

**Explorations of Black Health in America:
The Effects of Trust on Health Care Utilization between U.S.-Born Black Americans and
Black Foreign-Born African Immigrants**

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Abstract

Historically, those that identify with the African diaspora have had a complicated and understudied relationship with the United States medical system. Available literature makes generalizations related to different populations across the African diaspora because they are all labeled under the “black” racial group. Consequently, this qualitative study investigated the impact of trust on health care utilization between black foreign-born African immigrants, including first and second-generation immigrants, compared to black Americans born in the United States. There were six U.S.-born black American participants and five black foreign-born African immigrants, resulting in a total of eleven in-depth interviews. When evaluating the role of trust in using resources within the healthcare system across both study populations, there seemed to be no clear conclusion on its impact. Some participants considered trust as one of their top three factors influencing how they utilized health care resources, while others indicated that it was not important to them at all. Some participants also noted that trust interacted with their personal identifiers – such as gender, race, and socioeconomic status – and their health care utilization. Additionally, the study revealed a high level of trust in individual providers but not the healthcare system as an institution for U.S.-born black Americans. On the other hand, black foreign-born African immigrants from West Africa had a significantly higher level of trust in the United States healthcare system compared to those from the Central, Eastern, and Southern regions of Africa. While there is variability in trust between the sample populations, participants mentioned that their level of trust in the United States healthcare system and their usage of resources would increase if there was more staff diversity, improvements in cultural competency surrounding different medical practices, and greater accessibility to quality care, especially in low-income communities.

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Introduction

Since the establishment of organized medicine within the United States, there has been a complicated and understudied dynamic between those that identify with the African Diaspora and the United States medical system (American Medical Association. n.d.). This complex relationship has introduced cultural, social, political, and economic factors influencing the perception and usage of resources within the health system for those within that community (National Academies of Sciences, Engineering, and Medicine et al. 2018). In turn, it has become evident that Black individuals in the United States are facing an increase in health disparities, with poorer health outcomes and lower life expectancies (Albert et al. 2010; Arias et al. 2021; Mays, Cochran, and Barnes 2007).

One common assumption is that unequal health service access is the primary driving force for the gaps between life expectancy in different racial and ethnic identity groups (World Health Organization 2019). However, recent racial injustices have suggested that there are more social, cultural, and historical factors linked to medical trust that may play a more significant role in impacting black communities' relationship with the United States healthcare system, especially for those with different backgrounds within black communities (Kennedy, Mathis, and Woods 2007; Omenka, Watson, and Hendrie 2020). For example, black women born in the United States have a growing distrust of the healthcare system because of the injustices and unethical use of black bodies to advance the field of medicine (Zellars 2018). On the other hand, some black immigrants may be more inclined to trust the United States medical community because of the abundant resources and technological advancements found in America that may not be available in their home country (Omenka, Watson, and Hendrie 2020).

The connection between black individuals and the United States medical system becomes further strained when limited work is done to evaluate differences in needs between different identity groups within the African diaspora, specifically U.S.-born black Americans and black foreign-born African immigrants (Omenka, Watson, and Hendrie 2020). A recent 2020 scoping review identified that publicly available literature often groups the two populations together because they fall under the same racial classification, “black.” However, this similarity overshadows key differences, such as religious beliefs, cultural differences, and financial costs, that influence the way each group perceives and uses treatment for their health (Omenka, Watson, and Hendrie 2020).

The impact of trust and the relationship with the United States medical system becomes even more confusing when a study showed that U.S.-born black women are more likely to have a consistent provider they go to for medical needs than African immigrant women. (Ahad et al. 2019). On the other hand, according to the Association of American Medical Colleges, in 2018, there were approximately 45,000 active black- or African American-identifying physicians, but nearly half of those were foreign-born African immigrants (Association of American Medical Colleges 2019; Batalova 2020). These claims raise the possibility that there are far more complexities concerning personal factors that are not being studied when considering health care utilization between the study populations. Moreover, these limitations highlight the need to explore this topic as there have been greater efforts to reduce health care disparities. After the violent racially charged protests due to police brutality in 2020, the apparent differences in experiences during the peak of the coronavirus pandemic, and the constant outpour of reports of racial discrimination at all levels in the medical system, many institutions have started to invest resources into shifting the narrative surrounding health care disparities within black

communities. Yet from what is available, studies fail to include any details on efforts being made to support or evaluate sub-identities within black communities, such as the black foreign-born African immigrant population (Hostetter and Klein 2021; Williams, Chaturvedi, and Gabriel 2020).

Currently, there is extensive general research on how African Americans have low levels of trust in the United States health care system (Kennedy, Mathis, and Woods 2007). However, there is little discussion about how these levels of trust differ based on personal identifiers such as age, beliefs, and socioeconomic class. This statement is true for both study populations, but there is an even greater deficiency in studies about black foreign-born African immigrants. There are currently very few studies reviewing levels of trust toward the health care system as a whole for that community.

As a result, this paper will investigate the impact trust has on healthcare utilization between black foreign-born African immigrants, including first and second-generation immigrants, compared to black Americans born in the United States. Before exploring sociological theories related to health care utilization, I will first provide more background information on the two study populations and their relationship with the United States medical system. Using qualitative interview methods, I will evaluate the role of trust, if any, experienced in both study groups.

