drugs they used to buy without a prescription in Ethiopia are not available over the counter here in the US. Sishat and Yetim shared their experience as follows.

> I arrived in the US and got sick with a tapeworm. I thought I would easily buy the medicine at CVS, but I was required to show a prescription. I had no insurance, and I was shocked I couldn't easily buy something available everywhere in Ethiopia with no restrictions. (Sishat)

> I was at a part-time job and that didn't give me health insurance. I had a boil on my skin and was too painful. I couldn't get antibiotics easily without a prescription. I found a Habesha physician and begged him to get me something and he brought it for me. (Yetim)

The number and complexity of documents and paperwork required to apply for enrollment in insurance and health programs is another barrier. Participants expressed difficulties in generating documents, fill in complex and lengthy paperwork to access PHC services. Meba said,

> I was in a small town in Iowa, and I went to the only hospital there and I was told it was out of my insurance network and couldn't fulfill the expectations on the paperwork. I had to wait for eight months to finish school, get a job, new insurance, and get treated. It was too late, I suffered. (Meba)

Participants shared that insurance and health-related documents are lengthy, complex, and too technical to easily understand. "Filling out insurance documents is very hard for me. I just sign them without understanding every detail" said Seble. The inability to understand all the information in insurance and health contracts increased fear and uncertainty about potential debt among participants, and eventually hindered their decision-making. The categorized health insurance system that covers some and leaves others out (such as dental care, vision, tests, screenings, vaccinations, and others) confused participants. Most participants assumed that once they have insurance, that should cover everything. Here is what Marda experienced:

> In my first enrollment, I didn’t think my vision was not my health care. I didn’t enroll for vision, so I had issues with my eye and then I wanted to see an ophthalmologist. They told me that I wasn’t covered, and my employer said I have to wait until the next enrollment season which is in October. So basically, for an entire year, I had no vision care. (Marda)

Understanding co-payments and deductibles, and the insurance payment process was also challenging for EIW. Participants also stated that enrolling as a family has been difficult because there are variations in the requirements for each member. Maya said,

> We have family insurance, and one day I took my son to healthcare, and they told me children are not included. I was embarrassed, I didn’t know that and couldn’t know why. I don’t even know how to include my newborn in the insurance as I am struggling to understand. (Maya)

Participants also found it difficult when referred to a different provider or a specialist located far, as it requires more effort, communication and is often expensive. Participants shared that they are used to PHC where they find all services in one place. They believe that the U.S. healthcare system is fragmented and being referred to different specialists and places is not compatible with their experience, time, and financial capacity. Meba said,

> Here, you have to start with the General MD and go to other places for specialists for everything they are uncertain about. I understand the need but becomes too much in terms of time, money, and the burden of navigating all. (Meba)

A limited understanding of insurance and the healthcare system, in general, makes decision-making very difficult for EIW. Selecting the appropriate/better insurance, choosing the right provider, and making treatment-related decisions (when given the option to decide from multiple treatment plans) were difficult for participants. As Maya said,

> It wasn't just understanding the system, it is also about making the choice as a Black immigrant woman. It is very difficult to make health-related decisions in a very racially and politically divided environment. It was hard for me to choose my doctor, to be honest. (Maya)

Primary Healthcare is Unaffordable for EIW

Participants, regardless of their income levels, agreed that health insurance is unaffordable and that vitally affected their ability to access and utilize PHC services. The following section presents the main reasons of unaffordability and its mental health implications on EIW.

Limited Financial Capacity and Expensive Healthcare Cost

Because of their unstable work conditions and changing legal status, EIW have weak financial capacities. Their poor financial situation directly impacts their ability to afford healthcare services and insurance, and most participants delay seeking PHC. Haben said “There was no way I could pay for my healthcare while going to school. I simply waited for six months until I had the money to get treated”. Maya added, “We didn’t have insurance, COVID-19 hit, I was unemployed, and my teeth pain was unbearable. I went to a private dental clinic. It was very expensive, but I had no choice. I paid and suffered from a financial crisis”. All participants believed that healthcare cost, including insurance and medicine, is ridiculously expensive in the U.S. Participants expressed they had an unpleasant surprise when they learned the cost of some PHC services that are available for free in Ethiopia. For example, Hager shared her feelings about accessing contraceptives in the U.S. “I was a student, and I finished the contraceptive tablets I brought from Ethiopia. I tried to get some here, but it was so expensive for me to regularly buy. I was so stressed I might get pregnant”.

Most participants particularly stated that dental, vision, and skin care services are unthinkable to access due to their higher costs. Some delayed care until they travel to Ethiopia and received their dental treatment there. A participant with relatively good work insurance coverage, Marda, said she avoids seeking care because of the cost. She said,

> I had some skin issues and I needed to see a dermatologist. With the relatively good work insurance, I still had to get authorization, and even with that, I was supposed to pay a higher deductible for that, which was very expensive. I skipped it. (Marda)

Although participants living in Washington DC have access to public healthcare coverage, the program has limitations and does not always meet their PHC needs. The first limitation is that users are expected to renew their coverage every six months and the approval process takes time. Second, there is an expectation that users may not have over $10, 000 in their bank accounts. Seble said, “You have more than $10, 000 means they will assume you can afford private insurance”. Because of their ever-changing legal, employment, and eligibility conditions, some EIW find it difficult to even move to better-paying jobs and save money as this might be short-lived and once they lose it, getting back their coverage might be difficult. Third, users must wait for longer periods of time to get appointments and services. This is very difficult, especially for those who have children. Tirsit said,

> When you have kids, relying on public healthcare programs is tough. Such services have limited services, and they are unavailable when you need them the most because of time and resource constraints. Affording private insurance for all your family members is unthinkable given the income and job you have. (Tirsit)

Multiple Costly Tests and Lack of Financial Transparency

According to participants, providers require multiple screenings and tests to reach medical decisions. In some cases, those tests may not be covered by their insurance, and participants are asked to pay out of pocket. Yetim said,

> I was pregnant and the physician asked me to do many ultrasounds because they saw a problem with the Placentia. My insurance covered only one ultrasound and the rest were on me. It was hard. During my second pregnancy, I said ‘no, I will do it at my 20th week and delayed it and other screening. Nothing happened. (Yetim)

Participants attributed the tendency to require multiple tests to 1) the fear of potential misdiagnosis and avoiding the risk of being held accountable and 2) a way to generate more money. Meba said, “In Ethiopia, health professionals would easily give their suggestions. Here, they’re afraid and hesitant. You have to do multiple tests; some I believe are unnecessary and costly to us”. Some participants believed that insurance companies and providers try to take financial advantage over immigrants. Here is what Samiya and Maya said:

> Once the insurance company sent me several bills that I already paid and some I didn’t use the service at all. They tried to threaten me to send it to the credit center and I said I had all the documents and sent them the copies. They refrained from doing it. If I panicked and paid, they would still take my money. (Samiya)
>
> I was pregnant, perfectly well. Just citing that I am above 35 years of age, they asked me to do several tests. Although I feel perfectly fine, I was scared because the way they tell you is as if something life-threatening is happening. The truth is they just want you to use the insurance, so they collect their money. That has affected my perception and motivation in seeking healthcare. (Maya)

Hager also shared an incident that forced her to never trust the insurance companies. She said,

> One of my classmates, an immigrant, was expecting a baby and chose the lowest possible insurance. After the delivery, she received an additional bill of $5,000 and she was shocked. They never told her there was an additional charge and she got into a financial crisis. (Hager)

Participants also shared that the irregularity in the payment process heightens their suspicion towards the transparency of healthcare providers. According to participants, healthcare bills arrive at different times and with varied amounts of money, and that affects their financial planning. Given the unpredictability of their employment and financial situations, receiving separate multiple bills is financially and emotionally frustrating for EIW. Etalem shared,

> I wish they would send the bills once, whatever the amount is. So, I can plan how and when to pay. But they send many bills of different amounts, and you don't know when you will be done paying. It forces me to live in continuous financial anxiety and insecurity. (Etalem)

The Mental Health Impacts of Unaffordability

The inability to afford healthcare not only endangered EIW's physical health but also affected their mental and emotional health. Participants expressed fear, frustration, and anxiety about being unable to get treated when critical health situations emerge. Experiencing health issues where they have no adequate social support was extremely stressful for some participants. Meba shared, "sometimes I seriously think about undertaking assisted suicide if I become sick and dependent. This is against my faith, but I think about it a lot. I can't see myself sick and be dependent on an institution". For participants like Maya, who have children, the anxiety is very high. She said,

> The fear and anxiety about the financial cost of healthcare here equal the pain itself, it even exceeds sometimes…I had a prestigious job with all healthcare benefits back in Ethiopia. I came here and stayed unemployed until they

> processed my work authorization, it was a nightmare because I was worried about the well-being of my family. (Maya)

For some of the participants, access to healthcare determines their ability to make major life decisions. Participants expressed the struggle of making decisions to change jobs or move to other states because of the implications it will have on their legal status and eligibility for healthcare coverage. Seble said, “I live in continuous fear. I decided to remain in DC because I am afraid, I will lose my coverage and I can’t afford the cost if I move to other states”.

Doubts on the Quality and Adequacy of PHC Services affected EIW’s Healthcare Decisions

Participants, especially those using PHC services through public programs stated that services are not of the expected quality and adequacy. For example, dental services are limited to cleaning services, and women’s screening will be limited to pap smears or pap test examinations. Some participants mentioned that no adequate pain management/relief medicine is prescribed. Most feel that this could be related to the opioid crisis in the U.S. and providers avoid prescribing pain relief medicines. Maya said, “My tooth was hurting me badly, but they didn’t even give me antibiotics that we easily take in Ethiopia”. In some cases, misdiagnosis and unsuccessful treatments played a constraining role in participants’ pursuit of PHC. Meba and Salem said,

> Once, I was sick and they diagnosed me with completely unrelated stuff. They prescribed me a ton of medicine and I was confused. I came home and I started checking myself. It was tonsilitis, and they didn’t recognize it. I threw away the

> medicine and used a homemade treatment. That incident still discourages me from seeking care. (Meba)

> I had a dental treatment. I wanted to get a cleaning, but they insisted I should get extraction, refiling and canal treatment. It has been downhill from that time on. My pain escalated instead, and I lost my trust and stopped it. I will get it fixed when I go home. (Salem)

Participants also raised a concern about the knowledge of health professionals regarding health issues prevalent among the immigrant community. Some participants believed that the educational preparation of most providers is focused on the needs of the local US population and some health providers struggle to understand some locally uncommon medical conditions. Chaltu shared,

> I have thyroids and I don't believe the physician was well qualified or fully knowledgeable to treat me because the care plan is very different from the one I am used to in Ethiopia. The physician suggested a yearly follow-up, but I believe there had been actions that should be taken, not just a yearly check-up. I am a public health graduate, and my health issue happens mostly in developing countries, and I don't think providers here are well-trained to treat some less-prevalent conditions in the US. For example, some White dermatologists struggle to address the skin issues of Black people or immigrants of color because they are not trained or are not used to treating non-White people. (Chaltu)

Most participants specifically questioned the quality of dental care and stated avoiding it. Seble said "They cleaned my teeth when I gave birth. After that cleanup the pain couldn't stop. I went to another clinic, and they said they have to extract five of my teeth. I just walked out."

Participants also stated that some PHC centers are understaffed, and they must wait long hours during treatment, and even to get appointments. "I experienced difficulties getting treated even in urgent care centers. They don't have adequate human resources" Meba said. The lack of follow-up and not providing adequate information (communication) have also been mentioned as one of the challenges by participants. Etalem said, "They didn't send me my mammography results multiple times, even though I reminded them". Such negative experiences with PHC services have a direct effect on EIW's motivation and decisions to seek healthcare in the future. Halima said,

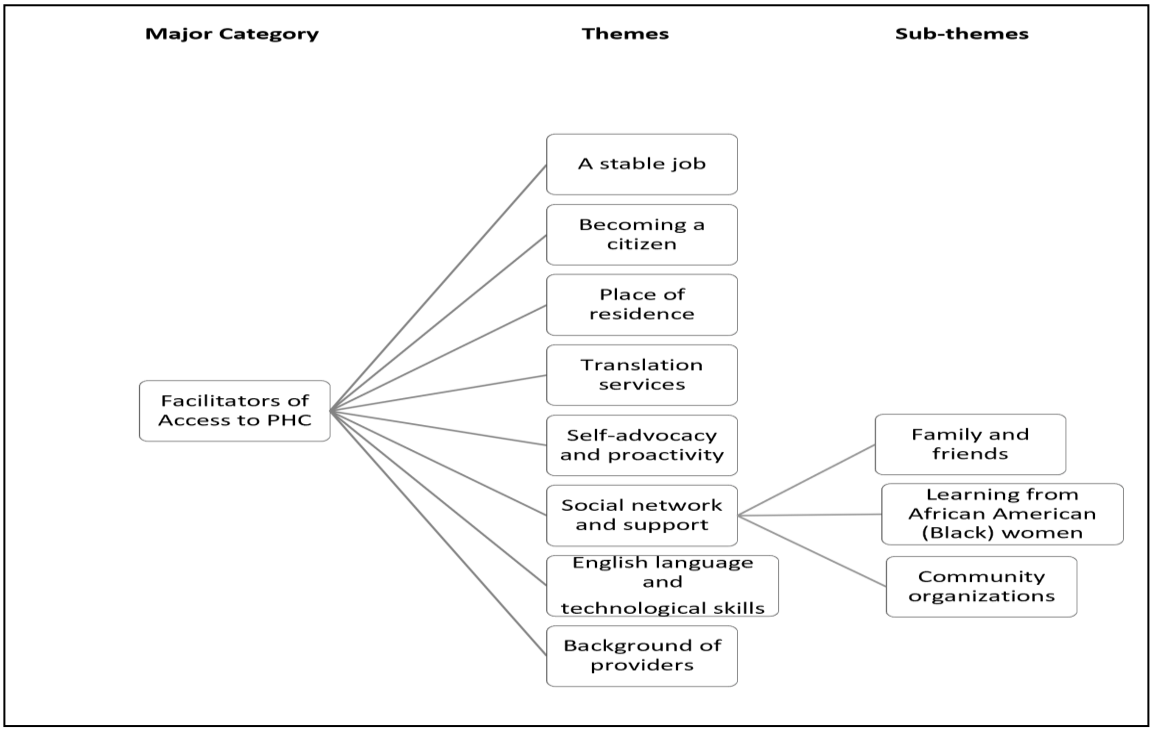
> Whenever I go to healthcare, they prescribe me something. They will tell me to fill up or replace other medicine, even if I am feeling well. One day I received an email saying, 'because of the discontinuation of production of the medicine, we advise you to stop taking it and to trash what you have' and I was shocked. I never trusted what they prescribed to me from that day on. If not very concerning, I don't go to health centers at all. (Halima)

Part Four: Facilitators of Access to PHC

This section presents the fourth major category which is facilitators of access to PHC. Eight themes were identified under the category of facilitator of access to PHC. 1) a stable job, 2) becoming a citizen, 3) place of residence, 4) translation services, 5) self-advocacy and proactivity, 6) social network and support, 7) English language and technological skills and 8) background of providers (See Figure 11).

Figure 11

Facilitators of Access: Themes and Subthemes



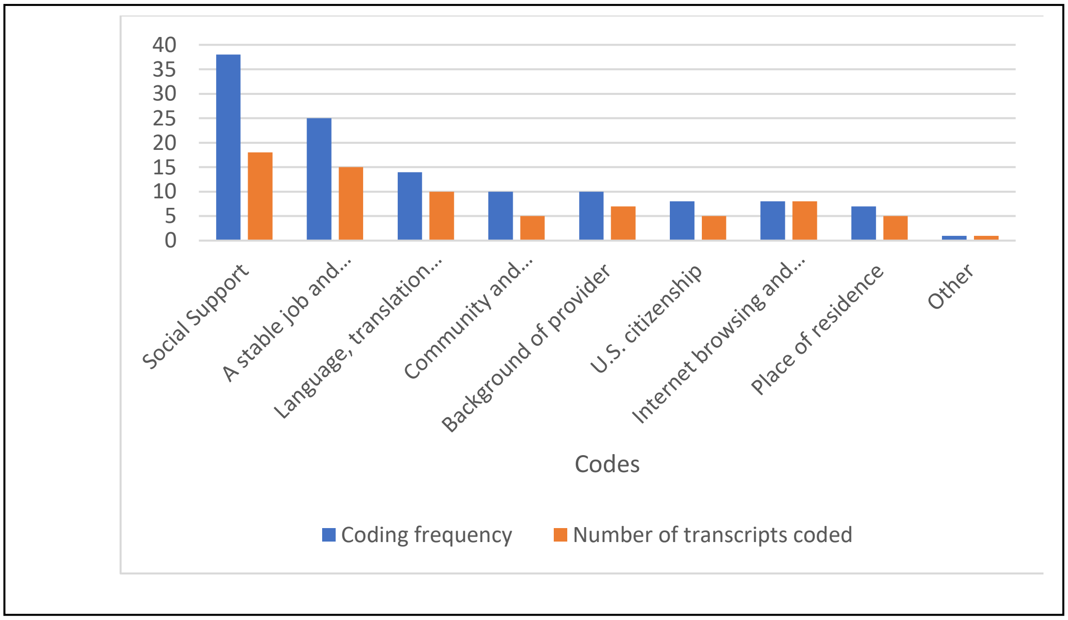
Having a Stable Job is the Main Gateway to PHC

Despite the irregularities of getting EAD and the precarious work conditions that negatively affected participants' experience, having a stable job with insurance coverage remained one of the main facilitators to access PHC (See Figure 12). When they have proper jobs, participants relied on employment-related health insurance. However, that is not always the case, especially for asylum seekers and those who don't have a stable professional career. Gelila said, "when I am working, I am safe. I can get coverage, although I still struggle financially". That means the nature of the jobs matters when it comes to the scope of coverage and benefits included. For example, two of the participants, one who works for a government organization and the other whose spouses work for a federal office reported having better healthcare coverage. “I used to have many problems accessing PHC. Now my husband works for a federal agency, and we are safe,” said Hager. On the contrary, most participants suffer because of the insecure and unstable jobs they have. Saba said,

> I started a good job after graduation, and I was financially stable and had good coverage. Then I left California because of my immigration-related issues and got into a low-paying job that has very poor coverage. Employment is key to accessing PHC. (Hager)

Figure 12

Facilitators of Access Coding



Becoming a U.S. Citizen Eases the Burden of Access

The interviews revealed that participants with U.S. citizenship have better healthcare access, especially public healthcare programs. Within the green card holders, those who came as refugees have the advantage of being provided with time-limited coverage upon arrival, and they struggle later once the coverage expires as most of them have lower education and limited English skills. A refugee, Ametsah, said “I was assigned a caseworker when I arrived who helped me with healthcare. But that ended shortly, and I had to do things on my own, which has been very difficult as I am not well educated or have language skills”. Asylum seekers and those in transitional status are the ones with the least access to PHC since their legal status restricts them from having stable jobs and utilizing public healthcare services. The fact that people have to wait for 5 years to use public healthcare (in most states in the U.S.) even after getting a green card and the fear of legal consequences hinder every non-citizen’s experience despite legal status.