Literature Review

Defining the Black Population

After 1662, the implementation of the “one-drop-rule” in Virginian law required people to identify themselves as a black individual if they had even a “single drop of blood” from black ancestry (Bradt 2010). The legislation was used to preserve white racial purity during the colonial period prior to the birth of the United States of America and persisted until the 20th century (Sharfstein 2006). Consequently, this has led to millions of people automatically being grouped in the black racial category even with a limited percentage of black ancestry (Bradt 2010). Such categorizations make it difficult to clearly identify black communities because we measure blackness in 3 different ways: politically, visually, and culturally (Azuonye 1996).

From a political standpoint, anything associated with the black racial group was represented as inferior or bad in comparison to their white European counterparts. Many used these ideologies to justify the enslavement of other human beings (Azuonye 1996). Secondly, the physical characteristic of having “colored” or darker skin had become an attribute related to being black, despite the fact that brown or black skin tones do not belong to one body of people (Azuonye 1996). The one-drop rule designated those with limited black heritage as black, so visual appearances varied. Subsequently, this led to the development of colorism, “the tendency to perceive or behave toward members of a racial category based on the lightness or darkness of their skin tone” (Hochschild and Weaver 2007; Maddox and Gray 2002:250). Lastly, one’s blackness can be tied to their connection with black culture. As a product of slavery, many black individuals did not initially share the same cultural background (Azuonye 1996). After decades, black culture became a mix of elements connected to the African continent as well as symbols linked with the survival of black people during slavery and the period of systematic oppression

that followed (National Museum of African American History and Culture 2019). These three measures have shaped and generated generations of black people with distinct backgrounds.

Accordingly, past research fails to thoroughly explore different identities that fall under the black racial category. With its unique establishment, it is complicated to outline the black experience in America since it can be affected by personal identities, such as age, country/state origin, gender identity, and more. Thus, before exploring issues related to the study population, it is critical to define who is included in this investigation and why we label racial/ethnic groups the way we do.

Context on the Study Populations

To state it explicitly for this analysis, a black individual is anyone who has African ancestral origins (Agyemang, Bhopal, and Bruijnzeels 2005). According to the U.S. Census Bureau, black or African Americans accounted for 14.2 percent of the United States population in 2020, which is 46.9 million people (Jones et al. 2021). Although the terms black and African American are often used synonymously, they can represent different ethnic groups. African Americans have African ancestral origins, but those who often affiliate themselves with that terminology are descendants of people who entered the Americas through the slave trade prior to the 19th century. Simply put, African Americans can identify as black, but not all black people are African American (Agyemang, Bhopal, and Bruijnzeels 2005). Thus, while continuing to review information related to this study, keep in mind that when the word black is used to describe an individual's racial identification, it is not limited to African Americans.

Additionally, labeling someone as black is mainly done in the western world due to the political and skin color-based racial categories that were developed in the past. In other words,

people outside of the western world may not use the same terminology, identify with the terminology, or understand what it really means to be a black individual after coming from non-predominantly white spaces (Asante 2012).

This investigation examines two significant groups within black communities: individuals born in the United States and foreign-born African immigrants. In 2019, it was reported that 90 percent of black people in the United States were born in the United States, while 10 percent of black people are foreign-born. Out of the 10 percent that are foreign-born, 42 percent of them were born in African nations (Tamir 2021). Despite the fact that the majority of black people in the United States are born in America, differences between each of the study communities must be studied because of four key reasons: there is/are (1) a growing number of people who identify as black in the United States, (2) epigenetic differences between each group, (3) variations in disparities experienced by each group, (4) and inconsistent social and political beliefs.

Historically, black people have always been the minority in the United States of America, but their share in the United States population has grown over the years. For instance, in 2000, 13 percent of the population self-identified as black compared to 14 percent in 2019; this accounts for an increase of 10 million people (Tamir 2021). Likewise, the increase in the black population can also be attributed to the growth in the black immigrant population. After 2000, the population of the foreign-born black African community has risen by 137 percent (Anderson 2017; Tamir 2021).

Alternatively, one may assume that the study populations would share greater health similarities given their shared genomic ancestry (Zakharia et al. 2009). Available research contradicts this assumption and points out several aspects where the health of immigrants ranks

higher than native-born black people. Firstly, black women born in the United States have a more than 50 percent increased risk of preterm birth and low birth weight compared to their foreign-born counterparts (McKenzie-Sampson et al. 2021). Secondly, between 2008 and 2014, 110,452 black adults were reportedly diagnosed with HIV. Of that number, more than 80 percent were U.S.-born black individuals. Additionally, they were more likely to be older and have an infection attributed to heterosexual contact (Demeke et al. 2019). Lastly, African immigrants have the lowest burden of risk factors, including high blood pressure, smoking, diabetes, and obesity (Turkson-Ocran et al. 2020). These examples have cautionary notes that require, when comparing the foreign-born black experience to those of the U.S.-born people, systematic racism and social factors to be accounted for as they are key drivers impacting black Americans' health.

Undoubtedly, it is difficult to continue this discussion without covering the distinct disparities and stressors encountered by U.S.-born and foreign-born black individuals. U.S.-born people are more likely to suffer from racial trauma, while foreign-born immigrants suffer from both migration and racial trauma (Franklin, Boyd-Franklin, and Kelly 2006; Lee and Ahn 2013; León-Gómez Sonet 2020; Smith 2020; Paradies et al. 2013; Priest et al. 2013).