Place of Residence Matters

Place of residence, particularly the state of residence, played a facilitative role in accessing PHC. This is because of the differences in public healthcare program eligibility from one state to the other. Participants in Washington DC have better access to PHC through free public insurance based on their income levels. Although it has its own limitations such as the requirement to frequently renew (within six months) and inability to get appointments and long waiting hours, participants from DC agreed it is better than the surrounding Maryland and Virginia, and other states at large. Even in Washington DC, the quality and speed of healthcare services are different from one part of the city to the other. For example, Seble said, “services in the Southeastern part, a Black neighborhood, are very poor compared to the Northeastern part”. Compared to places like Missouri, Virginia and Maryland have expanded Medicaid coverage that allows some immigrants access to PHC services, and participants stated using it. However, participants still were unsure about its implication later in their application to adjust their immigration status.

Social Network and Support Improves PHC Experience

Support from Family and Friends

Participants relied on spouses, family members, and friends to help them navigate the healthcare system, interpret health information, communicate on their behalf/respond to emails and consult them on various health-related issues. The support also included providing transportation services to and from healthcare centers. Especially, participants with limited education and English skills utilized social support very often. Ametsash said, “My daughter helps me to understand the emails and letters. I also have a Rwandese friend that helps me with transportation when I needed”. Etalem also added, “For information related to healthcare and insurance, I am very careful. I don’t want to make a mistake. So, I consult my uncle with everything because he lived here for four decades”.

When they have the opportunity, participants stated that they try their best to find an Ethiopian health professional to seek advice. Hager said, “I am fortunate to have a family friend who is a physician. I always consult him with any health-related issues. He has helped me a lot in making decisions during my pregnancy and giving birth”. Some participants mentioned seeking help from families back in Ethiopia. Halima said, “My brother is a dentist in Ethiopia, and they have a clinic. I used to consult him virtually and they even sent me medicine because I couldn’t purchase it because I had no ID at the time”. Some benefited from the cultural wisdom of their parents too. Saba said, “I still call my mother in Ethiopia so she can tell me how to prepare home remedies and deal with my migraine or any stomach-related issues. I rely on her advice for my reproductive healthcare issues too”.

Learning from African American (Black) Women

A few of the participants shared that they received helpful advice and tips from African American women friends on how to communicate and present themselves in the healthcare environment. Marda said,

> After that discriminatory experience at the hospital, my African American friend said ‘I told you to use your title, you should introduce yourself as Dr. [ANONYMIZED] and that is the way to get through as a Black woman. It doesn’t matter if it is on the telephone or in person’ then I started using my title and I clearly saw the difference. My African American friends are my biggest support system. (Marda)

Interaction with African American women helped these participants to learn from the lived experiences of discrimination and racism of African American women and make sense of what happens to them in the healthcare system. Haben said,

> As a nurse, I experience aggression from some patients, supervisors, and others. It sometimes is difficult for me to conceptualize what is going on, and my African American colleagues help me understand it and stand up for myself. It also helped me to be more confident in dealing with providers when I seek healthcare. (Haben)

Support from Community Organizations

Although it was limited to participants from the Washington DC area and those who came in as refugees, participants stated that support from community organizations helped them access PHC. The Ethiopian Community Center (ECC) provides informational support to new residents of Washington DC and connects them with the public healthcare program. However, the ECC receives payments to support them in processing the public health insurance program and assigns staff to handle the process. Participants also stated that the payments have been increasing recently and there is a shortage of staff to adequately support immigrants. In addition, participants mentioned that ECC is still not well known by the larger Ethiopian immigrant community and only a few who have the information would utilize the services. Participants also stated that they sometimes get PHC-related information through their engagement with religious organizations such as the church in the Ethiopian diaspora. Gelila said, “I know some Habesha professionals through the church, and I reach out to them for help”. Participants who came as refugees receive limited support on their arrival and relocation to the US. According to participants, they were connected to housing services and provided with some basic materials and their healthcare papers filled out with help from staff at Refugee and Immigration Services (RIS).

Translation Services Help but Need to Improve

Participants in the DMV area reported the availability of translation/interpreter services because of the large presence of the Ethiopian immigrant community in the area. Having translation options, according to participants, eased the stress of explaining themselves and made them more comfortable in interacting with providers. Salem said

"In Maryland, we have the option to use Amharic to communicate with the healthcare providers, and helps to have confidence. But we still experience challenges because of personnel shortages, and it is hard to capture everything in English" But participants in other areas have said the services are limited and the quality is poor. Ametsash, said "sometimes the translators are worse than me. Sometimes I prefer to try by myself."

Self-Advocacy and Proactivity

A few of the participants stated that being proactive in seeking healthcare, asking questions, and engaging in decision-making improved their PHC experience. Chaltu, who has public health training background, said "I would say I almost prescribe to myself because I provide very detailed information to the provider, ask questions, and try to participate as much as possible in the decisions making process. My personality and educational background help me" Halima also said "before going to the doctor, I try to find the right term to describe what I am feeling by googling. If needed, I advocate for myself and that improved my PHC experience".

English Language and Technological Skills

Participants with better English proficiency and technological skills reported that they tend to rely on browsing the internet for health information and decision-making. For these participants, using technology buffered the potential stress from verbal miscommunication with customer service and providers. Chaltu said "For me using digital systems makes it easier. Even to make appointments, I tend to use online platforms as it avoids the hassle of miscommunication and probably judgmental conversation because of my accent". Hager also said, "I always google before going to a provider or about the medicine and all". For Saba, who is a very introverted person, browsing the internet has been a good option. She said, “I prefer getting online information than asking people. That is comfortable for me. It decreases my in-person interaction with healthcare”. However, such responses were not prevalent among refugees, and those with lower academic backgrounds, English skills, and familiarity with technology.

Racial, Cultural, Linguistic, and Training Background of Providers

The interviews revealed that the background of providers influenced participants’ access and utilization of PHC services. The first element is the race of the provider. Particularly, participants with higher level of education and those who have work experience in the healthcare environment emphasized the importance of the racial background of the provider to access and utilize healthcare. These participants stated that because of their awareness of higher pregnancy and childbirth-related death among the Black community, and their knowledge of systemic racism in the US, they prefer to have a Black healthcare provider. Hager said, “I read a lot about clinical deaths among Blacks, and I decided to be treated by a Black female doctor. It gives me some psychological relief”. Haben also said,

> I and my husband were worried when I became pregnant. We know that many Black infants die due to the lack of adequate treatment during birth, and we were concerned. We intentionally chose a Black physician as I was afraid. I am a nurse and imagine what other immigrant women with no familiarity with the healthcare system would feel. (Haben)

Participants also pointed out that with Black or POC providers, they do not have to struggle to explain or justify their pains. It eases the burden of validity and trustworthiness that is often questioned in the interaction with White providers. The following long quote details Marda’s experience with White and Black providers:

> My son’s pediatrician was White. During COVID-19, I took him to her. She was wearing all the PPE and my toddler started crying non-stop. I kindly told her she has to give him time and space and stay away for a bit so he can calm down. She didn’t listen to me. She instead was irritated and asked me if I suspect him of Autism. She has been seeing him all the time and just came up with this question because he was scared of her and crying? She wasn’t listening to me at all and I immediately called my primary doctor, who is Black asked him to be our family doctor and I moved all the files…unfortunately, we are a different breed to them (White providers). I am not their typical human. ”. Marda also added that “there is always a ‘deficit of credibility when you are Black. Whatever you say or do, they don’t take you seriously…that is not the case with providers of color because I know that I am credible….That place I was discriminated against, we were going to that practice the entire year and my husband never missed my appointment, still, they didn’t know our names and had to read my name every time. With my Black primary provider, she immediately started saying ‘Hi [name]’ and felt so connected and comfortable. The other time, I visited a gynecologist, a brown doctor, and she was asking me what I do. I was naked with the paper scrubs rope on that table, and we were talking about my research. With White providers, this would never happen, because at first, they don’t care about who I am and what I do. I literally heard my White provider once coming into my room and telling another person, ‘I will be in this room for two minutes only’. (Marda)

Participants also stated that the training of providers is crucial in influencing their access and utilization of PHC. This is mainly related to providers' experience and familiarity in dealing with health issues prevalent among people of color, specifically Black people. Chaltu said, "My dermatologist is African, and I strongly believe that it makes a difference as a Black person, to have someone who has been dealing with the same people and cases". Besides familiarity with common health issues among Blacks, having someone with the same racial and cultural background enhances patient-provider interaction, according to participants. Marda added,

> Most people going to medical school are from privileged White backgrounds, and maybe only two percent of doctors are Black. That means most doctors don't get to interact with or treat people of color, and the entire medical training process presents White cases. So, their interaction with Black people becomes mechanical. They wouldn't see me first as a human, a mother, a sister, or a friend they can relate to because they don't have the lived experience. (Marda)

Providers with the same cultural and linguistic background are better positioned to understand them, as participants stated. They expressed having a Habesha (Ethiopian/Eritrean) provider makes a difference in their healthcare experience. Gelila said,

> Because I live in the DMV area, I know a Habesha doctor, and that is a huge relief given my cultural and linguistic limitations. I go there and talk to him in Amharic. It is not easy to tell what your medical issues are in English. I feel so comfortable. (Gelila)

Participants also expressed that having a provider who is an immigrant, even though she/he is not Habesha or Black, would still be helpful. They said providers with an immigrant background have a better understanding of immigrants' health behaviors and culture. Halima shared her experience and preference as follows:

> I would be happy if the providers were racially diverse in the Midwest. I was used to a Hispanic provider and here I am still confused about how to pick my provider because all are White and culturally different. Having a provider with a cultural understanding helps. For example, my Hispanic provider understood that regular check-ups and screening are not part of my culture, even though she is not from Ethiopia. She was the one who told me I need to have a vaginal and cervical checkup every six months; I had no idea before. (Halima)

Chapter five presented the findings of the study under four major categories and a number of main themes emerged from the thematic analysis. Each of the main categories will be discussed using the integrated framework and existing literature in the next chapter.

CHAPTER 6: DISCUSSION

This study aimed to explore the perceptions, barriers and facilitators experienced by Ethiopian immigrant women in accessing PHC in the U.S. Despite the significant presence of Ethiopian immigrants in the U.S., being the second-largest African diaspora in the nation, this is the first known study to examine barriers of PHC access among EIW. This chapter presents the discussion of the study findings in light of existing literature, the integrated theoretical framework, and the perspectives of participants. The chapter will have four main sections consistent with the structure of the findings chapter: 1) transition and overall perception, 2) personal barriers, 3) structural barriers and 4) facilitators of access to PHC. Various sub-sections are also included pertinent to their importance in synthesizing the evidence presented from the interview data and narratives in the immigrant health literature.

Transition and Overall Perceptions of EIW about PHC in the U.S.

The findings of the study showed that the overall perceptions of EIW about PHC in the U.S. are shaped by two major forces: 1) their settlement in a new country and 2) their transition from a relatively universal healthcare system to a non-universal healthcare system. First, before EIW start to make sense of the healthcare system or start seeking PHC, they need to figure out how to settle in and understand the new country (U.S.) they have just moved into. As confirmed through a meta-synthesis of 83 studies (Rodriguez-Alcalá et al., 2019), most studies on perceptions and experiences of immigrants in accessing PHC and healthcare in general focus on issues happening after contact is established with the healthcare system (Armenta & Sarabia, 2020; Dias et al., 2010; Fisher & Hinchliff, 2013). A concept that has been relatively widely researched in relation to the adjustment of immigrants in a new country and healthcare has been ‘acculturation’-“the acquisition of the cultural elements of the dominant society such as language, food choice, dress, music, sports, etc.” (Lara et al., 2005, p. 369). Although the findings support the importance of acculturation in predicting immigrants’ healthcare experience (Berdahl & Torres Stone, 2009; Rodriguez-Alcalá et al., 2019), they also implicated that efforts to understand immigrants’ perceptions and experiences should start before they make contact with the healthcare system, and include examining non-cultural aspects of immigrants’ struggles such as adjusting legal status, securing housing and employment, and fulfilling other basic necessities. A previous study (Lebrun, 2012) that used the U.S. National Health Interview Survey and Canadian Community Health Survey of 2007-2008, also confirmed that immigrants in their first couple years of arrival find it extremely challenging to access and utilize PHC services as their adjustment priorities hinder their ability to seek healthcare. Beyond the material and legal needs, EIW go through mental and emotional challenges including homesickness and loneliness resulting from leaving their families and communal lifestyle in Ethiopia behind, and the stress of adjusting to an individualistic lifestyle in the U.S. The findings underlined the importance of viewing access to healthcare in relation to immigrants’ everyday struggle to adjust to their new life. Using an integrated approach, as demonstrated in Figure 5, helped to develop a holistic understanding of what access to healthcare means to EIW by examining their socioeconomic context beyond their interaction with the healthcare system. Following such an integrated and holistic approach yields a better understanding of healthcare experiences, especially for minoritized and invisible sections of populations (Rhodes & Hergenrather, 2003).

Secondly, the findings uncovered that EIW’s transition from a relatively universal healthcare system in Ethiopia to a non-universal healthcare system in the U.S. shaped their overall perception and experience with PHC. As presented in the findings, EIW have mixed perceptions about PHC in the U.S. On the one hand, they found PHC in the U.S to be advanced in technology and quality relative to PHC in Ethiopia, and on the other hand, they believe that PHC in the U.S. is inaccessible, especially for immigrants. The same perceptions were reflected by Brazilian immigrant women who expressed satisfaction with the quality of healthcare services but stated multiple barriers impeded their ability to access and utilize PHC (Lindsay et al., 2016). As EIW come from a relatively universal healthcare system in Ethiopia, they are new to the nature and procedure of the health care system in the U.S. EIW had no awareness about health insurance and the standard procedures of having health insurance, identifying providers in their network, the need to make appointments, prescriptions coverage, etc. The findings demonstrated that EIW’s expectations of healthcare in the U.S. were met with a different reality. The same experiences were reported in previous studies that documented immigrants coming from countries with universal healthcare systems, for example, Russian speaking immigrants from the former Soviet Union (Ivanov, 2002) struggled in navigating healthcare and finding timely services (Armenta & Sarabia, 2020; Ramos et al., 2016). It was also clear that most EIW arrive in the U.S. with little or no information about healthcare, except the assumption that they will have a better healthcare given the country’s profile as a developed and prosperous nation. This study is an indicator that providing pre-arrival health information for immigrants is highly needed instead of only requiring test results of infectious diseases (e.g., TB) from visa applicants or potential immigrants (Chuke et al., 2014). The transition also means EIW bear the burden of navigating the referral system on their own instead of getting all PHC services in one place, as they are used to in Ethiopia.

Another important aspect in EIW's overall experience is the change in the reasons (or perceived needs, See Figure 5) for PHC visits since moving to the U.S. EIW started undertaking general checkups in the U.S. Given the consistently reported low rates of checkups and health screening among immigrants (Lin et al., 2005; Sewali et al., 2015), the findings from EIW are positive but still inadequate. Being the other top reason for visiting PHC among EIW (62% of the participants), this study underlines the necessity of prioritizing maternal health in efforts to make PHC accessible for immigrant women. Despite the encouraging report on regular check-ups, most EIW reported avoiding healthcare for illnesses, which is consistent with findings on other immigrant women groups including Latina and Asian immigrants (Bustamante et al., 2022; Hacker et al., 2015). EIW clearly adjusted their perceived needs since moving to the U.S. and limited their PHC visits to only critical conditions to avoid the legal and financial burden of accessing care. Details on the personal and structural barriers that hinder EIW's access to PHC are presented in the following sections.

Personal Barriers of Access to PHC

The themes emerged as personal barriers of access to PHC resonated with the personal factors portrayed in the integrated model proposed to guide this study (See Figure 5). Three personal level factors impacted EIW's ability to access and utilize PHC services: 1) contradicting health beliefs (and health behavior), 2) English language and communication challenges and 3) limited health literacy.

Behavioral Factors: Contradicting Health Beliefs, Behavior, and Mistrust

Compared to the other two, contradicting health beliefs is the strongest personal barrier that affected EWI's motivation and ability to access and utilize PHC. Although the contradicting beliefs manifested in different ways, all have a common denominator which is the loss of trust in U.S. healthcare that affected their decisions in pursuing PHC. In each of the dimensions presented below, the erosion or lack of trust takes the central position.

First, EIW believe that the PHC in the U.S. is highly reliant on medication which is different from what they are used to in Ethiopia. According to EIW, unlike providers in the U.S., providers in Ethiopia do not tend to prescribe medicine for every case. Instead, they tend to advise non-medicine options, such as getting enough sleep, giving it a time, or taking herbs. Second, EIW expressed they preferred traditional homemade remedies over modern drugs/medicine. Distrust in medications have been reported previously among Somali immigrant women that was specific to mental health (depression) medications because of stigma (Hill et al., 2012). Although the findings of this study support the role of cultural and religious factors and preference of traditional herbs in concerns over medication adherence among immigrants (Cabassa et al., 2007; Peeters et al., 2015; Wittkowski et al., 2017), EIW's case has an additional layer. According to the findings, EIW believe that the healthcare system in the U.S. is profit oriented and manipulated by the pharmaceutical industry that prioritizes money over people's lives. This belief is further strengthened by instances such as occasional ineffective medicine, the higher tendency of providers to prescribe drugs, or receiving notices to stop taking a drug because it is no longer produced. The study has clearly shown the high possibility of misinformation having a strong influence among EIW's utilization of PHC. Although research documented the impact of health misinformation and its impact on vaccination and global pandemics such as COVID-19, ebola and Zika Virus; there is gap in the literature on its impact on immigrant healthcare access (Y. Wang et al., 2019). This study can be an example that health misinformation and beliefs held by immigrants could contribute to widening access and health disparities, and needs due attention (Southwell et al., 2023).

Third, EIW's reliance on their faith influenced their healthcare decisions. Particularly, the study uncovered that EIW showed higher level of reliance on their faith and hesitance of following medical recommendations during their pregnancy in relation to potential fetal deformity/abnormality tests (e. g., amniocentesis). Except for one participant, all EIW who went through pregnancy reported saying 'no' to the test because it contradicts their faith. The study builds on previous studies exploring resistance to prenatal screening among immigrant women, particularly for religious reasons (Gitsels-van der Wal et al., 2014; Tsianakas & Liamputtong, 2002). Although EIW stated faith as their reason for declining prenatal screening, their decisions were also related to the deeply rooted distrust they have in the healthcare system. This takes us to the fourth dimension which is EIW's belief that there is lack of transparency and discrimination towards immigrants, hence, it is difficult for them to trust tests, vaccines, and medications. Examples of such uncertainties included not knowing what the amniocentesis (deformity test) could cause to their unborn baby, suspecting immigrants would be subject to secretive medical/research trials, and the potential of their medical history being shared with immigration authorities.

Although there is a great deal of research on acculturation, cultural competency and linguistic and communication issues in serving immigrants, adequate attention has not been given to the issue of trust/distrust (Alpers, 2018; L. M. Anderson et al., 2003; Lebrun, 2012), and this study can serve as a catalyst to initiate further investigation. Research on mistrust (of healthcare) so far has been largely focused on the Black/African-American population because of the legacies of long standing discrimination and historic events such as the Tuskegee Syphilis Study (Jaiswal, 2019; Kennedy et al., 2007), and it is time to expand efforts to other unresearched and minoritized groups such as immigrants, religious and sexual minority groups.

The fifth dimension is related to EIW's struggle to follow health recommendations in relation to healthy diet and exercising. Coming from a culture that is predominantly traditional agriculture-based, developing a habit of controlling their diet in the U.S. is difficult. The study supports similar studies that reported Latinx immigrant women find it difficult to transition from natural diet to processed and frozen food culture in the U.S. (Carney, 2015; Luque et al., 2018). Besides, the price of organic food is unaffordable given the already limited financial capacity of EIW. As also reported in multiple studies, the overdemanding work conditions of immigrant women forces them to rely on fast foods and do not allow them to have a work-life balance or have regularly exercise. Issues of precarious work conditions redirect us to structural issues including the immigration and labor laws that put immigrants in disadvantaged positions (Carney, 2015; Popovic-Lipovac & Strasser, 2015; Ramos Salas et al., 2016).The situation is more difficult for those with chronic health conditions such as diabetes, hypertension and others whom health providers advice to strictly follow dietary recommendations (Popovic-Lipovac & Strasser, 2015).

Skill Factors

As pointed in the integrated framework (See Figure 5) EIW's access to PHC was affected by their English language skills and limited health literacy. Especially, those with lower levels of education and those who are refugees suffer the most from limited English language skills and communication problems. Although multiple studies documented language barriers in accessing healthcare (Pandey et al., 2021; Timmins, 2002), further research is needed to understand the relationship between educational level, language, and access to healthcare. The research showed language limitations created miscommunication and anxiety of misdiagnosis, limited EIW's ability to ask questions, understand providers and advocate for themselves in PHC. Fear of misdiagnosis is also related to mistrust and could lead to nonadherence to medical recommendations (Baezconde-Garbanati et al., 2013; Numeroso et al., 2015). The lack of and poor quality of translation services also hindered EIW's access and experience in utilizing PHC. Especially EIW living in places where there is no significant amount of Ethiopian community struggled more. Poor quality of interpretation services creates additional stress to EIW and contributes to increased fear of misdiagnosis. Interpretation/translation services mostly happen over the phone, and lack cultural and emotional aspects of interpretations (Lor et al., 2016). Unlike linguistic barriers, EIW at both levels of education expressed difficulties of processing health information and making informed health decisions. Although a previous study reported English proficiency as the strongest predictor of health literacy among immigrants (Jacobson et al., 2016), this study proved otherwise. The fact that EIW with both limited and professional proficiency levels had difficulties calls for further in-depth investigation.

Structural Barriers of Access to PHC

The findings of the study revealed that, compared to personal-level barriers, structural barriers dominate the experiences of EIW in accessing PHC. As indicated in Figure 10, four of the topmost coded barriers (unaffordability, immigration, discrimination, and complexity of the healthcare system) are structural in nature. Although the fifth most coded barrier, trust/mistrust, was presented under personal barriers in relation to health beliefs, it still reflects the gaps the PHC system that causes mistrust among EIW. As depicted in the integrated framework (See Figure 5), these structural factors are a mixture of a) socioeconomic and political context as well as b) socioeconomic status/characteristic that are imbedded in and outside the healthcare system. The findings demonstrated that structural factors are interrelated with one another and have a strong influence on the personal barriers presented in the section above. As demonstrated by the postcolonial feminist perspective, the structural forces that shaped the experience of EIW in accessing PHC are not limited to gender, or culture/acculturation issues as echoed by most immigrant health research (O'mahony & Donnelly, 2010; Viruell-Fuentes et al., 2012). Instead, the study findings demonstrated that the barriers move beyond individualized/personalized gender and cultural issues and include multiple structural oppressive forces and dimensions of inequality that intersect to limit immigrant women's ability to access and utilize PHC. As argued in the postcolonial feminist perspective, although gender can be taken as an organizing force in shaping women's life, it is important to analyze the simultaneous role of forces such as race, social class, colonialism and history in women's access and utilization of resources and services including healthcare (O'mahony & Donnelly, 2010). The following section presents a) the intersecting forces of inequality related to EIW's social identity (immigration status, race, gender, and culture), and b) gaps in the PHC system that hindered their access to PHC services.

Intersecting Social Identities as Forces of Inequality in Primary Healthcare

One of the biggest determinants of EIW's access to PHC was their immigration status. EIW's immigration status determines their ability to legally work in the U.S. and have income to support their life. Except for those who have green card or citizenship, there is a continuous requirement to apply for and renew EADs. The long processing times of EAD both in new applications and renewals leave EIW out of employment, means they cannot have employment-based insurance or have income to cover costs on their own. In addition, immigration rules put restrictions on immigrants' access and utilization of public health programs such as Medicaid, CHIP, and ACA, except for those with citizenship status (Castañeda et al., 2015). Similar to previous reports, the findings showed that the fear of legal implications and the potential of losing their status prevents EIW from utilizing health services, even after having a green card or citizenship (Asad & Clair, 2018; Gelatt, 2016). Those who are asylum seekers and within their first couple of years struggled the most in getting EADs, having a stable employment, and living addresses that hinder their eligibility for PHC services. The inability to have timely and proper employment documentations force EIW to pursue low paying, unreliable, highly demanding, physically exhausting, and hazardous jobs that do not provide healthcare coverage. More concerning is that companies and industries take advantage of immigrants' legal situation to employ them as contract or temporary workers to avoid paying for benefits and health insurance (Castañeda et al., 2015; Yao & Hillemeier, 2014). To survive and not to risk the cancellation of their immigration status, EIW overburden themselves with such jobs, and do not have the time to pay attention to their wellbeing or pursue healthcare. The emergence of immigration status (See Figure 10) as the primary force in this study underlines the need for a shift in public health policy dialogue. The findings strongly support the claim made by Viruell-Fuentes (2012) that immigration policy should be seen as health policy and treated accordingly. Over-reliance on individual culture-based frameworks obscure the impacts of structural and oppressive immigration policies the fuel health disparities (Castañeda et al., 2015; Viruell-Fuentes et al., 2012).

The second force that hindered EIW's access is race and racial discrimination. Conversations on racial discrimination with EIW had three important aspects: the difficulty of understanding/discussing racial discrimination, the struggle between the two identities (Black African and African American), and the actual experience of racial discrimination in PHC. The findings showed most EIW find it difficult to understand or call out discriminatory actions as racial discrimination when asked directly. Instead, they tended to open-up as the interview progresses. The reasons included a) limited knowledge around race and racial relations b) history or coming from a country that was not colonized that limited their exposure and awareness (postcolonial feminist perspective). It was also evident that growing up in a country where the narrative of being a victorious nation over colonialism is dominant influenced EIW to be somehow ignorant and unprepared to racial discrimination until they are encountered with one. Further research is needed to adequately understand the implication of history, self-perception and access to PHC among EIW.

In addition, EIW had trouble in navigating the healthcare system as Black Africans in America as they are often seen as a Black African American first, and then as an immigrant by providers. Not only providers, but health literature and data simply put them in the “Black” category ignoring their unique needs and healthcare experiences as immigrants and continental Africans (Omenka et al., 2020). The study showed EIW feel trapped between the two identities in the way they are perceived but struggle on how to handle race and racial discriminatory aspects as they do not have previous or lived experience as Black African Americans do.

The study strengthens evidence from a prior study that African immigrants experience significant challenges because they are discriminated as ‘Black’ and the discrimination doubles because they are a “different Black” which is an “immigrant Black” (Olukotun et al., 2020, p. 246). The simplistic categorization of EIW (and African immigrants in general) as Blacks makes them more invisible in the PHC system. It perpetuates their isolation in the current health policy advocacy and support system (Olukotun et al., 2020; Venters & Gany, 2011). Despite their limitation in understanding and responding to racial discrimination, EIW experienced racial stereotypes and discrimination in PHC in two main forms: being seen as pain resistant and experiencing ‘deficit of credibility’. The study confirms prior research on the underassessment and underestimation of pain in Black people that lead to misdiagnosis, under-prescription and undertreatment (Booker, 2015; Burgess et al., 2014). Providers are twice as likely to underestimate Black patients’ pain compared to other racial/ethnic groups (Staton et al.,

2007) leading to less accurate treatment recommendations (Hoffman et al., 2016). Black patients bear the burden of legitimizing their pain or concerns in healthcare. The burden becomes even worse for Black immigrants as the layers of discrimination increase fueled by cultural and communication gaps (Okoro et al., 2022; Tulli et al., 2020). EIW's challenges in gaining validity/credibility of their pain and concerns strengthens existing evidence on the systemic racism and the need to focus on structural changes including policies, training, and workforce diversity (Bailey et al., 2017; Yearby et al., 2022).

The study showed that gender plays an important role in the historic socioeconomic and educational disparities that put EIW, especially refugee women, in a disadvantaged position that eventually limited their ability to have better English language skills, communication and navigation of the healthcare system. Although gender has been established a strong social determinant of health, (Read & Smith, 2018), there is limited research that investigated its historic role in determining immigrant women's educational achievement thereby its proxy impact on access to PHC. Similar to other immigrant groups including Latina and Asian immigrant women (Lu & Racine, 2015; Luque et al., 2018; J. M. O'Mahony & Donnelly, 2013), Ethiopian women are affected by traditional gender roles and are primary caretakers/givers of their family and moving to the U.S. increased their burden of providing their family by working in and outside home. Hence, the chance of paying attention to their wellbeing and having the time to pursue healthcare becomes very limited. In addition, being a woman at a reproductive age increases EIW's healthcare needs and the chance of interacting with the PHC system, mainly through maternal care and reproductive health issues. This implicates an increased need for insurance coverage, limited financial capacity, communication and navigation burden, and chances of exposure to different forms of discrimination. Especially for those going through maternity care, the absence of adequate maternity leave in the U.S. and unavailability of social support in caregiving was extremely difficult. As documented in previous research, lack of adequate social support and adjustment challenges put immigrant women at a greater risk of postpartum depression (Alhasanat & Fry-McComish, 2015; Falah-Hassani et al., 2015). Gender also matters when it comes to EIW's preference of the gender of the provider. Most of them preferred having a female provider, especially for reproductive health matters, OB/GYN and other diagnosis that involve revealing or touching private parts of their body. Unmet preferences for female provider, particularly obstetricians/gynecologists could result in avoidance of care and psychological stress among immigrant women (Aubrey et al., 2017).

Cultural insensitivity is one of the challenges experienced by EIW in PHC settings. Some providers showed no patience to listen to the concerns of EIW, especially to those with limited English proficiency, had stereotypes that undermine the faith/beliefs of EIW, and demonstrated prejudice by assuming EIW as having no knowledge, weak and as someone taking advantage of the healthcare system. The study solidifies existing evidence that lack of cultural competence and sensitivity is prevalent in PHC, and results in avoidance of PHC among immigrant women (da Conceição F. Santiago & Figueiredo, 2015; Higginbottom et al., 2016). Besides the gaps on provider's side, culture also determines how EIW conduct themselves in PHC settings. The study showed that EIW's cultural background that sets traditional expectations on women to talk less and softer and portrays speaking up as disrespect which hindered their healthcare experience. Most importantly, it affected EIW’s ability to question, effectively communicate and advocate for their rights in the healthcare system. The study implicated the need for a) healthcare providers to understand their position in relation to the client and how they respond to their needs and b) empowering immigrant women through building their knowledge and providing information on how to navigate and negotiate their rights in healthcare (O’mahony & Donnelly, 2010; Tefera, 2022).

Approachability, Affordability and Appropriateness of PHC

As indicated in the integrated framework, the nature of the healthcare system can create a structural challenge on people’s access to healthcare. The current study revealed that the PHC in the U.S. is highly complex and difficult to navigate for EIW. The lack of readily available and understandable health information that targets immigrant women makes it unapproachable (Levesque et al., 2013). Lack of transparency and lengthy paperwork that is highly technical caused frustration and increased EIW’s mistrust in the PHC that often led to delaying or avoidance of care. As previous research showed, the fragmented care and complex referral system limited EIW’s capacities to effectively navigate the healthcare system (Gui et al., 2018). EIW struggled to identify and select insurance coverage they can afford, understand better and trust. The study revealed the lack of prior orientation or outreach programs or systems in place to support those like EIW who come from a different healthcare system.

Besides the complexity of the system, EIW’s ability to access and utilize PHC is constrained by its unaffordability. The gap between EIW’s financial capacity, undermined by the immigration status and low paying jobs, and the healthcare cost forced them to avoid care unless it is life threatening. It is well documented that healthcare expense is one of the biggest barriers forcing diverse immigrant groups to delay or forgo seeking PHC (Adekeye et al., 2018; Luque et al., 2018). Dental and vision care are reported to be extremely unaffordable that some EIW preferred to wait until they travel to Ethiopia to get care and import medications from Ethiopia. The findings strengthen evidence around the growing transnational healthcare seeking among immigrants because of the exponential healthcare cost (Calvasina et al., 2015; Kemppainen et al., 2018; L. Wang & Kwak, 2015). Hidden costs and tests that are not covered by insurance, and irregular payment structure and bills signal lack of financial transparency that discouraged EIW from accessing PHC. The inability to afford healthcare comes with mental and emotional distress among EIW. The study showed that, because of financial insecurities and the potential healthcare costs, EIW struggle to make changes in their career and residential addresses. Although the mental health consequences of excess healthcare cost has been documented in the larger population (Khushalani et al., 2018; Vasiliadis et al., 2013), research is needed to better understand the situation in immigrant populations.