Racial trauma, also known as race-based traumatic stress, is defined as the mental or emotional injury provoked by experiences with racial bias and ethnic discrimination, racism, and hate crimes (Helms, Nicolas, and Green 2010). Those who suffer from race-based discrimination are more likely to present psychological impairments such as post-traumatic stress disorder, especially if they have been subject to the discrimination over a prolonged time (Carter et al. 2013). Negative psychological consequences can display themselves through aggression, low self-esteem, and depression (Carter et al. 2017). Although racism can be endured individually and systematically, systematic racism correlates strongly with racial stressors and socioeconomic

outcomes. For black U.S.-natives, systematic racism can induce a cycle of poor health, violence, economic insecurity, and trauma (Evans 2020). According to researchers, Morsy and Rothstein, black people born in the United States who are low-income and belong to a lower social class – referring to those that have “low parental educational levels, low parental occupational status, the intergenerational persistence of these conditions, and membership in a minority group suffering systematic discrimination” – are more likely to be exposed to frequent life-threatening and traumatic events (2019:8).

On the other hand, foreign-born black immigrants suffer from migration trauma in addition to racial trauma. Migration trauma can be characterized as “traumatic experiences prior to, during and post-migration, [such as] physical assault, sexual assault, detention, persecution and discrimination and being forcibly separated from caretakers” (Abbasi 2015; Erazo 2018:para 4; Perreira and Ornelas 2013). It is challenging to talk about migration trauma specifically for black immigrants because of limited research on the group. In general, a team of researchers discovered that 34 percent of foreign-born adults and 29 percent of foreign-born children endure migration trauma on their journey to the United States. Even though the percentage of people who experience said trauma is minor, these individuals are more at risk for developing post-traumatic stress disorder (Perreira and Ornelas 2013). Moreover, foreign-born black immigrants are also three times more likely to be detained, deported, policed, criminalized, and violated than other immigrant groups (The Movement for Black Lives 2021). Therefore, it is critical to recognize the struggles faced in this community.

Furthermore, a growing literature suggests that although foreign-born black immigrants have a health advantage and protective factors over U.S.-born black individuals, this protection erodes the longer the immigrant stays in the United States. It is hard to measure, but there is

some speculation that this deterioration in health is a result of stress-related pathways such as exposure to racial trauma, economic hardship, discrimination, and social marginalization (Engelman and Ye 2019). A decline in health is also associated with the black immigrant's continent or region of origin. This is shown in a 2011 study that found that African immigrants can also maintain their health advantage for more than 20 years post entering the United States (Hamilton and Hummer 2011).

Based on the current racial climate in the United States, noting the variation in social and political views between the study populations is vital. After the birth of the Black Lives Matter movement in 2013 and the death of George Floyd in May 2020, it has become evident that there is a perceived rift between the two groups (Capatosto 2021; Neuman 2020). More than ever, black immigrants were less likely to self-identify with U.S.-born black individuals. Some would declare, "I am a [insert country or continent of origin] immigrant," rather than associate themselves with black culture, which is synonymously used to describe African American culture (The Immigrant Learning Center 2020). This distinction is established to differentiate class and status from a U.S.-born person. However, while some may not think this is important, the greater society perceives the small change by treating certain community groups differently. Black immigrants are welcomed into spaces with less aversion than U.S.-born black people. Over time, this has led to black immigrants outperforming black Americans in terms of English proficiency and jobs (Okonofua 2013; Rosentiel 2006).

Although some in the immigrant community will not recognize themselves as black, they are put at risk due to black issues in America. Regarding the topic of police brutality, some black immigrants do not side with U.S.-born black Americans as they believe that police brutality is not their problem. However, black immigrants are still viewed as physically similar to U.S.-born

black Americans and can get caught up in the crossfire. Plus, black immigrants can potentially jeopardize their chances of residency if they are considered a threat or violate United States laws (Galvan 2020; Sangal 2020; Smith 2020). Then again, some black immigrants are more willing to stand in support of dismantling systematic racism to ensure equity for all (Neel 2020).

Discrepancies and Barriers Concerning Health Care Utilization

Due to the many differences between the two study populations, this investigation will compare and contrast health care utilization between U.S.-born black Americans and black foreign-born African immigrants. Prior to examining components that have been well studied in the available literature, it is imperative to define health care utilization. According to Carrasquillo (2013),

Health Care Utilization [sic] is the quantification or description of the use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis.

When it comes to the usage of the United States healthcare system, those that fall into the black racial category seem to have worse outcomes than other racial groups (Lopes and Muñana 2020). While there is an apparent need to help improve outcomes of those in the black communities by studying causes and influential factors, publicly available information still struggles to provide representative specifications on different subgroups within black communities. While there is a small body of research that discusses the experience of African immigrants, some of the papers only provide niche results that may not be generalizable to

everyone within that community. For this reason, I will evaluate four major realms that guide health care utilization in the United States for black communities.

Insurance Coverage

It has become common knowledge that insurance impacts Americans' access and usage of medical resources, regardless of their racial and ethnic background. In the novel *Care Without Coverage: Too Little, Too Late*, the Institute of Medicine (US) Committee on the Consequences of Uninsurance discovered that adults without health insurance coverage are less likely to receive preventative and screening services. Additionally, they explicitly state that the presence of health insurance could reduce racial and ethnic disparities concerning preventative and screening care (2002). After years of reporting racial disparities, the Affordable Care Act was instituted in 2014 to help expand health insurance coverage and make it more affordable. Researchers have discovered that black Americans have benefited the most after its implementation (Chen et al. 2016; Robin 2021).