Although EIW generally perceived the PHC in the U.S. as advanced, they also had occasional doubts on the appropriateness (quality and adequacy) of the services they received. Public health programs particularly lack adequate human power (understaffed) and quality, as reported in the findings. Based on some unsuccessful diagnosis and treatments, EIW also questioned the knowledge and educational preparation of providers in dealing with conditions prevalent among immigrants and people of color. The study points toward the structural problems in the medical training curriculum that is based on research, health conditions and medication centering White people, the under representation of Black students and providers of color in medical training and practice, and implicit bias towards patients of color (Nuriddin et al., 2020; Polanco Walters et al., 2020; Serchen et al., 2020).

Facilitators of Access to PHC among EIW

Based on the findings of this study, the facilitators of access to PHC can be summarized in two categories. The first group of facilitators are related to EIW's socioeconomic and legal conditions, and the second group of facilitators are directly related to the PHC system. As presented earlier, immigration status is the key to access to healthcare as it determines employment (employment-based insurance) and the right to use public health programs. Of all immigration statuses, having U.S. citizenship is the primary facilitator for access to PHC among EIW. Once again, the study solidifies the notion that immigration policy is indeed a public health policy, and should be treated as such (Gurrola & Ayón, 2018).

Although it is highly affected by immigration-related challenges and EAD renewal issues, having a stable job is the main way to have access to PHC through employment-based health insurance. Despite their academic preparation and qualifications (majority the participants having graduate/undergraduate degrees), EIW are forced to pursue only temporary job positions that have limited coverage. The study strengthened existing structural exploitation of immigrant labor without protecting their basic rights (Misra et al., 2021). The other facilitator is place of residence that determined access to public health programs. Despite adequacy and quality problems, EIW living in Washington DC have access to a public health program if they fall under the minimum income category. Place of residence also mattered in getting quality service between various zip codes within Washington DC. Living in states like Virginia has an advantage over other states because of Meicaid expansion. But most EIW hesitated utilizing PHC because of the fear of Public Charge Rules. The Public Charge Rule that restricts immigrants from utilizing public health benefits and results in inadmissibility of immigrants created fear among EIW, and continues to create confusion although it was said changes has been made to it that lifted the restrictions (Haq et al., 2020; Touw et al., 2021).

As demonstrated in the integrated framework (Figure 5), social capital served as an important factor in EIW's ability to access and utilize PHC. Although social capital in the full sense of the term was not used, similar to most immigrant groups, EIW received vital social support from family and friends in navigating the PHC system, transportation, facilitating communications, helping them use their residential addresses, and medical advice (from professional friends) (Khanlou et al., 2014; Msengi et al., 2015; Wasserman et al., 2006). Although limited to only a few EIW, the relatively unique facilitator uncovered by this study is learning from the lived experiences of other Black women, especially in understanding systemic racism in healthcare and how to handle or navigate it. Although such minority-to-minority alliances are rare (Rogers, 2004), the study can serve as an indicator to the potential benefit of strengthening support networks between African/other Black immigrant women and African American women in navigating the complex realities of healthcare in the U.S. (Olukotun et al., 2020). Limited to the residents of DMV area and a few of Missouri residents, community organizations (ECC and RIS) played a facilitating role to access PHC. The study revealed the unavailability of community health organizations specifically tasked with serving immigrant populations, and the need for equipping traditional social organizations such as churches and mosques with healthcare information and resources.

Within the PHC system, some EIW, especially those with better education, relied on their English language and internet browsing skills to communicate with providers as well as to access and utilize health information. A handful of EIW with familiarity with healthcare environment also used self-advocacy and proactivity to improve their healthcare experience and outcomes. The study showed linguistic, technological and educational disparities affect EIW's PHC experience, and building the capacity of those with limited skills in those domains is vital in expanding access (Tsai et al., 2018). Despite quality-related problems, available translation services eased EIW's ability to communicate with providers and utilize PHC services. The study also showed that there is a strong need to expand translation services in other places as these services are currently limited to the DMV area where there is significant presence of the Ethiopian diaspora.

The last facilitator is the background (linguistic, racial and cultural) of health provider. EIW women stated having a Habesha (Ethiopian/Eritrean) provider gives them a linguistic and cultural advantage that eases their PHC experience and motivation to seek care. In addition, EIW expressed that having a Black or POC as their provider improves their access and healthcare experience. The reasons included: a) reduced chance of racial discrimination that eases their anxiety and burden of credibility, and increases trust in the treatment/service b) easier to establish patient-provider relationship and understanding, especially with those who have migratory background c) potential familiarity of providers health problems prevalent in Black and immigrant populations that enhances EIW’s confidence in the treatment. The study directs us to the significance and need for diversifying the healthcare workforce as called by previous studies (Baumann et al., 2021; Whitt-Glover, 2019), and strengthens the evidence that increasing the presence of providers from minority background could help address health disparities (Marrast et al., 2014). However, this needs a multi-sectoral reform that involves increasing access and recruitment of minority students into medical schools, improving immigration regulation that limit qualified minority providers from getting medical practice licenses and joining the healthcare workforce, and building anti-racist and inclusive system that help improve work conditions for minority providers (Hassen et al., 2021; Philbin et al., 2018). The following section presents the implications of the study.

Implications for Policy and Practice

Immigration policy reform is strongly needed in three broad areas to resolve the current disruptive rules that impede immigrants’ ability to access and utilize PHC. First, the current waiting period to get and renew EAD should be cut significantly so immigrants can legally get employed and have access to employment-based health insurance. The validity of EADs should be made longer to avoid the staggering backlog in EAD applications that put millions of people without health coverage. Due to the delays in processing EADs, immigrant women are exposed to precarious and hazardous job conditions that put them at more health risk, limited coverage, exploitation, low income, and inability to seek care when they need it. Labor laws that protect the dignity of immigrant women and impose extended maternity and sick leaves for everyone should be advocated for (NASW, n.d.). Second, immigration rules that restrict access to publicly available healthcare insurance programs perpetuate social injustice should be reversed

(Tefera et al., 2022). The damaging effect of laws such as PRWORA that deny non-US citizens from accessing services such as Medicaid and CHIP has been immense and needs to be reversed. It is crucial that policy makers and practitioners join hands in promoting and ensuring social justice in access and utilization of healthcare among immigrants (NASW, n.d.). Information on eligibility and implications on immigrants' green card and citizenship applications should be made clear to avoid the fear of inadmissibility and deportation among immigrants. Third, the extremely difficult path to getting work authorization for international as well as immigrant health professionals should be revisited and resolved. International and immigrant health professionals with similar levels of medical training and credentials in their home countries are expected to go again through long training years to be able to get their licenses and start medical practices. Creating shorter and more effective paths could help diversify the healthcare workforce, thereby improving the trust levels of EIW/immigrant women in the healthcare system. It is also vitally important to increase the preparation and recruitment of students of color into medical schools. Revisiting medical school curriculums to integrate diverse cases and non-western medicine courses could help produce providers with a better understanding of the needs of immigrants of color.

Structural and policy reforms stated above will pave the way to decolonizing the healthcare system, mitigating racial discrimination, and promoting an inclusive PHC environment. Decolonizing the healthcare system starts with recognizing the system is designed to serve the White majority population, segregates minorities and rejecting the injustice and the status quo (Tefera, 2022). Critical measures are needed in revisiting medical curriculums to equally incorporate research and case studies from minorities, and diversify the student body by recruiting trainees from less privileged communities. Policy-supported recruitment of culturally and linguistically diverse providers, receptionists, call-center workers, and insurance workers is vital. Equipping the healthcare workforce with the awareness and skills of serving diverse and minoritized populations is critical to building trust and improving utilization. Emphasis should be given to reproductive health and maternal services as the major healthcare needs of EIW/immigrant women. Specifically, recruiting more female providers of color could improve EIW's/immigrant women's PHC experience and health outcomes. Efforts to promote cultural sensitivity through training providers, and providing interpretation/translation services should be strengthened, but systemic reforms should be in place for sustained impact. Anti-racist approaches that help to monitor, report, and hold providers accountable should be implemented to create a safe environment for immigrants in PHC.

Besides the policy reforms and ensuring inclusiveness, building transparency in diagnosis, testing, and prescriptions are equally important to restore trust among immigrants. Healthcare approaches that encourage healthy living, dietary and natural ways of healing, and recovery could lead to better results in treating EIW/immigrant women who are unfamiliar with medication-heavy treatments. In addition, ensuring financial transparency in the health insurance system and structured payment processes is strongly suggested. Efforts should be made to have extended hours of PHC services, shorten the long waiting times for appointments, and emergency room care to accommodate the needs of immigrants.

The production and availability of understandable and usable healthcare and insurance information is critical to improving EIW's PHC access and utilization of PHC. Availing this information to EIW/immigrant women should start at U.S. embassies and consulates during the time of their application to enhance early preparation. The request for medical tests at embassies/consulates should include providing adequate healthcare information in the immigrant's native language. In the U.S., there is a strong need to establish information centers dedicated to helping immigrant women navigate the complex healthcare system. Instead of leaving the task to resettlement agencies (such as RIS) that provide a one-time service, having centers with the primary purpose of providing health information and navigation support could bear better results. Health information for EIW/immigrants should be brief, with as little technicality as possible, and understandable. Besides having materials translated into EIW's languages (Although Amharic is widely spoken, there are EIW who understand other languages better), using demonstrative tools, pictures and other visuals could simplify the complex health information.

To help address unaffordability, the expansion of community health clinics with reduced-cost alternatives is essential in areas where there are immigrant women populations. Well-funded dental and vision programs and the expansion of free and accessible reproductive health services are warranted. Strong and collaborated advocacy work from health social workers and reproductive health rights groups could help voice the concerns of immigrant women.

Since access to PHC is related to EIWs/immigrant women's academic, work, immigration, and employment situations; a holistic approach to empower EIW/immigrant women is needed. Expanding education and English language training, without discriminating based on immigration status, is vital to improving employment opportunities for EIW. Priority should be given to refugees who most likely have lower educational levels and limited English language skills. In addition to formal education, health education programs that target immigrant women are strongly needed. Furthermore, including lessons that improve EIW's awareness around racism in healthcare and ways of responding to discriminatory acts is essential. For those with academic credentials/degrees, there is a need to create mechanisms of validating or process of equivalence to getting U.S. credentials and increase their employability and capacity to afford PHC. Immigrant women with high levels of education are often forced to stay put because of the intersecting impacts of discriminatory immigration laws and favoritism in the academic and labor market. Expanding employment opportunities is key to expanding access to health insurance and access to PHC. In addition, providing caregiving support for EIW/immigrant women could ease their burden and make a space for them to focus on fulfilling their healthcare needs.

Given the size of EIW in the U.S., there is a need to establish strong collaborations with immigrant community organizations within the Ethiopian diaspora. Strengthening existing partnerships with ECC and establishing similar relations with Ethiopian immigrant community organizations throughout the U.S. could be an effective way to reach EIW with healthcare information. Community organizations could also be helpful in developing customized, culturally, and linguistically relevant health information. Religious institutions are the glue in the Ethiopian diaspora's social life and could be leveraged to tackle misinformation, reach newly arriving EIW, and enhance trust in the PHC. Partnerships with community organizations could also help in health resource mapping and communicating emerging policy changes that affect EIW's healthcare access. In addition to immigrant community organizations in the Ethiopian diaspora, an alliance with Black African American women could create a venue for learning and sharing experiences on how to navigate the complex realities of PHC in the U.S. as women of color.

Limitations

One of the limitations of this study is related to the type of immigration status and residence of participants. Due to the hard-to-reach nature of the population, the study included EIW regardless of their immigration status. Although the majority of the themes were shared by most participants, there were differences of experience based on specific immigration statuses. Future research could focus on investigating PHC experiences for each immigration category to gain in-depth understanding and developed customized solutions. Similarly, the study recruited participants from six different states and one district (Washington DC), and the implication of the residential differences have limited the specificity of the findings. To help address this limitation, information on geographic settings (states) of participants was included in the findings. However, future research focusing on specific geographies to analyze the varying state-based health-related regulations, and their implication on EIW's access to PHC is warranted. The use of convenience sampling (purposive and snowball sampling) might have caused under- or over-representation of certain groups within the study population which might have affected the findings. To address this, an effort was made to present extensive demographic information on each participant and present individual quotes with thick descriptions.

It is also important to recognize that the gender and nationality of the researcher (as a male Ethiopian) might have an impact on participants openness in sharing sensitive health information. In addition, the coding process was carried out solely by the researcher and this limited the opportunity of having alternative views. Peer debriefing and member checking were used to counter this limitation. Lack of adequate prior research on African immigrants and Ethiopian immigrant women in particular has also affected the ability to provide specific and comparative discussion of the research findings.

Implications for Research

Despite the limitations presented above, the study has important theoretical and research implications. This is the first known study that explored EIW's experiences and challenges in accessing PHC in the U.S. It will contribute its part in bridging the knowledge gap on the extremely understudied immigrant group in the U.S. and expand the knowledge base on African immigrants in the immigrant health literature.

The study advanced the conceptualization of access to healthcare as a broad process that starts before contact was initiated with the healthcare system and involves both material and emotional aspects of immigrant women's journey and adjustment to the new country. It underscores the need to investigate access through the lens of the everyday socioeconomic, legal and emotional struggle of immigrant women, instead of a mere emphasis on availability and adequacy (Gulliford et al., 2002). By presenting the complex personal and structural forces in determining EIW's access to PHC, the study demonstrated the need for a shift from the predominant ‘culture and acculturation’ research that focuses on the individual immigrant’s integration into the host community, to a more integrated and intersectional approach that analyzes structural forces that perpetuate disparity in accessing healthcare. Particularly, the study highlighted the role of immigration/immigration status as a strong determinant of access to PHC by uncovering its oppressive role along with other social identities including race, gender, and culture. Future research is needed to further investigate the intersecting roles of these forces using a larger sample of African immigrant women. More emphasis is needed on researching and exposing the oppressive and discriminatory roles of US immigration laws to ignite change and realize inclusive policies that foster immigrants’ right to access and utilize healthcare without the fear of legal consequences.

In addition to immigration status, this study revealed that a lack of trust in the U.S. healthcare system that is caused by contradicting health beliefs reinforced by structural barriers is central to EIW’s decisions in accessing PHC. Although mistrust is addressed under personal barriers in relation to contradicting health behaviors, this study demonstrated that the roots of the problem are structural. Using the precursors of mistrust presented in this study, it is imperative for future research to deeply investigate factors behind the erosion of trust in the PHC and develop viable recommendations to restore it.

The study will also make a meaningful contribution to portraying the diversity within the African immigrant population that is often treated as a singular group (homogenous group) in immigrant health literature. For example, the unique perspectives and realities of EIW in understanding and responding to racial discrimination in PHC, add to the richness of African immigrant health literature. The study invites further investigation into the relationship between the lack of colonial past/history and its implication on immigrants' understanding of racial discrimination in healthcare. For example, due to differences in their experience of colonialism and racism, the assessment and criticality of an immigrant woman from Ethiopia and South Africa towards racial discrimination could be quite different. The study reaffirms the Postcolonial Feminist Perspective's proposition to critically review the colonial past when studying non-western, and women of color. The study also draws researchers' attention to the double layer of discrimination EIW, and potentially other African and Black immigrant women suffer in PHC as 'Black', and 'immigrant' women. Instead of relying on a simplistic categorization of African immigrant women in the larger Black women, the study contributes to an approach that looks into the diversity in the Black women population and increases the visibility of EIW and other African immigrant women in the PHC system along with their unique healthcare needs. Future research should also pay attention to the diversity in immigrant women's legal status and investigate the implications of each specific category on access to health services. In addition, differences in places of residence and state health regulations should be taken into consideration in future research.

Although the main PHC services utilized by EIW were general check-ups and maternity health services, it was evident that EIW often avoided seeking PHC despite the need exists for other illnesses. The fact that most arrived within the last 5 years and rated their overall health as good and above supports part of the healthy immigrant effect proposition. However, their avoidance of care while in need of it triggers to question if the healthy immigrant effect proposition is still valid and warrants further study. Further study is also needed to understand the relationship between access to PHC and mental health among EIW, and the larger population of African immigrant women.

Conclusion

This study aimed to understand the experiences and challenges of EIW in accessing PHC in the U.S. The findings uncovered that EIW's have mixed perceptions about PHC in the U.S. that is characterized by advanced technology and inaccessibility. The burden of transitioning into their new life in the U.S. where the healthcare system is non-universal caused delays in PHC access and utilization. Structural barriers, mainly immigration status, unaffordability, discrimination, and complexity of PHC system, outweighed the personal level barriers. Lack of trust underlined most of the personal barriers that affected EIW's PHC access and utilization. Having social support and a stable job were the primary facilitators of access to PHC followed by English and technological skills. Being the first in its type in investigating one of the most invisible immigrant groups in the literature, this study will significantly contribute in filling the gap in the immigrant health literature. This exploratory research paves the way for future studies to look into the identified multiple barriers of access to PHC, especially the intersecting structural barriers, by using larger study sample across the U.S. The study has significant implications for policy reform needs, particularly immigration and public health, and potential interventions aiming to tackle healthcare and access disparities among African immigrant women in the U.S.

References

Adekeye, O. A., Adesuyi, B. F., & Takon, J. G. (2018). Barriers to healthcare among African immigrants in Georgia, USA. *Journal of Immigrant and Minority Health*, *20*(1), 188–193. https://doi.org/10.1007/S10903-017-0549-9/TABLES/4

Agency for Healthcare Research and Quality. (2020). *National healthcare quality and disparities reports*. https://www.ahrq.gov/research/findings/nhqrdr/index.html

Alhasanat, D., & Fry-McComish, J. (2015). Postpartum depression among immigrant and Arabic women: Literature review. *Journal of Immigrant and Minority Health*, *17*(6), 1882–1894. https://doi.org/10.1007/s10903-015-0165-5

Allen, D. G. (1985). Nursing research and social control: Alternative models of science that emphasize understanding and emancipation. *The Journal of Nursing Scholarship*, *17*(2), 58–64. https://doi.org/10.1111/j.1547-5069.1985.tb01419.x

Alpers, L. M. (2018). Distrust and patients in intercultural healthcare: A qualitative interview study. *Nursing Ethics*, *25*(3), 313–323. https://doi.org/10.1177/0969733016652449

American Immigration Council. (2020). *Immigrants in Missouri*. https://www.americanimmigrationcouncil.org/research/immigrants-in-missouri

Andersen, R. (1968). A behavioral model of families' use of health services. In *A behavioral model of families' use of health services.* (Issue 25). Center for Health Administration Studies.

Andersen, R. M. (1995). Revisiting the Behavioral Model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*(1), 1–10.

Anderson, E. (2021). *Black in White space: The enduring impact of color in everyday life*. University of Chicago Press.

Anderson, J. M. (1985). Perspectives on the health of immigrant women: A feminist analysis. *Advances in Nursing Science*, *8*(1), 61–76. https://doi.org/10.1097/00012272-198510000-00008

Anderson, J. M. (2000). Gender, race, poverty, health and discourses of health reform in the context of globalization: A postcolonial feminist perspective in policy research. *Nursing Inquiry*, *7*, 220–229.

Anderson, J., & McCann, E. K. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of post-colonial and Black feminist scholarship. *Nurse Researcher*, *9*(3), 7–27. https://doi.org/10.7748/nr2002.04.9.3.7.c6186

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*(3 SUPPL.), 68–79. https://doi.org/10.1016/S0749-3797(02)00657-8

Annansingh, F., & Howell, K. (2016). Using Phenomenological Constructivism (PC) to discuss a mixed method approach in information systems research. Electronic. *The Electronic Journal of Business Research Methods*, *14*(1), 39–49.

Anuwe, P. (2020). *Perception of breast cancer screening among African immigrant women in Dallas* [Walden University]. https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=9783&context=dissertations

Armenta, A., & Sarabia, H. (2020). Receptionists, doctors, and social workers: Examining undocumented immigrant women's perceptions of health services. *Social Science and Medicine, 246*(112788). https://doi.org/10.1016/j.socscimed.2020.112788

Asad, A. L., & Clair, M. (2018). Racialized legal status as a social determinant of health. *Social Science & Medicine*, *199*, 19–28. https://doi.org/10.1016/j.socscimed.2017.03.010

Assefa, Y., Hill, P. S., Gilks, C. F., Admassu, M., Tesfaye, D., & Van Damme, W. (2020). Primary health care contributions to universal health coverage, Ethiopia. *Bulletin of the World Health Organization*, *98*(12), 894-905A. https://doi.org/10.2471/BLT.19.248328

Aubrey, C., Chari, R., Mitchell, B. F. (Peter), & Mumtaz, Z. (2017). Gender of provider-barrier to immigrant women's obstetrical care: A narrative review. *Journal of Obstetrics and Gynaecology Canada*, *39*(7), 567–577. https://doi.org/10.1016/j.jogc.2017.01.013

Baezconde-Garbanati, L., Murphy, S. T., Moran, M. B., & Cortessis, V. K. (2013). Reducing the excess burden of cervical cancer among Latinas: Translating science into health promotion initiatives. *Californian Journal of Health Promotion*, *11*(1), 45–57.

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, *389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Bajgain, B. B., Bajgain, K. T., Badal, S., Aghajafari, F., Jackson, J., & Santana, M. J. (2020). Patient-reported experiences in accessing primary healthcare among immigrant population in Canada: A rapid literature review. *International Journal of Environmental Research and Public Health 2020, Vol. 17, Page 8724*, *17*(23), 8724. https://doi.org/10.3390/IJERPH17238724

Batalova, J., Hanna, M., & Levesque, C. (2021). *Frequently requested statistics on immigration in the United States*. Migration Policy Institute. https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-2020

Bauer, H. M., Rodriguez, M. A., Quiroga, S. S., & Flores-Ortiz, Y. G. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of Health Care for the Poor and Underserved*, *11*(1), 33–44. https://doi.org/10.1353/hpu.2010.0590

Baumann, A., Crea-Arsenio, M., Ross, D., & Blythe, J. (2021). Diversifying the health workforce: A mixed methods analysis of an employment integration strategy.

Human Resources for Health, *19*(1), 62. https://doi.org/10.1186/s12960-021-00606-y

Berdahl, T. A., & Torres Stone, R. A. (2009). Examining Latino differences in mental healthcare use: The roles of acculturation and attitudes towards healthcare. *Community Mental Health Journal*, *45*(5), 393–403. https://doi.org/10.1007/s10597-009-9231-6

Betancourt, J. R. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*(4), 293–302. https://doi.org/10.1093/phr/118.4.293

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Blewett, L. A., Johnson, P. J., & Mach, A. L. (2010). Immigrant children's access to health care: Differences by global region of birth. *Journal of Health Care for the Poor and Underserved*, *21*(2 Suppl), 13–31. https://doi.org/10.1353/hpu.0.0315

Bolter, J. (2019). *Explainer: Who is an immigrant?* Migration Policy Institute. https://www.migrationpolicy.org/content/explainer-who-immigrant

Booker, S. Q. (2015). Are nurses prepared to care for Black American patients in pain? *Nursing2023*, *45*(1), 66. https://doi.org/10.1097/01.NURSE.0000458944.81243.eb

Boulware, L. E. (2003). Race and trust in the health care system. *Public Health Reports*, *118*(4), 358–365. https://doi.org/10.1093/phr/118.4.358

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research, 4*, 1–8. https://doi.org/10.1177/2333393617742282

Bristow, R. E., Powell, M. A., Al-Hammadi, N., Chen, L., Miller, J. P., Roland, P. Y., Mutch, D. G., & Cliby, W. A. (2013). Disparities in ovarian cancer care quality and survival according to race and socioeconomic status. *Journal of the National Cancer Institute*, *105*(11), 823–832. https://doi.org/10.1093/jnci/djt065

Burgess, D. J., Nelson, D. B., Gravely, A. A., Bair, M. J., Kerns, R. D., Higgins, D. M., van Ryn, M., Farmer, M., & Partin, M. R. (2014). Racial differences in prescription of opioid analgesics for chronic noncancer pain in a national sample of veterans. *The Journal of Pain*, *15*(4), 447–455. https://doi.org/10.1016/j.jpain.2013.12.010

Bustamante, A. V., Félix-Beltrán, L., Nwadiuko, J., & Ortega, A. N. (2022). Avoiding Medicaid enrollment after the reversal of the changes in the public charge rule among Latino and Asian immigrants. *Health Services Research, 57*(S2), 195–203. https://doi.org/10.1111/1475-6773.14020

Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). “It’s like being in a Labyrinth:” Hispanic immigrants’ perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health*, *9*(1), 1–16. https://doi.org/10.1007/s10903-006-9010-1

Calvasina, P., Muntaner, C., & Quiñonez, C. (2015). Transnational dental care among Canadian immigrants. *Community Dentistry and Oral Epidemiology*, *43*(5), 444–451. https://doi.org/10.1111/cdoe.12169

Carney, M. A. (2015). Eating and feeding at the margins of the state: Barriers to health care for undocumented migrant women and the “clinical” aspects of food assistance. *Medical Anthropology Quarterly*, *29*(2), 196–215. https://doi.org/10.1111/maq.12151

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E. D. T., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health*, *36*, 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Chan, Z. C., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The Qualitative Report*, *18*(30), 1–9.

Chaumba, J. (2011). Health status, use of health care resources, and treatment strategies of Ethiopian and Nigerian Immigrants in the United States. *Http://Dx.Doi.Org/10.1080/00981389.2011.581999*, *50*(6), 466–481. https://doi.org/10.1080/00981389.2011.581999

Chavez, L. R. (2012). Undocumented immigrants and their use of medical services in Orange County, California. *Social Science and Medicine*, *74*(6), 887–893. https://doi.org/10.1016/j.socscimed.2011.05.023

Choi, J. Y. (2009). Contextual effects on health care access among immigrants: Lessons from three ethnic communities in Hawaii. *Social Science and Medicine*, *69*(8), 1261–1271. https://doi.org/10.1016/j.socscimed.2009.08.001

Chuke, S. O., Yen, N. T. N., Laserson, K. F., Phuoc, N. H., Trinh, N. A., Nhung, D. T. C., Mai, V. T. C., Qui, A. D., Hai, H. H., Loan, L. T. H., Jones, W. G., Whitworth, W. C., Shah, J. J., Painter, J. A., Mazurek, G. H., & Maloney, S. A. (2014). Tuberculin skin tests versus Interferon-Gamma Release Assays in Tuberculosis screening among immigrant visa applicants. *Tuberculosis Research and Treatment*, *2014*, e217969. https://doi.org/10.1155/2014/217969

Cleaveland, C., & Ihara, E. S. (2012). "They treat us like pests:" Undocumented immigrant experiences obtaining health care in the wake of a "crackdown" ordinance. *Journal of Human Behavior in the Social Environment*, *22*(7), 771–788. https://doi.org/10.1080/10911359.2012.704781

Clough, J., Lee, S., & Chae, D. H. (2013). Barriers to health care among Asian immigrants in the United States: A traditional review. *Journal of Health Care for the Poor and Underserved*, *24*(1), 384–403. https://doi.org/10.1353/hpu.2013.0019

Creswell, J. W., & Clark, V. L. P. (2018). *Designing and conducting mixed methods research* (Issue 2). Sage.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches*. Sage.

da Conceição F. Santiago, M., & Figueiredo, M. H. (2015). Immigrant women's perspective on prenatal and postpartum care: Systematic review. *Journal of Immigrant and Minority Health, 17*(1), 276–284. https://doi.org/10.1007/s10903-013-9915-4

Danielle, F. (2016). *Access to healthcare: EPF's survey-final report*. European Patients Forum.

Debie, A., Khatri, R. B., & Assefa, Y. (2022). Contributions and challenges of healthcare financing towards universal health coverage in Ethiopia: A narrative evidence synthesis. *BMC Health Services Research*, *22*(1), 866. https://doi.org/10.1186/s12913-022-08151-7

Dedania, R., & Gonzales, G. (2019). Disparities in access to health care among US-born and foreign-born US adults by mental health status, 2013–2016. *American Journal of Public Health*, *109*(S3), S221–S227. https://doi.org/10.2105/AJPH.2019.305149

DeShaw, P. J. (2006). Use of the emergency department by Somali immigrants and refugees. *Minnesota Medicine*, *89*(8), 42–45.

DeVoe, J. E., Baez, A., Angier, H., Krois, L., Edlund, C., & Carney, P. A. (2007). Insurance + access ≠ health care: Typology of barriers to health care access for low-income families. *The Annals of Family Medicine*, *5*(6), 511–518. https://doi.org/10.1370/AFM.748

Dias, S., Gama, A., & Rocha, C. (2010). Immigrant women's perceptions and experiences of health care services: Insights from a focus group study. *Journal of Public Health*, *18*(5), 489–496. https://doi.org/10.1007/s10389-010-0326-x

Donabedian, A. (1973). *Aspects of medical care administration: Specifying requirements for healthcare*. Harvard University Press.

Doyal, L. (2000). Gender equity in health: Debates and dilemmas. *Social Science and Medicine*, *51*(6), 931–939. https://doi.org/10.1016/S0277-9536(00)00072-1

Echeverria-Estrada, C., & Batalova, J. (2019). *Sub-Saharan African Immigrants in the United States*. Migration Policy. https://www.migrationpolicy.org/article/sub-saharan-african-immigrants-united-states-2018

Edmonds, W. A., & Kennedy, T. D. (2020). *An applied guide to research designs: Quantitative, qualitative, and mixed methods*. Sage.

Edward, J. (2014). Undocumented immigrants and access to health care: Making a case for policy reform. *Policy, Politics, and Nursing Practice*, *15*(1–2), 5–14. https://doi.org/10.1177/1527154414532694

EINSURE. (2017). *The difference between primary, secondary and tertiary health care*. https://www.einsure.com/blog/the-difference-between-primary-secondary-and-tertiary-health-care/

Falah-Hassani, K., Shiri, R., Vigod, S., & Dennis, C. L. (2015). Prevalence of postpartum depression among immigrant women: A systematic review and meta-analysis.

Journal of Psychiatric Research, *70*, 67–82. https://doi.org/10.1016/j.jpsychires.2015.08.010

Fang, M. L., Sixsmith, J., Lawthom, R., Mountian, I., & Shahrin, A. (2015). Experiencing “pathologized presence and normalized absence”; Understanding health related experiences and access to health care among Iraqi and Somali asylum seekers, refugees and persons without legal status Health behavior, health promotion and society. *BMC Public Health*, *15*(1), 1–12. https://doi.org/10.1186/S12889-015-2279-Z/PEER-REVIEW

Fisher, J., & Hinchliff, S. (2013). Immigrant women’s perceptions of their maternity care: A review of the literature part 1. *The Practising Midwife*, *16*(1), 20–22.

Fortney, J. C., Burgess, J. F., Bosworth, H. B., Booth, B. M., & Kaboli, P. J. (2011). A re-conceptualization of access for 21st century healthcare. *Journal of General Intermal Medicine*, *2*(2), 639–686. https://doi.org/10.1007/s11606-011-1806-6

Frost, Nollaig. (2011). *Qualitative research methods in psychology: Combining core approaches*. Open University Press.

Galobardes, B., Shaw, M., Lawlor, D. A., Lynch, J. W., & Smith, G. D. (2006). Indicators of socioeconomic position. *Journal of Epidemiology and Community Health*, *60*(1), 7–12. https://doi.org/10.1136/jech.2004.023531

Gelatt, J. (2016). Immigration status and the healthcare access and health of children of immigrants. *Social Science Quarterly*, *97*(3), 540–554. https://doi.org/10.1111/ssqu.12261

Gitsels-van der Wal, J. T., Manniën, J., Ghaly, M. M., Verhoeven, P. S., Hutton, E. K., & Reinders, H. S. (2014). The role of religion in decision-making on antenatal screening of congenital anomalies: A qualitative study amongst Muslim Turkish origin immigrants. *Midwifery*, *30*(3), 297–302. https://doi.org/10.1016/j.midw.2013.04.001

Goldsmith, L. J. (2007). *Access to health care for disadvantaged individuals: A qualitative inquiry* [University of North Carolina]. https://search.proquest.com/openview/ff8436474543f82305428daf4674526d/1?pq-origsite=gscholar&cbl=18750

Goodman, R. D., Vesely, C. K., Letiecq, B., & Cleaveland, C. L. (2017). Trauma and resilience among refugee and undocumented immigrant women. *Journal of Counseling & Development*, *95*(3), 309–321. https://doi.org/10.1002/jcad.12145

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*(179), 1–7. https://doi.org/10.3389/FPUBH.2018.00179/BIBTEX

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, *3*(1), 42–55.

Gui, X., Chen, Y., & Pine, K. H. (2018). Navigating the healthcare service “Black box”: individual competence and fragmented System. *Proceedings of the ACM on Human-Computer Interaction*, *2*(CSCW), 61:1-61:26. https://doi.org/10.1145/3274330

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does “access to health care” mean? *Journal of Health Services Research and Policy*, *7*(3), 186–188. https://doi.org/10.1258/135581902760082517

Gurrola, M. A., & Ayón, C. (2018). Immigration policies and social determinants of health: Is immigrants’ health at risk? *Race and Social Problems*, *10*(3), 209–220. https://doi.org/10.1007/s12552-018-9239-z

Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy*, *8*, 175–183. https://doi.org/10.2147/RMHP.S70173

Hailemeskel, B., Habte, A., Fullas, F., & Al-Matari, R. A. (2017). A survey on the use of complementary and alternative medicine among Ethiopian immigrants in the USA. *Complement Med Alt Healthcare J Complement Med Alt Healthcare*, *1*(4).

Hall, E., & Cuellar, N. G. (2016). Immigrant health in the United States: A trajectory toward change. *Journal of Transcultural Nursing*, *27*(6), 611–626. https://doi.org/10.1177/1043659616672534

Haq, C., Hostetter, I., Zavala, L., & Mayorga, J. (2020). Immigrant health and changes to the public-charge rule: Family physicians’ response. *Annals of Family Medicine, 18*(5), 458–460. https://doi.org/10.1370/afm.2572

Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing anti-racism interventions in healthcare settings: A scoping review.