While these data may be optimistic about the future of black health in America, there are no specific details about the immigrant community. Another study indicated that foreign-born black men were more likely to be uninsured than their U.S.-born black counterparts. This led to immigrant men having worse health outcomes due to their lack of healthcare coverage (Lucas, Barr-Anderson, and Kington 2003). In regards to black foreign-born African immigrants, the consequences of not having health insurance pose a bigger problem to their community because the jobs they take do not provide health insurance or do not pay enough for them to afford health care services (Blanas et al. 2015; Omenka, Watson, and Hendrie 2020). Furthermore, those who did have an insurance plan were shocked to find out when their medical treatments and services were not covered under their plan. This then turned to potential out-of-pocket costs and financial

devastation. Some patients have even reported that they are less likely to return to the hospital because it seems fiscally irresponsible to utilize medical resources if nothing is wrong and it turns out they are not sick (Kaplan, Ahmed, and Musah 2013; Omenka, Watson, and Hendrie 2020). While funds from Medicaid have been allocated to care for these communities, research on their well-being and overall health outcomes is inadequate and very new (Artiga and Diaz 2019).

Language Barriers

Growing evidence supports the claim that language barriers indirectly impact the quality of care that patients can receive. Communication plays a big part in delivering medical treatment and patient advocacy, as patients who endure language barriers are more likely to experience adverse events and utilize more health care services (Al Shamsi et al. 2020). This determinant is important for black foreign-born African immigrants due to obvious language differences. There have been reports of patients struggling to translate their health needs to their medical providers, even in emergency circumstances. Some even believe that the language barriers led to them being treated worse due to their provider's negative prejudices (Foley 2005; Omenka, Watson, and Hendrie 2020).

Even though it may not be as clear that a language barrier poses a problem to the black American population because the most commonly spoken language in the community is English, there is burgeoning awareness around African American Vernacular English (AAVE). AAVE is “systematic, rooted in history, and important as an identity marker and expressive resource for its speakers” (Rickford et al. 2015). Outside of the health care system, it has been noted that AAVE can cause discrimination in the search for housing, the education system, and in workplaces (Rickford et al. 2015). These details raise the question of whether or not AAVE may play a role

in communication with medical professionals, resulting in an unofficial language barrier and subsequently affecting healthcare utilization.

Conflicts with Cultural Beliefs

Over the past decade, the United States has made headway in promoting a more culturally competent healthcare system. This means the United States Healthcare system would have the ability to provide quality care to patients with diverse behaviors and beliefs while meeting their needs and respecting their backgrounds (American Hospital Association n.d.; Brach, Hall, and Fitall 2019). There has been a great push in this direction in order to reduce racial and ethnic disparities within the system (American Hospital Association n.d.). There is now extensive research supporting the benefits of having a more culturally competent healthcare system as well as increased rates of satisfaction from patients during their medical visits (Alizadeh and Chavan 2016; Dana 1996; McKesey et al. 2017).

On the other hand, this is another area where literature fails to account for African immigrants. Cultural competency is important especially when many are serving black communities. Even though there have been some papers published on the topic, it has been acknowledged that health care providers that work with African immigrants still face challenges while trying to deliver care. This struggle is related to identifying appropriate resources they need to maintain treatment and understand their cultural needs (Martin et al. 2014). Another area of concern is the frequency with which African immigrants are likely to consult oracles and traditional healers in their home countries by phone or in-person for medical advice. This practice may lead them to delay office visits until their condition worsens to a critical point (Omenka, Watson, and Hendrie 2020). Though there have been some efforts to introduce

programs to support these patients, it is unknown whether or not there has been a significant improvement in the care of foreign-born African immigrants (Martin et al. 2014).

Trust in the United States Healthcare System

Trust is a complex component to examine because there needs to be a greater understanding of what has shifted trust levels in the United States. Historically, black Americans have suffered at the hands of the healthcare system in the name of advancing the field. Several methodologies have been put into practice as a result of unethical experimentation conducted on black bodies (Kennedy, Mathis, and Woods 2007). Accordingly, the vast majority of the U.S.-born black population distrusts the medical system.

The Tuskegee Syphilis Study in 1932 is often referenced as a critical moment in American history that shifted the level of trust in black communities with regard to healthcare (Scharff et al. 2010; Thomas and Quinn 1991). The investigation consists of 600 black men, more than half with syphilis. The men were not informed of their condition and were told they had “bad blood.” During the experiment, penicillin was discovered in 1943. This antibacterial drug can be used to treat syphilis but was not provided to the study participants. The mistreatment continued until 1972, which was 29 years after finding a cure to the medical problem (Center for Disease Control and Prevention 2021; Park 2017). It becomes clear why black Americans distrust medical authorities, but one paper suggests that medical mistrust stems from broader historical and personal experiences rather than the Tuskegee study (Brandon, Isaac, and LaVeist 2005). Such results warrant further exploration as it is possible there could be understudied historical events, like the history of gynecology, that trigger variations in levels of trust (Zellars 2018).