International Journal of Environmental Research and Public Health, *18*(6), Article 6. https://doi.org/10.3390/ijerph18062993

Haywood, C., Tanabe, P., Naik, R., Beach, M. C., & Lanzkron, S. (2013). The impact of race and disease on sickle cell patient wait times in the emergency department. *American Journal of Emergency Medicine, 31*(4), 651–656. https://doi.org/10.1016/j.ajem.2012.11.005

Healthy People 2030. (n.d.). *Health care access and quality*. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality

Healthy People 2020. (2017). *Family planning*. https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning

Higginbottom, G. M., Safipour, J., Yohani, S., O'Brien, B., Mumtaz, Z., Paton, P., Chiu, Y., & Barolia, R. (2016). An ethnographic investigation of the maternity healthcare experience of immigrants in rural and urban Alberta, Canada. *BMC Pregnancy and Childbirth*, *16*(1). https://doi.org/10.1186/s12884-015-0773-z

Hill, N., Hunt, E. & Hyrkas, K. (2012). Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. *Journal of Transcultural Nursing*, *23*(1), 72–81. https://doi.org/10.1177/1043659611423828

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and Whites. *Proceedings of the National Academy of Sciences*, *113*(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

Howell, E. M. (1988). Low-income persons’ access to health care: NMCUES Medicaid data. *Public Health Reports*, *103*(5), 507–514.

International Organization for Migration. (2019). *Key migration terms*. https://www.iom.int/key-migration-terms

Ivanov, L. L. (2002). Health care utilization patterns of Russian-speaking immigrant women across age groups. *Journal of Immigrant Health*, *4*(1), 17–27. https://doi.org/10.1023/A:1013055110631

Jacobson, H. E., Hund, L., & Soto Mas, F. (2016). Predictors of English health literacy among U.S. Hispanic Immigrants: The importance of language, bilingualism and sociolinguistic environment. *Literacy & Numeracy Studies : An International Journal in the Education and Training of Adults*, *24*(1), 43–64. https://doi.org/10.5130/lns.v24i1.4900

Jaiswal, J. (2019). Whose responsibility is it to dismantle medical mistrust? Future directions for researchers and health care providers. *Behavioral Medicine*, *45*(2), 188–196. https://doi.org/10.1080/08964289.2019.1630357

Jenkins, C. N. H., Le, T., McPhee, S. J., Stewart, S., & The Ha, N. (1996). Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? *Social Science and Medicine*, *43*(7), 1049–1056. https://doi.org/10.1016/0277-9536(95)00368-1

John, D. A., de Castro, A. B., Martin, D. P., Duran, B., & Takeuchi, D. T. (2012). Does an immigrant health paradox exist among Asian Americans? Associations of nativity and occupational class with self-rated health and mental disorders. *Social Science and Medicine*, *75*(12), 2085–2098. https://doi.org/10.1016/j.socscimed.2012.01.035

Johnson, C. E., Mues, K. E., Mayne, S. L., & Kiblawi, A. N. (2008). Cervical cancer screening among immigrants and ethnic minorities. *Journal of Lower Genital Tract Disease*, *12*(3), 232–241. https://doi.org/10.1097/LGT.0b013e31815d8d88

Johnson, K. (2009). The intersection of race and class in U.S. immigration and law enforcement. *Law and Contemporary Problems, 72*(1), 1–36.

Kaiser Family Foundation. (2019). *Health coverage of immigrants fact sheet*. www.kff.org

Kantartzis, S., & Molineux, M. (2011). The influence of Western society’s construction of a healthy daily life on the conceptualisation of occupation. *Journal of Occupational Science*, *18*(1), 62–80. https://doi.org/10.1080/14427591.2011.566917

Kemppainen, L., Kemppainen, T., Skogberg, N., Kuusio, H., & Koponen, P. (2018). Immigrants‘ use of health care in their country of origin: The role of social integration, discrimination and the parallel use of health care systems. *Scandinavian Journal of Caring Sciences, 32*(2), 698–706. https://doi.org/10.1111/scs.12499

Kennedy, B. R., Mathis, C. C., & Woods, A. K. (2007). African Americans and their distrust of the health care system: Healthcare for diverse populations. *Journal of Cultural Diversity*, *14*(2), 56–60.

Kerani, R., Narita, M., Lipira, L., Endeshaw, M., Holmes, K. K., & Golden, M. R. (2019). Challenges in recruiting African-born, US-based participants for HIV and Tuberculosis research. *Journal of Immigrant and Minority Health*, *21*(3), 533–539. https://doi.org/10.1007/S10903-018-0776-8/FIGURES/2

Khan, K., McDonald, H., Baumbusch, J. L., Kirkham, S. R., Tan, E., & Anderson, J. M. (2007). Taking up postcolonial feminism in the field: Working through a method. *Women's Studies International Forum*, *30*(3), 228–242. https://doi.org/10.1016/j.wsif.2007.03.004

Khan, S. (2014). Qualitative research method-phenomenology. *Asian Social Science*, *10*(21), 298–310. https://doi.org/10.5539/ass.v10n21p298

Khanlou, N., Haque, N., Sheehan, S., & Jones, G. (2014). "It is an issue of not knowing where to go": Service providers' perspectives on challenges in accessing social support and services by immigrant mothers of children with disabilities. *Journal of Immigrant and Minority Health*, *17*(6), 1840–1847. https://doi.org/10.1007/s10903-014-0122-8

Khushalani, J. S., Qin, J., Cyrus, J., Buchanan Lunsford, N., Rim, S. H., Han, X., Yabroff, K. R., & Ekwueme, D. U. (2018). Systematic review of healthcare costs related to mental health conditions among cancer survivors. *Expert Review of*

Pharmacoeconomics & Outcomes Research, *18*(5), 505–517. https://doi.org/10.1080/14737167.2018.1485097

Kreuger, Larry., & Neuman, W. L. (2006). *Social work research methods: Qualitative and quantitative approaches*. Pearson.

Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology*, *30*(4), 668–677. https://doi.org/10.1093/ije/30.4.668

Krieger, N., Williams, D. R., & Moss, N. E. (1997). Measuring social class in us public health research: Concepts, methodologies, and guidelines. *Annual Review of Public Health*, *18,* 341–378. https://doi.org/10.1146/annurev.publhealth.18.1.341

Ku, L. (2006). *Why immigrants lack adequate access to health care and health insurance*. Migration Policy Institute. https://www.migrationpolicy.org/article/why-immigrants-lack-adequate-access-health-care-and-health-insurance

Ku, L., & Matani, S. (2001). Left out: Immigrants' access to health care and insurance. *Health Affairs*, *20*(1), 247–256. https://doi.org/10.1377/hlthaff.20.1.247

Kubzansky, L. D., Sparrow, D., Vokonas, P., & Kawachi, I. (2001). Is the glass half empty or half full? A prospective study of optimism and coronary heart disease in the normative aging study. *Psychosomatic Medicine*, *63*(6), 910–916. https://doi.org/10.1097/00006842-200111000-00009

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. Sage.

Lara, M., Gamboa, C., Kahramanian, M. I., Morales, L. S., & Hayes Bautista, D. E. (2005). Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. *Annual Review of Public Health*, *26*(1), 367–397. https://doi.org/10.1146/annurev.publhealth.26.021304.144615

Lebrun, L. A. (2012). Effects of length of stay and language proficiency on health care experiences among immigrants in Canada and the United States. *Social Science & Medicine*, *74*(7), 1062–1072. https://doi.org/10.1016/j.socscimed.2011.11.031

Leclere, F. B., Jensen, L., & Biddlecom, A. E. (1994). Health care utilization, family context, and adaptation among immigrants to the United States. *Journal of Health and Social Behavior*, *35*(4), 370–384. https://doi.org/10.2307/2137215

Lenz, R. (1988). Jakarta kampung morbidity variations: Some policy implications. *Social Science & Medicine (1982)*, *26*(6). https://doi.org/10.1016/0277-9536(88)90029-9

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health 2013 12:1*, *12*(1), 1–9. https://doi.org/10.1186/1475-9276-12-18

Lin, J. S., Finlay, A., Tu, A., & Gany, F. M. (2005). Understanding immigrant Chinese Americans’ participation in cancer screening and clinical trials. *Journal of Community Health*, *30*(6), 451–466. https://doi.org/10.1007/s10900-005-7280-5

Lindsay, A. C., De Oliveira, M. G., Wallington, S. F., Greaney, M. L., Machado, M. M. T., Freitag Pagliuca, L. M., & Arruda, C. A. M. (2016). Access and utilization of healthcare services in Massachusetts, United States: A qualitative study of the perspectives and experiences of Brazilian-born immigrant women. *BMC Health Services Research*, *16*(1), 467. https://doi.org/10.1186/s12913-016-1723-9

Lofters, A. K., Moineddin, R., Hwang, S. W., & Glazier, R. H. (2011). Predictors of low cervical cancer screening among immigrant women in Ontario, Canada. *BMC Women's Health*, *11*(1), 1–11. https://doi.org/10.1186/1472-6874-11-20/TABLES/3

Lor, M., Xiong, P., Schwei, R. J., Bowers, B. J., & Jacobs, E. A. (2016). Limited English proficient Hmong- and Spanish-speaking patients' perceptions of the quality of interpreter services. *International Journal of Nursing Studies*, *54*, 75–83. https://doi.org/10.1016/j.ijnurstu.2015.03.019

Lu, Y., & Racine, L. (2015). Reviewing Chinese immigrant women's health experiences in English-speaking Western Countries: A postcolonial feminist analysis. *Health Sociology Review*, *24*(1), 15–28. https://doi.org/10.1080/14461242.2015.1006656

Lucas, J. W., Barr-Anderson, D. J., & Kington, R. S. (2011). Health status, health insurance, and health care utilization patterns of immigrant Black men. *American Journal of Public Health*, *93*(10), 1740–1747. https://doi.org/10.2105/AJPH.93.10.1740

Luque, J. S., Soulen, G., Davila, C. B., & Cartmell, K. (2018). Access to health care for uninsured Latina immigrants in South Carolina. *BMC Health Services Research*, *18*(1), 310. https://doi.org/10.1186/s12913-018-3138-2

Mantwill, S., & Schulz, P. J. (2017). Low health literacy and healthcare utilization among immigrants and non-immigrants in Switzerland. *Patient Education and Counseling*, *100*(11), 2020–2027. https://doi.org/10.1016/j.pec.2017.05.023

Marrast, L. M., Zallman, L., Woolhandler, S., Bor, D. H., & McCormick, D. (2014). Minority physicians' role in the care of underserved patients: Diversifying the physician workforce may be key in addressing health disparities. *JAMA Internal Medicine*, *174*(2), 289–291. https://doi.org/10.1001/jamainternmed.2013.12756

Marrow, H. B., & Joseph, T. D. (2015). Excluded and frozen out: Unauthorised immigrants' (non) access to care after US Health Care Reform. *Journal of Ethnic and Migration Studies*, *41*(14), 2253–2273. https://doi.org/10.1080/1369183X.2015.1051465

Marshall, K. J., Urrutia-Rojas, X., Mas, F. S., & Coggin, C. (2005). Health status and access to health care of documented and undocumented immigrant Latino women. *Health Care for Women International*, *26*(10), 916–936. https://doi.org/10.1080/07399330500301846

Martinez, O., Dodge, B., Reece, M., Schnarrs, P. W., Rhodes, S. D., Goncalves, G., Muñoz-Laboy, M., Malebranche, D., van der Polf, B., Nix, R., Kelle, G., & Fortenberry, J. D. (2011). Sexual health and life experiences: Voices from behaviourally bisexual Latino men in the Midwestern USA. *Culture, Health and Sexuality*, *13*(9), 1073–1089. https://doi.org/10.1080/13691058.2011.600461

Medelyan, A. (2021). *Coding qualitative data: How to code qualitative research*. Thematic. https://getthematic.com/insights/coding-qualitative-data/

Menjívar, C. (2002). The ties that heal: Guatemalan immigrant women’s networks and medical treatment. *International Migration Review, 36*(2), 437–466. https://doi.org/10.1111/j.1747-7379.2002.tb00088.x

Merriam-Webster. (n.d.). *Access definition and meaning*. https://www.merriam-webster.com/dictionary/access

Migration Policy Institute. (2014). *The Ethiopian diaspora in the United States*. www.migrationpolicy.org/about/copyright-policy.

Millman, M. (1993). *Access to health care in America*. Institute of Medicine. http://www.nap.edu/catalog/2009.html

Misra, S., Kwon, S. C., Abraído-Lanza, A. F., Chebli, P., Trinh-Shevrin, C., & Yi, S. S. (2021). Structural racism and immigrant health in the United States. *Health Education & Behavior*, *48*(3), 332–341. https://doi.org/10.1177/10901981211010676

Mohanty, C. T. (1984). Under Western eyes: Feminist scholarship and colonial discourses. *Feminist Review*, *2*(3), 333–358.

Mohseni, M., & Lindstrom, M. (2007). Social capital, trust in the health-care system and self-rated health: The role of access to health care in a population-based study.

Social Science and Medicine, *64*(7), 1373–1383. https://doi.org/10.1016/j.socscimed.2006.11.023

Montazer, S., & Wheaton, B. (2011). The impact of generation and country of origin on the mental health of children of immigrants. *Journal of Health and Social Behavior*, *52*(1), 23–42. https://doi.org/10.1177/0022146510395027

Morley, J. (2010). It's always about the epoche'. *Les Collectifs Du Cirp*, *1,* 223–232.

Msengi, C. M., Arthur-Okor, H., Killion, L., & Schoer, J. (2015). Educating immigrant women through social support. *SAGE Open*, *5*(4), 2158244015611935. https://doi.org/10.1177/2158244015611935

NASW. (n.d.). *Code of Ethics: English*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Numeroso, F., Benatti, M., Pizzigoni, C., Sartori, E., Lippi, G., & Cervellin, G. (2015). Emergency physician's perception of cultural and linguistic barriers in immigrant care: Results of a multiple-choice questionnaire in a large Italian urban emergency department. *World Journal of Emergency Medicine*, *6*(2), 111–117. https://doi.org/10.5847/wjem.j.1920-8642.2015.02.005

Nuriddin, A., Mooney, G., & White, A. I. R. (2020). Reckoning with histories of medical racism and violence in the USA. *The Lancet*, *396*(10256), 949–951. https://doi.org/10.1016/S0140-6736(20)32032-8

Okoro, O. N., Hillman, L. A., & Cernasev, A. (2022). Intersectional invisibility experiences of low-income African-American women in healthcare encounters. *Ethnicity & Health, 27*(6), 1290–1309. https://doi.org/10.1080/13557858.2021.1899138

Okoro, O. N., & Whitson, S. O. (2017). HIV risk and barriers to care for African-born immigrant women: A sociocultural outlook. *International Journal of Women's Health*, *9*, 421. https://doi.org/10.2147/IJWH.S129355

Oliphant, S. M. (2015). *The impact of social networks on the immigration experience of Ethiopian Women*. [Catholic University of America].

Olukotun, O., Kako, P., Dressel, A., & Mkandawire-Valhmu, L. (2020). A qualitative exploration of the experiences of undocumented African immigrant women in the health care delivery system. *Nursing Outlook*, *68*(2), 242–251. https://doi.org/10.1016/j.outlook.2019.08.002

Olukotun, O., Mkandawire-Valhmu, L., & Kako, P. (2019). Navigating complex realities: Barriers to health care access for undocumented African immigrant women in the United States. *Health Care for Women International*, 1–20. https://doi.org/10.1080/07399332.2019.1640703

O'Mahony, J., & Donnelly, T. (2010). Immigrant and refugee women's post-partum depression help-seeking experiences and access to care: A review and analysis of the literature. *Journal of Psychiatric and Mental Health Nursing*, *17*(10), 917–928. https://doi.org/10.1111/j.1365-2850.2010.01625.x

O'mahony, J., & Donnelly, T. T. (2010). A Postcolonial Feminist Perspective inquiry into immigrant women's mental health care experiences. *Isssues in Mental Health Nursing*, *31*(7), 440–449. https://doi.org/10.3109/01612840903521971

O'Mahony, J. M., & Donnelly, T. T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in Mental Health Nursing*, *28*(5), 453–471. https://doi.org/10.1080/01612840701344464

O'Mahony, J. M., & Donnelly, T. T. (2013). How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *Journal of Psychiatric and Mental Health Nursing*, *20*(8), 714–725. https://doi.org/10.1111/jpm.12005

Omenka, O. I., Watson, D. P., & Hendrie, H. C. (2020). Understanding the healthcare experiences and needs of African immigrants in the United States: A scoping review. *BMC Public Health*, *20*(1), 27. https://doi.org/10.1186/s12889-019-8127-9

Pandey, M., Maina, R. G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C. R., & Maroof, R. (2021). Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: A qualitative study. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06750-4

Pannell, K., & Altman, M. (2009). Minding the gap: Feminist perspectives on policies affecting immigrant labor in the domestic services industry in Europe. *Cahiers de l'Urmis*, *12*, 1–22. https://doi.org/10.4000/URMIS.810

Pavlish, C. L., Noor, S., & Brandt, J. (2010). Somali immigrant women and the American health care system: Discordant beliefs, divergent expectations, and silent worries. *Social Science & Medicine*, *71*(2), 353–361. https://doi.org/10.1016/J.SOCSCIMED.2010.04.010

Peeters, B., Van Tongelen, I., Duran, Z., Yüksel, G., Mehuys, E., Willems, S., Remon, J. P., & Boussery, K. (2015). Understanding medication adherence among patients of Turkish descent with type 2 diabetes: A qualitative study. *Ethnicity & Health*, *20*(1), 87–105. https://doi.org/10.1080/13557858.2014.890174

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, *19*(2), 127–140. https://doi.org/10.1097/00005650-198102000-00001

Perez, D., Sribney, W. M., & Rodríguez, M. A. (2009). Perceived discrimination and self-reported quality of care among Latinos in the United States. *Journal of General Internal Medicine*, *24*(3 SUPPL.). https://doi.org/10.1007/s11606-009-1097-3

Perreira, K. M., Yoshikawa, H., & Oberlander, J. (2018). A new threat to immigrants' health—The Public-Charge Rule. *New England Journal of Medicine*, *379*(10), 901–903. https://doi.org/10.1056/nejmp1808020

Philbin, M. M., Flake, M., Hatzenbuehler, M. L., & Hirsch, J. S. (2018). State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Social Science & Medicine*, *199*, 29–38. https://doi.org/10.1016/j.socscimed.2017.04.007

Phillips, S. P. (2005). Defining and measuring gender: A social determinant of health whose time has come. *International Journal for Equity in Health*, *4*(1), 1–4. https://doi.org/10.1186/1475-9276-4-11

Pirie, A., & Gute, D. M. (2013). Crossing the chasm of mistrust: Collaborating with immigrant populations through community organizations and academic partners. *American Journal of Public Health*, *103*(12), 2126–2130. https://doi.org/10.2105/AJPH.2013.301517

Pitkin Derose, K., Bahney, B. W., Lurie, N., & Escarce, J. J. (2009). Immigrants and health care access, quality, and cost. *Medical Care Research and Review*, *66*(4), 355–408. https://doi.org/10.1177/1077558708330425

Polanco Walters, F., Anyane-Yeboa, A., & Landry, A. M. (2020). The not-so-silent killer missing in medical-training curricula: Racism. *Nature Medicine*, *26*(8), Article 8. https://doi.org/10.1038/s41591-020-0984-3

Ponce, N. A., Hays, R. D., & Cunningham, W. E. (2006). Linguistic disparities in health care access and health status among older adults. *Journal of General Internal Medicine*, *21*(7), 786–791. https://doi.org/10.1111/j.1525-1497.2006.00491.x

Popovic-Lipovac, A., & Strasser, B. (2015). A Review on changes in food habits among immigrant women and implications for health. *Journal of Immigrant and Minority Health*, *17*(2), 582–590. https://doi.org/10.1007/s10903-013-9877-6

Racine, L. (2003). Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry*, *10*(2), 91–102.