On the contrary, these analyses do not commonly mention black foreign-born African immigrants, but some research explores their experiences in general. For example, some African immigrants distrust the United States healthcare system because they feel unwelcomed in other public spaces (Sellers, Ward, and Pate 2006; Omenka, Watson, and Hendrie 2020). On top of that, some African patients have reported that they do not believe their medical providers have their best interests at heart. They think they may be misused to advance profits in the pharmaceutical industry or be administered bad medicine (Sellers, Ward, and Pate 2006; Omenka, Watson, and Hendrie 2020). It is unclear what triggers these feelings, hence the importance of studying this population in this investigation.

Another added challenge to analyzing trust is that some of the common reasons that affect levels of trust can also significantly impact healthcare utilization. For instance, a lack of cultural competency can deter a person from seeking out medical service, but this lack of cultural competency also decreases the amount of trust the individual has in the medical system, usually due to a negative experience. (Brach, Hall, and Fitall 2019; Kennedy, Mathis, and Woods 2007). Thus, it is complicated to isolate trust as its own factor when studying health care utilization in the study populations. Moreover, there are fewer studied causes that change levels of trust in relation to the healthcare system, such as concerns about privacy, past experience of poor quality of care, mistrust of other institutions, and past experience and expectations of racism and discrimination (Brandon, Isaac, and LaVeist 2005; Jacobs et al. 2006; Komen 2020).

As a result of the previously mentioned factors, this study hopes to expand the literature on which population utilizes healthcare resources more if there is a difference in perceptions of the health care system and, if possible, outline the role trust plays compared to other factors when influencing usage of the health care system.

Theoretical Perspectives on Health Care Utilization

To fully understand users' decision making when it comes to health care utilization, it is best to turn to four theoretical models: Suchman's (1965) model on stages of illness behavior and medical care, Powell's (2016) theoretical framework on African American healthcare utilization, and Andersen's (1995, 2008) behavioral model of health services use alongside Yang and Hwang's (2016) modified version of Andersen's framework.

In Suchman's (1965) five-stage model, he identifies areas of influence when people decide to seek health care when faced with an illness. His framework provides greater insight into health service utilization and fills gaps present in Talcott Parson's 1951 sick role theory model that does not explain variation in behavior for those who are sick (Parsons 2013; Suchman 1965; Yang and Hwang 2016).

The Symptom Experience Stage is the first stage in Suchman's model. At this stage, the person initially realizes that something is wrong. This discovery can result from physical discomfort, cognitive interpretation of symptoms, or fear and anxiety resulting from a mix of physical discomfort and cognitive interpretation. There are two main pathways people end up taking after the realization of the presence of symptoms: denial or a "flight to health" (Suchman 1965).

The second stage is the Assumption of the Sick Role Stage. According to Suchman (1965), this phase is when the individual decides that they are officially sick and need help from a medical provider. During this time, the person looks for information, support, and advice from their personal networks in order to receive confirmation and validation about their presenting symptoms. They also try to find solutions to alleviate their symptoms in the same manner.

In the third stage of the model, known as the Medical Care Contact Stage, the individual makes an active effort to receive a medical diagnosis and treatment from a professional. In other words, the person is shifting from lay-person support in their personal network to getting assistance from the scientific community because there is legitimate cause for them to be concerned about their sickness. However, it is possible that this stage will be delayed or prolonged as the sick person searches for a provider that matches their needs or belief. Moreover, this phase is crucial when evaluating how health care services will be utilized, given the prognosis and recommendations from a provider (Suchman 1965).

Subsequently, the sick individual enters the Dependent-Patient Role Stage, where they transfer control of their illness over to their physician. The sick person now assumes the title of the patient and may follow the treatment directed by their medical provider. While it is highly likely for patients to follow their physician's guidance, they can still be influenced by external factors such as conflicts with administrative, social, psychological, and physical barriers (Suchman 1965).

The final stage of Suchman's (1965) model on illness behavior and medical care is the Recovery or Rehabilitation Stage. In this period, the patient loses their identity as a patient and must assume their existence and responsibilities as a "well" person. The return to being a healthy person can vary because their condition may not have been significant enough for the person to change their lifestyles prior to their illness. On the other hand, the condition may have been serious enough to develop a chronic problem or conclude with a physical impairment that requires continued support from a medical source. For those individuals, the rehabilitation stage includes establishing new relationships and daily routines to accommodate a new lifestyle.

Though Suchman's model encompasses the experience of a sick person, it does not include discussion around accessibility to healthcare resources or how medical resources are delivered (Suchman 1965; Yang and Hwang 2016). Not only that, but this framework does not have any guidelines tailored to black communities, whether that be for black Americans or black African immigrants.

The theoretical framework based on Salloway and Dillon's (1973) work, as extended by Powell (2016), provides a foundation for understanding black Americans' healthcare utilization. Powell's model has four prominent domains. It begins with indicating attitudes and issues that cause black Americans to underutilize health care, such as perception of discrimination, lack of social support, and expected lower quality of care. These problems feed into the second domain of complications related to care like cultural mistrust, perceived barriers, and low perceived efficacy of treatment. All the challenges then generate a reduction in healthcare utilization, which produces poor health outcomes.

To orient readers into having a better awareness of experiences faced by black foreign-born African immigrants, one must review Yang and Hwang's (2016) analytical framework for immigrant health service utilization. They constructed this model based on Andersen's health behavior model, which was first proposed in 1968. His original version underwent several phases of revisions, resulting in a five-phase model, though his core concepts remain the same. These three concepts include: (1) predisposing factors, (2) enabling factors, and (3) need factors (Andersen 1995, 2008; Babitsch, Gohl, and von Lengerke 2012).