Ramos, A. K., Correa, A., & Trinidad, N. (2016). Perspectives on breast health education and services among recent Hispanic immigrant women in the Midwest: A qualitative study in Lancaster County, Nebraska. *Journal of Cancer Education*, *31*(4), 666–672. https://doi.org/10.1007/s13187-015-0886-0

Ramos Salas, X., Raine, K., Vallianatos, H., & Spence, J. C. (2016). Socio-cultural determinants of physical activity among latin american immigrant women in Alberta, Canada. *Journal of International Migration and Integration*, *17*(4), 1231–1250. https://doi.org/10.1007/s12134-015-0460-y

Read, J. G., & Smith, P. B. (2018). Gender and national origin differences in healthcare utilization among U.S. Immigrants from Mexico, China, and India. *Ethnicity & Health*, *23*(8), 867–883. https://doi.org/10.1080/13557858.2017.1297776

Rhodes, S. D., & Hergenrather, K. C. (2003). Using an integrated approach to understand vaccination behavior among young men who have sex with men: Stages of change, the health belief model, and self-efficacy. *Journal of Community Health*, *28*(5), 347–362. https://doi.org/10.1023/A:1025444629753

Richardson, L. D., & Norris, M. (2010). Access to health and health care: How race and ethnicity matter. *Mount Sinai Journal of Medicine*, *77*(2), 166–177. https://doi.org/10.1002/msj.20174

Ritchie, J., Lewis, J., Nicholls, C., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage.

Roberts, D. A., Abera, S., Basualdo, G., Kerani, R. P., Mohamed, F., Schwartz, R., Gebreselassie, B., Ali, A., & Patel, R. (2021). Barriers to accessing preventive health care among African-born individuals in King County, Washington: A qualitative study involving key informants. *PLOS ONE*, *16*(5), e0250800. https://doi.org/10.1371/JOURNAL.PONE.0250800

Rodríguez, M. A., Vargas Bustamante, A., & Ang, A. (2009). Perceived quality of care, receipt of preventive care, and usual source of health care among undocumented and other Latinos. *Journal of General Internal Medicine*, *24*(3 Sup), S508–S513. https://doi.org/10.1007/s11606-009-1098-2

Rodriguez-Alcalá, M. E., Qin, H., & Jeanetta, S. (2019). The role of acculturation and social capital in access to health care: A meta-study on Hispanics in the US. *Journal of Community Health*, *44*(6), 1224–1252. https://doi.org/10.1007/s10900-019-00692-z

Rogers, R. R. (2004). Race-based coalitions among minority groups: Afro-Caribbean immigrants and African-Americans in New York City. *Urban Affairs Review*, *39*(3), 283–317. https://doi.org/10.1177/1078087403258960

Romanelli, M., & Hudson, K. D. (2017). Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *American Journal of Orthopsychiatry*, *87*(6), 714–728. https://doi.org/10.1037/ORT0000306

Royse, D. D. (David D. (2020). *Research methods in social work*. Cognella Academic Publishing.

Ryvicker, M. (2018). A conceptual framework for examining healthcare access and navigation: A behavioral-ecological perspective. *Social Theory and Health*, *16*(3), 224–240. https://doi.org/10.1057/s41285-017-0053-2

Sabri, B. (2018). Perspectives on factors related to HIV risk and preventative interventions at multiple Levels: A study of African immigrant women survivors of cumulative trauma. *Https://Doi.Org/10.1521/Aeap.2018.30.5.419*, *30*(5), 419–433. https://doi.org/10.1521/AEAP.2018.30.5.419

Salinas, J. J., de Heer, H. D., Lapeyrouse, L. M., Heyman, J. M., & Balcázar, H. G. (2015). Insurance status is a greater barrier than income or acculturation to chronic disease screening in the Mexican origin population in El Paso, Texas. *Hispanic Health Care International*, *13*(4), 197–208. https://doi.org/10.1891/1540-4153.13.4.197

Scharf, D. P., Mathews, K. J., Jackson, P., Hofsuemmer, J., Martin, E., & Edwards, D. (2010). More than Tuskegee: Understanding mistrust about research participation. *Journal of Health Care for the Poor and Underserved*, *21*(3), 879. https://doi.org/10.1353/HPU.0.0323

Schenker, Y., Karter, A. J., Schillinger, D., Warton, E. M., Adler, N. E., Moffet, H. H., Ahmed, A. T., & Fernandez, A. (2010). The impact of limited English proficiency and physician language concordance on reports of clinical interactions among patients with diabetes: The DISTANCE study. *Patient Education and Counseling*, *81*(2), 222–228. https://doi.org/10.1016/j.pec.2010.02.005

Serchen, J., Doherty, R., Atiq, O., & Hilden, D. (2020). Racism and health in the United States: A policy statement from the American College of Physicians. *Annals of Internal Medicine*, *173*(7), 556–557. https://doi.org/10.7326/M20-4195

Sewali, B., Okuyemi, K. S., Askhir, A., Belinson, J., Vogel, R. I., Joseph, A., & Ghebre, R. G. (2015). Cervical cancer screening with clinic-based Pap test versus home HPV test among Somali immigrant women in Minnesota: A pilot randomized controlled trial. *Cancer Medicine*, *4*(4), 620–631. https://doi.org/10.1002/cam4.429

Shafiei, S., Yazdani, S., Jadidfard, M. P., & Zafarmand, A. H. (2019). Measurement components of socioeconomic status in health-related studies in Iran. *BMC Research Notes*, *12*(1), 1–11. https://doi.org/10.1186/S13104-019-4101-Y/FIGURES/1

Socías, M. E., Koehoorn, M., & Shoveller, J. (2016). Gender inequalities in access to health care among adults living in British Columbia, Canada. *Women's Health Issues*, *26*(1), 74–79. https://doi.org/10.1016/j.whi.2015.08.001

Southwell, B. G., Machuca, J. O., Cherry, S. T., Burnside, M., & Barrett, N. J. (2023). Health Misinformation Exposure and Health Disparities: Observations and Opportunities. *Annual Review of Public Health*, *44*(1), null. https://doi.org/10.1146/annurev-publhealth-071321-031118

Staton, L. J., Panda, M., Chen, I., Genao, I., Kurz, J., Pasanen, M., Mechaber, A. J., Menon, M., O'Rorke, J., Wood, J., Rosenberg, E., Faeslis, C., Carey, T., Calleson, D., & Cykert, S. (2007). When race matters: Disagreement in pain perception between patients and their physicians in primary care. *Journal of the National Medical Association*, *99*(5), 532–538.

Tapales, A., Douglas-Hall, A., & Whitehead, H. (2018). The sexual and reproductive health of foreign-born women in the United States. *Contraception*, *98*(1), 47–51. https://doi.org/10.1016/j.contraception.2018.02.003

Tefera, G.M. (2022). Decolonizing social work practice: A case from Ethiopian refugee settings. Journal of Social Service Research, *48*(2) 273-284.

Tefera, G.M. (2022). Toward culturally relevant practice: Combating gender-based violence among refugees in Ethiopia. *Journal of Ethnic and Cultural Diversity in Social Work*, 1-12

Tefera, G.M., Onyeaka, K., Conteh, N., David, I., Kehinde, O., Harvey, I.S. & Majee, W. (2023). COVID-19 and student life: An Ubuntu and resilience perspective on the experiences of African international university students in the United States. *Journal of International Students*, *13*(3)

Tefera, G. M., & Yu, M. (2022). Immigrant Women's Access to Healthcare Services in the United States: A Qualitative Meta-Synthesis. *Journal of Social Service Research*, *48*(2), 285–299. https://doi.org/10.1080/01488376.2022.2035300

Thomas, D. R. (2016). A General Inductive Approach for Analyzing Qualitative Evaluation Data: *American Journal of Evaluation*, *27*(2), 237–246. https://doi.org/10.1177/1098214005283748

Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of Midwifery & Women's Health*, *47*(2), 80–96. https://doi.org/10.1016/S1526-9523(02)00218-0

Touw, S., McCormack, G., Himmelstein, D. U., Woolhandler, S., & Zallman, L. (2021). Immigrant essential workers likely avoided Medicaid and SNAP because of a change to The Public Charge Rule. *Health Affairs, 40*(7), 1090–1098. https://doi.org/10.1377/hlthaff.2021.00059

Tsai, T.I., Lee, S.Y. D., & Yu, W.R. (2018). Impact of a Problem-Based Learning (PBL) health literacy program on immigrant women's health literacy, health empowerment, navigation efficacy, and health care utilization. *Journal of Health Communication*, *23*(4), 340–349. https://doi.org/10.1080/10810730.2018.1445798

Tsianakas, V., & Liamputtong, P. (2002). Prenatal testing: The perceptions and experiences of Muslim women in Australia. *Journal of Reproductive and Infant Psychology*, *20*(1), 7–24. https://doi.org/10.1080/02646830220106767

Tulli, M., Salami, B., Begashaw, L., Meherali, S., Yohani, S., & Hegadoren, K. (2020). Immigrant Mothers' Perspectives of Barriers and Facilitators in Accessing Mental Health Care for Their Children. *Journal of Transcultural Nursing, 31*(6), 598–605. https://doi.org/10.1177/1043659620902812

Turin, T. C., Rashid, R., Ferdous, M., Chowdhury, N., Naeem, I., Rumana, N., Rahman, A., Rahman, N., & Lasker, M. (2020). Perceived challenges and unmet primary care access needs among Bangladeshi immigrant Women in Canada. *Journal of Primary Care and Community Health*, *11*. https://doi.org/10.1177/2150132720952618

Uberoi, N., Finegold, K., & Gee, E. (2010). *ASPE issue brief health insurance coverage and the affordable care act*. ASPE. http://aspe.hhs.gov

Ursua, R., Aguilar, D., Wyatt, L., Tandon, S. D., Escondo, K., Rey, M., & Trinh-Shevrin, C. (2014). Awareness, treatment and control of hypertension among Filipino immigrants. *Journal of General Internal Medicine*, *29*(3), 455–462. https://doi.org/10.1007/s11606-013-2629-4

Vasiliadis, H.-M., Dionne, P.-A., Préville, M., Gentil, L., Berbiche, D., & Latimer, E. (2013). The excess healthcare costs associated with depression and anxiety in elderly living in the community. *The American Journal of Geriatric Psychiatry*, *21*(6), 536–548. https://doi.org/10.1016/j.jagp.2012.12.016

Venters, H., & Gany, F. (2011). African immigrant health. *Journal of Immigrant and Minority Health*, *13*(2), 333–344. https://doi.org/10.1007/S10903-009-9243-X/FIGURES/1

Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science and Medicine*, *75*(12), 2099–2106. https://doi.org/10.1016/j.socscimed.2011.12.037

Wafula, E. G., & Snipes, S. A. (2014). Barriers to health care access faced by Black immigrants in the US: Theoretical considerations and recommendations. *Journal of Immigrant and Minority Health*, *16*(4), 689–698. https://doi.org/10.1007/s10903-013-9898-1

Wang, L. (2018). Healthcare access among immigrants and transnational migrants. In K. Newbold & K. Wilson (Eds.), *A research agenda for migration and health* (pp. 29–49). Edward Elgar Publishing.

https://www.elgaronline.com/abstract/edcoll/9781786438355/9781786438355.00007.xml

Wang, L., & Kwak, M.-J. (2015). Immigration, barriers to healthcare and transnational ties: A case study of South Korean immigrants in Toronto, Canada. *Social Science & Medicine*, *133*, 340–348. https://doi.org/10.1016/j.socscimed.2014.11.039

Wang, Y., McKee, M., Torbica, A., & Stuckler, D. (2019). Systematic literature review on the spread of health-related misinformation on social media. *Social Science & Medicine*, *240*, 112552. https://doi.org/10.1016/j.socscimed.2019.112552

Wasserman, M. R., Bender, D. E., Lee, S.Y., Morrissey, J. P., Mouw, T., & Norton, E. C. (2006). Social support among Latina immigrant women: Bridge persons as mediators of cervical cancer screening. *Springer*, *8*(1). https://doi.org/10.1007/s10903-006-6343-0

Whitt-Glover, M. C. (2019). Diversifying the healthcare workforce can mitigate health disparities. *Journal of Best Practices in Health Professions Diversity*, *12*(1), iii–vi.

Williams, D. R., & Rucker, T. D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review*, *21*(4), 75–90. /pmc/articles/PMC4194634/

Wilson, F. A., & Stimpson, J. P. (2020). Federal and state policies affecting immigrant access to health care. *JAMA Health Forum*, *1*(4), e200271. https://doi.org/10.1001/jamahealthforum.2020.0271

Wittkowski, A., Patel, S., & Fox, J. R. (2017). The experience of postnatal depression in immigrant mothers living in Western countries: A Meta-Synthesis. *Clinical Psychology & Psychotherapy*, *24*(2), 411–427. https://doi.org/10.1002/cpp.2010

Wolf, K. M., Zoucha, R., McFarland, M., Salman, K., Dagne, A., & Hashi, N. (2016). Somali immigrant perceptions of mental health and illness: An ethnonursing study. *Journal of Transcultural Nursing*, *27*(4), 349–358. https://doi.org/10.1177/1043659614550487

World Health Organization. (2010). *A conceptual framework for action on the social determinants of health: Debates, policy and practice, case studies.* WHO.

Yao, N., & Hillemeier, M. M. (2014). Disparities in mammography rate among immigrant and native-born women in the U.S.: Progress and challenges. *Journal of Immigrant and Minority Health*, *16*(4), 613–621. https://doi.org/10.1007/s10903-013-9798-4

Yearby, R., Clark, B., & Figueroa, J. F. (2022). Structural racism in historical and modern US health care policy. *Health Affairs*, *41*(2), 187–194. https://doi.org/10.1377/hlthaff.2021.01466

Yosef, A. R. (2008). Health beliefs, practice, and priorities for health care of Arab Muslims in the United States implications for nursing care. *Journal of Transcultural Nursing*, *19*(3), 284–291. https://doi.org/10.1177/10436596083174

Appendix 1: Interview Guide

Instruction

The interviewer starts the interview by defining primary healthcare to participants. The following definition by Torrey (2022) will be used and additional explanation will be added if needed.

> Primary care is the initial point of contact between a patient and the healthcare system that provides individuals with access to the information and resources they need for optimal health outcomes. You might seek primary care for the following: 1) Illness: For Example, when you notice a new symptom or when you come down with a cold, the flu, or some other infection. 2) Injury: For example, a broken bone, a sore muscle, a skin rash, or any other acute medical problem. 3) Referral: Also, primary care is typically responsible for coordinating your care among specialists and other levels of care. Primary care providers may be doctors, nurse practitioners, or physician assistants. There are some primary care specialties as well. For instance, OB-GYNs, geriatricians, and pediatricians are all primary care doctors. But they also happen to specialize in caring for a particular group of people. (Torrey, 2022, np)[3].

1. Overall, what have your experiences been in accessing primary healthcare in the U.S.?
    - Could you tell me about one or two experiences specifically and how those experiences make you feel by the time?