The predisposing factors refer to the individual's demographic characteristics, education, occupation, and physiological factors around health beliefs. The enabling factors relate to the individual's wealth status and the price of health care, which can be affected by insurance

coverage. Other enabling factors can include but are not limited to means of transportation, waiting time for health care, locations of health service facilities, and health policies. Lastly, need factors correspond with community health, the perceived need for health services, and an individual's environment or surroundings. All these factors feed directly into health behaviors that become personal health practices and alter the use of health services (Andersen 1995, 2008; Babitsch, Gohl, and von Lengerke 2012).

The 2016 redesign of Andersen's framework by Yang and Huang keeps most of the original core principles but makes some noticeable changes. Yang and Huang (2016) maintained Andersen's predisposing, enabling, and need factors but made them specific to immigrants. They also demonstrate that macrostructural factors, such as government policy and experience of health service utilization in home country prior to emigration, needed to be accounted for to learn how immigrants utilize the United States medical system. One clear difference they make is that macrostructural/contextual factors, predisposing factors, enabling factors, and need factors all directly impact health service utilization. The authors also clearly distinguish that other key concepts can feed and influence other concepts. For example, need factors involve predisposing factors, which later affect health service utilization. It is also possible for health utilization to influence the need for health care. Furthermore, macrostructural/contextual factors can add to the enabling factors. This increased complexity is vital because it establishes that predisposing factors like immigration status and assimilation can change enabling factors such as financial and social resources and transnational access to healthcare. In addition, they underscore that health service utilization in their country of origin can play a part in how immigrants view and use health services in the United States (Yang and Hwang 2016). While Yang and Hwang's (2016)

model does not explicitly deal with African immigrants, it does help highlight some features affecting immigrants that are not mentioned in other frameworks.

Methodology

Interview Data Collection

In order to fully understand how U.S.-born black Americans and black foreign-born African immigrants use medical resources in the United States healthcare system, I took a qualitative approach to collect current thoughts and beliefs on factors influencing their usage. Through one-on-one interviews, I asked a series of questions relating to the participant's demographic background, current utilization of the healthcare system, beliefs surrounding trust in the United States healthcare system, thoughts on influential factors on health care utilization, and suggestions for areas of improvement.

Participants were recruited using three methods: flyers, emails, or social media platforms. When sharing my recruiting materials, I made it clear that participants would need to meet all three of the eligibility requirements to be selected for an interview. The requirements include: (1) being at least 18 years of age, (2) living in the United States, and (3) self-identifying as a U.S.-born black American or as a black foreign-born African immigrant (including first and second-generation immigrants). Failure to meet these qualifications prevented any participation in this investigation. Once an individual had expressed interest in participating in the study, they completed a screening form on Qualtrics that confirmed that they met eligibility requirements prior to the interview being scheduled.

During the initial push to gather interviewees, social media posts gathered the most interest, especially for participants under the age of 25. In order to increase age and regional diversity in my sample, I employed non-probability sampling, specifically convenience and snowball sampling, via email. Promotional emails were sent to student organizations or academic

departments at different undergraduate and graduate institutions that focused on or had access to black, African American, or African populations. Additionally, I asked if the participants could recommend any individual over the age of 50 from their personal networks that fit the eligibility criteria after completing an interview.

Participants

Ultimately, I conducted 11 semi-structured virtual Zoom interviews between March 4, 2022 and March 28, 2022. The average interview time was approximately 42 minutes, but the shortest interview lasted 21 minutes and 18 seconds, and the longest interview was one hour, 32 minutes, and 25 seconds. Of the 11 participants, six identified as U.S.-born black Americans, and five identified as black foreign-born African immigrants. A list of participants with the assigned pseudonyms can be found in Appendix A.

To provide a general description of both study populations, the majority of participants were male (55 percent). The average age of respondents was 28 years of age, but participants' ages ranged from 18 to 48 years old. The highest level of education completed by participants consisted of high school or secondary school (55 percent), bachelor's degree (9 percent), master's (27 percent), and doctorate (9 percent). Please note that secondary school is equivalent to high school; it is an alternative name that is commonly used outside of the United States. Nine out of eleven participants were identified as being in the middle-income socioeconomic class. The other two participants were of a lower-socioeconomic class and were black foreign-born African immigrants. All but one interviewee expressed that they were religious or spiritual. In regard to geographic distribution for the six U.S.-born black Americans, there were two people from the South, two from the West, one from the North, and one from the Midwest. Concerning the geographic distribution of the five black foreign-born African immigrants, two individuals

were from West Africa. One participant each was recruited from the Eastern, Central, and Southern regions of Africa. North Africa was not represented in this study due to participant attrition, even after several attempts to enlist participants who may identify with that community.

Interview Session

At the start of the virtual interview session, I introduced myself, provided a brief summary of the project, read the oral consent out loud, and asked participants whether they consented to participate in the study as well as if they wished to be audio recorded. All interviewees chose to continue with the study and were comfortable with being audio recorded. Afterward, I started the Zoom cloud recording and began the interview questions. The semi-structured interview guide can be found in Appendix B. Once the interview began, I read the questions from the interview guide to help with the discussion. Since the interview guide was semi-structured and contained open-ended questions, it encouraged discussions beyond the prepared interview items. Even though my investigation focused on health care utilization, I chose not to ask explicitly about health conditions due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Participants were able to, and did share medical details, but it was a personal choice.

Participants were welcome to stop the interview at any time and could skip any question they felt uncomfortable answering. Given that the interviews took place over Zoom, I tried my best to emphasize the importance of confidentiality and security so that participants felt at ease sharing their perspectives, practices, and beliefs. After completing the interview, participants were compensated for their time with a \$25 Amazon gift card.

Analytic Procedures

After each interview was completed, I exported the automatic VTT audio transcription file from the Zoom cloud recordings and transferred them to a secure cloud server. All transcripts were then imported into NVivo for coding and analysis. Prior to starting a thorough review of the data, I created a codebook with seven key themes that the responses would relate to: (1) Connection to the Health Care Field, (2) Cultural Competence, (3) Current Level of Trust, (4) Demographic Information, (5) Examples or Personal Anecdotes, (6) Factors Affecting Health Care Utilization, and (7) Future Improvements. I also created sub-nodes, or sub-themes. Refer to Appendix C for a full codebook with descriptions of each category.

Subsequently, when the coding in NVivo was concluded, I summarized important information and drew major conclusions based on a spreadsheet matrix framework method as described in Gale et al. (2013). The matrix sorted interviewees into rows and topics into columns. The majority of topics were a breakdown of demographic information, but it also included brief descriptions of participant's connection to the healthcare field, cultural competence issues, level of trust on a scale from 1 to 10, top three factors affecting health care utilization in the United States, areas of improvement for health systems, and any unique takeaways. The results section explains the findings from the NVivo transcript coding and the matrix.

Results

It is critical to mention that the goal of this investigation was to explore the role of trust, if any, on health care utilization for both U.S.-born black Americans and black foreign-born African immigrants. Not only did this study shed light on this matter, but it also revealed findings on the current level of trust participants have in the United States healthcare system, what factors have impacted levels of trust, and recommendations for health systems on ways to improve trust and utilization of resources by individuals in black communities.

Factors Impacting Health Care Utilization

Following the completion of three interviews, I knew the answer to my research objective was not going to be as straightforward as I had hoped. During the interviews, I explicitly asked my participants, “If you had to rank your top three factors influencing how you utilize health care resources, what would they be? Can you explain why you picked those three factors?” I chose to phrase the question in that manner to prevent any misinterpretations related to leading questions and to understand what comes to participants’ minds first when considering how they approach the healthcare system. If the respondent did not talk about trust when answering the question, I followed up and probed them about their reasoning for not including it on their top three list. Generally, the responses were mixed, but they ultimately fell into one of three categories.

Firstly, across both sample groups, 27 percent perceived trust as one of three factors influencing how they utilized health care resources. Devin, a 48-year-old U.S.-born black American, was the only participant that expressed trust as their number one element. However,

he clarified while answering this question that he did not want to give trust the number one spot because of how trust related to other factors influencing his decision-making process.

They're interconnected. They're not so separate - because of how I think you might feel about my race, there's a trust issue. Because I think you're more interested in money, and you might suggest surgery because you're going to get more money for doing a surgery than trying to heal me some other way. So, a lot of these things lead to the trust. So, I feel trust is an umbrella that encompasses it all, so I'll try to say three other things. But really, number one would be trust, but it's more of a - it filters through everything.

In the end, he ranked trust at the top of the list in his final answer. Gabriel, a 22-year-old U.S.-born black American, had ranked trust number two on his list only after being probed about it. In other words, he quickly changed his answer when reminded that trust was an option for a factor that could be influencing his choices. The last participant, Eric, who is a black foreign-born African immigrant, mentioned trust as his second biggest factor guiding how he utilized healthcare resources, but his answer more closely aligns with the second category of responses.

The second major category encompasses those who claimed trust worked in unison with their personal identifiers –such as gender, race, and socioeconomic status – and their health care utilization. Eric most clearly illustrated this in his response when he said,

When I mentioned race, I kind of just meant, I guess I would have a higher level of trust in someone with the same background as me.

After watching his father receive sub-optimal care due to his accent, the participant negatively perceived the United States healthcare system. Throughout his interview, Eric made it clear that trust in his providers, especially providers that were black or have African heritage, would increase his level of usage of medical resources. Interestingly, this participant also declared that affordability of care mattered more to him than the trust/race relationship.

The majority of participants, 73 percent, fell into the third category, which described those who did not include trust as one of their top three factors influencing their health care utilization in the United States healthcare system. Nevertheless, there are two sub-groups within this category. Some of the respondents said that it does not matter to them at all, while others simply claimed that it is just not one of their top three, but it is something they keep in the back of their minds.

Lance, a U.S.-born black American, was very explicit about how trust was of no importance to him. If he is in need of medical attention, trust would not prevent him from requesting or taking care from a health system.

I mean one I'll just say the urgency of my medical needs, I think is the biggest one because it like if I'm dying or whatever, I'm like 'okay, take me to a hospital.' Ambulance costs? It is what it is at this point. I still have a life to live or whatever. So then yeah, beyond that, I would probably say money, which I would tie to healthcare. I mean insurance, copays, premiums, things like that. Probably second is how much it costs, and then third, I'd probably say, for me, I guess the trust thing is not really a huge one. So, I'd probably say ... quality of the health care because even if I do need something, I'm not going to a clinic or whatever with a one-star rating. If they're just like 'Oh no, this place is ass,' I'm like, 'So I'm just going to waste my money then?' And not fix the problem? ... I definitely am very big on reviews of doctors and facilities and stuff like that, so if that's not up to par, then I can't go.