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[3] Torrey, T. (2022) Differences between primary, secondary, tertiary, and quaternary care. Verywell health. https://www.verywellhealth.com/primary-secondary-tertiary-and-quaternary-care-2615354#:~:text=Primary%20care%20is%20the%20main,specialized%20extension%20of%20tertiary%20care.

    - In what ways did those experiences differ from how you have accessed healthcare in your home country?

2. What is your overall opinion about primary healthcare in the U.S.?
    - What would you do in your home country vis-a-vis if you got sick here in the U.S.?
    - For what reasons would you go visit a healthcare provider in your home country? For what reasons would you visit a healthcare provider in the U.S.? How is the healthcare system different in the U.S. compared to your home country?
    - Would you tell me how easy or difficult it is to navigate the primary health system, and get appointments and treatments?
    - Which aspect of the primary healthcare system has been the most difficult for you to overcome?
3. What barriers/difficulties have you experienced when trying to access primary healthcare services in the U.S.?
    - Was there ever a time in which you needed primary healthcare but didn’t seek it out because of these barriers?
    - Would you tell me how easy or difficult it is to navigate the primary healthcare system?
    - How do you believe these challenges are magnified because you are an immigrant woman?
4. Would you tell me about the impact of your immigration status on your ability to access primary healthcare?

- Tell me about any situation where you are required to show legal documentation to access primary healthcare or are denied services?

5. In what ways do your past experiences and journey to the U.S. affect your access to primary healthcare in the U.S.?
    - Would you tell me about any traumatic experience or mistreatment in the past that is affecting your present decision and experience in accessing primary healthcare services?
    - How easy has it been to get settled into the U.S. community?
6. Would you tell me about times when you were denied access to health services because you are ineligible or meet any criteria?
    - Would you tell me any encounter where you were required extra checks on your eligibility to access healthcare?
7. Can you tell me about a time when you believe you have been treated differently or discriminated against in accessing primary services?
8. Would you tell me about your ability to access, understand and utilize health information (e.g., insurance covered benefits, cost-sharing provisions, coverage limitations, and expectations, filing claims, email or letters from health providers, etc.?
    - Would you tell me about times when you had to use English to communicate and receive primary health services?
    - Would you tell me about the moments you couldn’t communicate well due to language barriers? Tell me about your experience of using an interpreter when seeking healthcare services?

9. Tell me about the impact of any aspect of your culture on your preferences and decisions to access and utilize primary access healthcare?
    - How do you think your own culture contradicts the healthcare procedures in the U.S.
    - Would you tell me how your health habits and behavior influence your ability to access primary healthcare services?
    - Tell me about anything you find culturally and religiously inappropriate when accessing and using primary healthcare services?
10. Can you tell me about your health insurance coverage and how it affects your ability to access primary healthcare?
    - Would you tell me about the times you refrained from accessing primary healthcare services because of cost if there were any?
11. In what ways have you had to problem solve the barriers that you have experienced in accessing primary healthcare services?
    - Would you tell me about the resources to overcome your challenge?
12. What are the things that make it easier for you to meet your primary healthcare needs?
    - Would you tell me about the support you received from your health providers that made your primary healthcare access experience better?
13. Tell me about the social support you have in accessing primary healthcare?
    - Tell me about the support you get from a community, family, or friends in accessing healthcare?

14. What can be done to make access to primary healthcare better for Ethiopian immigrant women?
    - What aspects of the primary healthcare system need improvement to ease access for immigrant women like yourself?
    - What could health providers do differently to accommodate the primary healthcare needs of Ethiopian immigrant women?
    - What policies and regulations should be revised or introduced to overcome barriers to primary healthcare access for Ethiopian immigrant women?

Demographic Questions

Participant ID: ___________________

Date/Time: ______________________

Phone/Zoom/In-person: ___________

Recording number: ________________

1. What is your age? ____________________ years
2. How long have you been in the United States? _______ years
3. Which city do you live in the U.S.? _____________
4. What is your current immigration status?

    ☐ US Citizen: Naturalized

    ☐ Lawful Permanent Resident (Green card holder)

    ☐ Refugee

    ☐ Asylee

    ☐ Temporary Protected Status (TPS)

☐ Other (*please specify*): ______________________________________

5. What languages do you speak? ____________________________________

6. What is your level of English proficiency?

   ☐ No proficiency/no knowledge of English

   ☐ Elementary proficiency

   ☐ Professional working proficiency

   ☐ Full professional proficiency

   ☐ Native/bilingual proficiency

7. What is your relationship status?

   ☐ Divorced or separated

   ☐ Married or living in a partnership

   ☐ Single or never married

   ☐ Widowed

   ☐ Other (*please specify*): ______________________________________

8. If married or live in partnership, do you live with your partner? ☐ Yes ☐ No

9. Do you have children? ☐ Yes ☐ No

10. If yes, how many are your children? _______________

11. If yes, how many of your children live with you?____________

12. How many people live in your household, including yourself? ____________

13. What is the highest degree or level of school you have completed?

    ☐ Some high school, no diploma

    ☐ High school graduate or GED

    ☐ Trade / Technical / Vocational training

    ☐ Some college

    ☐ Graduated college

    ☐ Post graduate study

    ☐ Other__________________

14. Which of the following categories best describes your employment status?

    ☐ Not employed, not looking for work

    ☐ Not employed, looking for work

    ☐ Student

    ☐ Employed, full time

    ☐ Employed, part-time

    ☐ Retired

    ☐ With disability, not able to work

    ☐ Other, specify _____________________________

15. What is your annual household income?

☐ Less than $10,000

☐ $10,000 to $19,999

☐ $20,000 to $29,999

☐ $30,000 to $39,999

☐ $40,000 to $49,999

☐ $50,000 to $59,999

☐ $60,000 to $69,999

☐ $70,000 to $79,999

☐ $80,000 to $89,999

☐ $90,000 to $99,999

☐ $100,000 or more

16. Do you have access to health insurance?

☐ Yes ☐ No

17. If yes, is it ☐ Public ☐ Private

18. If no, how do you cover your primary healthcare costs?

____

19. Have ever accessed or used primary healthcare services in the United States?

☐ Yes ☐ No

20. If yes, how often do you or a member of your family access primary healthcare services?

☐ Not at all

☐ 1-2 times in a year

☐ 3-4 times in a year

☐ 5-6 times in a year

☐ 7-8 times in a year

☐ 9-10 times in a year

☐ 10+ times in a year

21. What are your common health needs/issues? ___________________________

22. How would you rate the primary healthcare services you have been receiving?

☐ Excellent

☐ Very good

☐ Good

☐ Fair

☐ Poor

23. How would you rate your overall health?

☐ Excellent

☐ Very good

☐ Good

☐ Fair

☐ Poor

Appendix 2: Information about the Study and Consent

Dissertation Research Title: Experiences and Challenges of African Immigrant Women in Accessing Primary Health Services in the U.S.: The Case of Ethiopian Immigrant Women

Researcher's Name: Gashaye Melaku Tefera

IRB Number: 2091618

You are being asked to participate in a research study. You must be 18 years of age or older. The purpose of this study is to gain insight into the challenges, experiences, and perspectives of Ethiopian immigrant women in accessing primary healthcare services in the U.S. You are being asked to participate in the study because your experience can help answer the research questions of the study and draw implications that can help inform health policymakers and providers to best serve the needs of Ethiopian immigrant women. Your participation is voluntary. You may refuse to participate or stop at any time, and you will not be penalized for making that decision.

Your participation involves a 45-75-minute-long semi-structured in-depth interview with the researcher via phone, Zoom, or in-person based on your preference. The interview will be audio-recorded, and you have every right not to respond to questions you prefer not to answer. You will also be asked to respond to demographic questions before the interview takes place. Any personal identifying data will be kept confidential, and the information gathered by this study will be stored in the investigator's file and identified by a record ID only. Information contained in your records may not be given to anyone unaffiliated with the study in a form that could identify you without your written consent, except as required by law.

Your verbal consent will be required before you participate in the research.

For questions about the study, please contact Gashaye Melaku Tefera (702 327 2958 or gtefera@mail.missouri.edu). You may contact the University of Missouri Institutional Review Board (IRB) if you have any questions about your rights as a study participant, want to report any problems or complaints, or feel under any pressure to take part or stay in this study. The IRB is a group of people who review research studies to make sure the rights of participants are protected. You can reach them at 573- 882-3181 or muresearchirb@missouri.edu. If you want to talk privately about your rights or any issues related to your participation in this study, you can contact University of Missouri Research Participant Advocacy by calling 888-280-5002 (a free call), or emailing MUResearchRPA@missouri.edu.

You can ask the researcher to provide you with a copy of this consent for your records, or you can save a copy of this consent if it has already been provided to you.

I fully agree to participate in this study and am aware of there are no known risks to participating in this study.

Appendix 3: Recruitment Flyer

Research Participants Needed

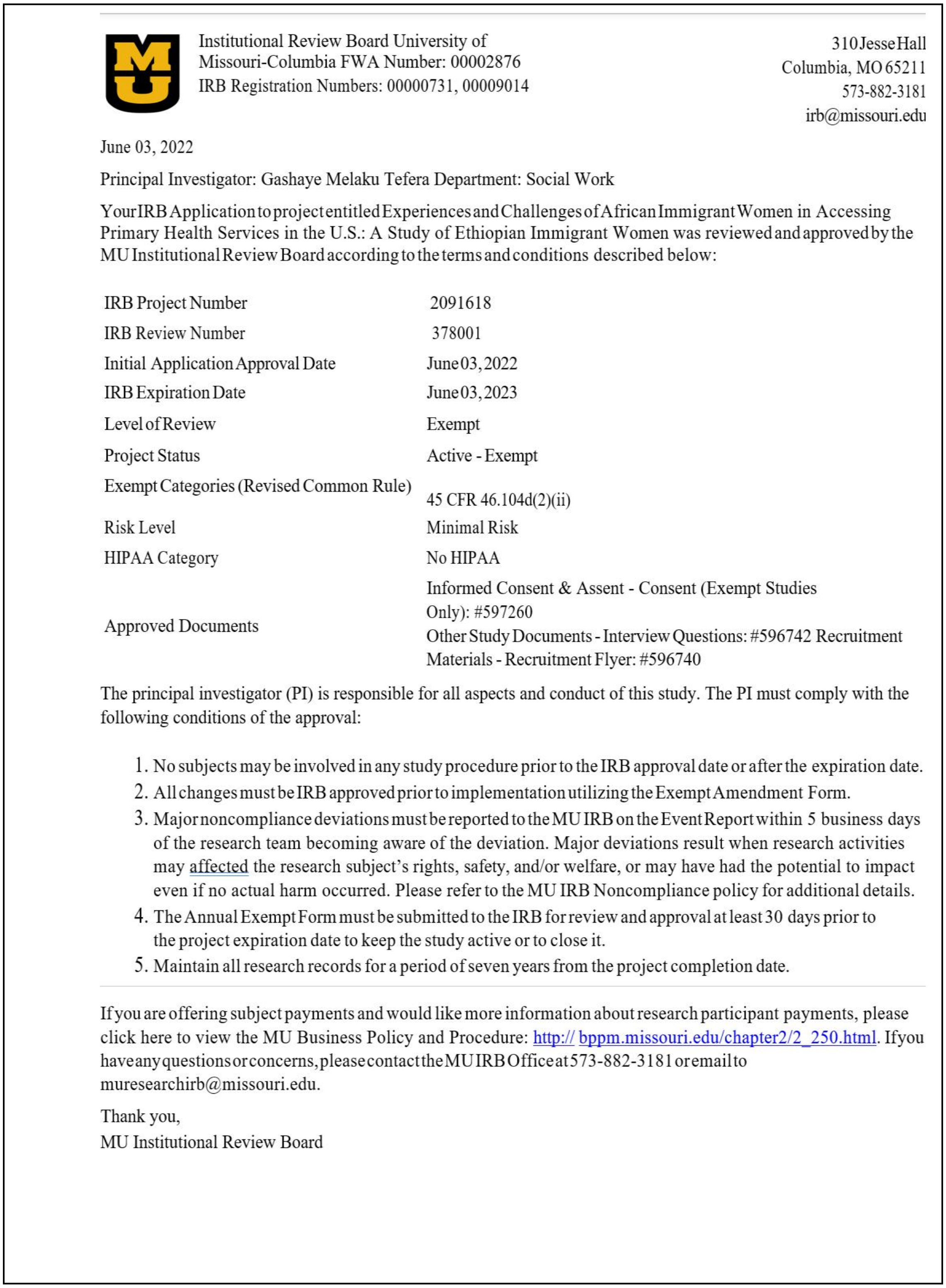
Experiences and Challenges of Ethiopian Immigrant Women in Accessing Primary Health Services in the U.S.

- **Who?** Identify as Ethiopian immigrant, female, age 18 and above, arrived in the U.S. within the last 5 years, speak Amharic or English
- **Why?** To ask questions about your experiences and challenges in accessing primary healthcare.
- **What is involved?** A 60 minutes interview, conducted at your convenience, via phone, Zoom, or in-person.
- **Confidentiality?** Participation in this study is confidential. No identifiable information will be used in the study findings

Questions?
Want to participate?

Contact:
Gashaye M. Tefera
702 327 2958
gtefera@mail.Missouri.edu

Appendix 4: IRB Approval Letter



Institutional Review Board University of
Missouri-Columbia FWA Number: 00002876
IRB Registration Numbers: 00000731, 00009014

310 Jesse Hall
Columbia, MO 65211
573-882-3181
irb@missouri.edu

June 03, 2022

Principal Investigator: Gashaye Melaku Tefera Department: Social Work

Your IRB Application to project entitled Experiences and Challenges of African Immigrant Women in Accessing Primary Health Services in the U.S.: A Study of Ethiopian Immigrant Women was reviewed and approved by the MU Institutional Review Board according to the terms and conditions described below:

IRB Project Number	2091618
IRB Review Number	378001
Initial Application Approval Date	June 03, 2022
IRB Expiration Date	June 03, 2023
Level of Review	Exempt
Project Status	Active - Exempt
Exempt Categories (Revised Common Rule)	45 CFR 46.104d(2)(ii)
Risk Level	Minimal Risk
HIPAA Category	No HIPAA
Approved Documents	Informed Consent & Assent - Consent (Exempt Studies Only): #597260 Other Study Documents - Interview Questions: #596742 Recruitment Materials - Recruitment Flyer: #596740

The principal investigator (PI) is responsible for all aspects and conduct of this study. The PI must comply with the following conditions of the approval:

1. No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date.
2. All changes must be IRB approved prior to implementation utilizing the Exempt Amendment Form.
3. Major noncompliance deviations must be reported to the MU IRB on the Event Report within 5 business days of the research team becoming aware of the deviation. Major deviations result when research activities may affected the research subject's rights, safety, and/or welfare, or may have had the potential to impact even if no actual harm occurred. Please refer to the MU IRB Noncompliance policy for additional details.
4. The Annual Exempt Form must be submitted to the IRB for review and approval at least 30 days prior to the project expiration date to keep the study active or to close it.
5. Maintain all research records for a period of seven years from the project completion date.

If you are offering subject payments and would like more information about research participant payments, please click here to view the MU Business Policy and Procedure: http:// bppm.missouri.edu/chapter2/2_250.html. If you have any questions or concerns, please contact the MU IRB Office at 573-882-3181 or email to muresearchirb@missouri.edu.

Thank you,
MU Institutional Review Board

VITA

Gashaye Melaku Tefera was born and raised in Gimbo town located in Kaffa, Ethiopia, the birthplace of coffee. He completed elementary school at Hibret (Sheda) Elementary School and attended junior and high school at Gimbo Comprehensive Secondary School. After attending the college preparatory program at Bonga Comprehensive Secondary School, he joined the University of Gondar and earned a Bachelor's Degree in Sociology. He then completed the Master of Social Work program at Addis Ababa University and a Diploma in Theology from the Holy Trinity Theological College. Gashaye worked as a sociology and social work lecturer at Jimma and Ambo Universities. He also has vast experience in the non-profit sector in Ethiopia where he developed and managed various projects focusing on women empowerment, education, human rights, and reproductive health. Gashaye was awarded the prestigious Erasmus Mundus scholarship to study in five European countries and completed a Master of Arts Degree in Advanced Development in Social Work from the University of Lincoln, U.K., and Aalborg University, Denmark, and partner universities. Gashaye won the Atlas Corps fellowship to come to the U.S. and serve in the world's largest non-profit, United Way Worldwide.

Gashaye started his Ph.D. study in Social Work at the University of Missouri-Columbia in 2019. He worked as Research Assistant at the Center for Eldercare and Rehabilitation Technology under Dr. Erin Robinson's supervision. Gashaye also has been teaching courses independently as a Teaching Assistant and worked as a Research Assistant to the Ph.D. program Director Dr. Virginia Ramseyer Winter. He served as a student representative in the Ph.D. Program Committee and a member and student contributor at the Center for Children and Families Across Cultures. Gashaye's dissertation research focused on access to health services among immigrant women under Dr. Mansoo Yu's advisership. His research interest also includes health disparities among vulnerable populations, gerontological social work, mental health, decolonization, and culturally relevant practice. Gashaye envisions to continue his research endeavor as an Assistant Professor at Florida State University College of Social Work. Gashaye successfully defended his dissertation on April 5, 2023, and graduated from the doctoral program in May 2023. Besides his professional life, Gashaye is a songwriter.