Similarly, Cecelia, a U.S.-born black American, shared the same sentiment with one exception.

Her response differs from Lance's because she was transparent about her trust in the United States healthcare system.

I feel like I wouldn't include [trust on the list] because I do trust the healthcare system, and I wouldn't expect to go to a doctor and not know what they're talking about or what they're doing. They spend so much time in school and do this every day, so I think there are definitely some doctors you connect with more than others and who are better suited for you, but I wouldn't question their ability to do the job.

Since she had foundational trust in the institution, she believed there was no reason to take trust into consideration. Her parents also reinforced the idea that “if you’re sick or you know something’s wrong, you should go to the doctor” in her from childhood. As a result, it can be inferred that trust plays a part, but it is not the most pressing factor in mind for this participant.

This perspective was not limited to only U.S.-born black Americans. Diane, a black foreign-born African immigrant from West Africa, is an active member of the workforce in the United States healthcare system. She has a unique perspective as she has been a patient and a provider of care. Despite this relationship, the severity of illness carried more weight when deciding whether to access medical resources.

No, trust has not impacted how I utilized the healthcare system in this country because I trust them. [laughs] I trust the system, okay. I trust the system. I have full faith in the – that if I reach out for help or if I go to talk to my doctor that he or she will pay attention to my need. So that hasn’t really been a factor in me accessing care in this country. Or this is where I want to be if I needed help; let’s put it that way.

After it became clear to me that trust did not have as much impact as I expected, I started to track what other factors respondents mentioned during the interview. Excluding trust, participants said financial costs/affordability, race (the race of the individual or race of the provider), gender, disability status, accessibility to care, provider/health system reputation, the severity of illness, socioeconomic status, openness to alternative means, insurance coverage, and family history were among their top three factors influencing how they utilize health care resources. In addition to their top three, a few reported that food accessibility, education and community outreach, and mode of transportation were other important components. Out of all the options, financial costs/affordability was the most common factor mentioned (55 percent of the interviewees) and was the number one factor for five of the participants. Out of the six people who mentioned financial costs/affordability as one of their top three choices, four were black

foreign-born African immigrants. Eric, a black foreign-born African immigrant, had summarized the reasoning best when he said:

Being financially secure would definitely make me more likely to reach out to a doctor if I'm ever feeling sick or something, but being in a - I don't know, like being financially insecure, I would be hesitant to want to visit a doctor knowing that I might have to pay a large sum.

Based on the interviews, money was a concern and barrier for many of the participants at one point in their lives. A 33-year-old U.S.-born black American (Emily), who frequently interacted with health systems, reflected on her past struggles during the interview. She admitted,

That probably was a limiting factor for me in my 20s for how I was interfacing with the medical system. I didn't have money, so I certainly wasn't trying to go to the doctor [laughs]. You know what I mean? Every time you pay a copay, that's money. If you have to go to a specialist, that's more money. If you have to go to urgent care, that's more money. It's a shame that you have to think about that when you are making a decision to get treatment when you don't have money.

Likewise, as conversations continued with my participants, it was hard to discuss costs and financial barriers without mentioning insurance coverage. Several participants stated that they had little understanding of how insurance coverage worked. When they were younger, many believed that if you had insurance and needed to go to a hospital, all of it would be covered. They later found out that their beliefs were incorrect, but they did not fully understand why that was not true and expressed displeasure about the current benefits of insurance coverage. The older participants in both sample populations had a greater understanding simply because they had encounters with the United States medical system that forced them to learn more about it. While they shared personal antidotes containing about them falling ill or needing urgent medical support while worrying over how to pay or who was paying for care, these stories are not included here since they contained potentially identifying information that would threaten confidentiality.

Recommendations for Health Systems

As I was developing my interview guide, I knew I wanted to include a question that focused on areas of improvement for health systems. During this investigation, I not only wanted to point out the fact that there was an issue, but I wanted to discover ways to move forward and improve the current climate for those who were in need. Thankfully, most of the participants had actionable suggestions for health systems. The most reoccurring recommendations included expanding diversity in medical staffing, developing more effective training around different medical practices to increase cultural competency, and providing access to quality care, especially for those who are low income.

In addition to those top three suggestions, there were a handful of other ideas that were presented, but they were only brought up once in all of the interviews. This list includes ending capitalism, making doctors train in different types of hospital settings (rural/low income to metropolitan/high-income settings), creating an easier method for patients to receive a second opinion, providing support for mental health, increasing research, using patient history to make more informed decisions, increasing communications with patients on decision making, reducing the number of bad medical stories that go viral, establishing more outreach and education programs for the general public, practicing more humility, and creating a stronger pipeline for minority students into the medical field.

Level of Trust in the United States Healthcare System

In order to fully understand the full effects of trust, I decided to ask my participants about their level of trust in the United States healthcare system. Although the literature and stories from friends and family gave me a general idea of how U.S.-born black Americans felt, I had little to

refer to for black foreign-born African immigrants. Surprisingly, the interviews revealed new data that contradicts current literature and common presumptions (Sellers, Ward, and Pate 2006; Omenka, Watson, and Hendrie 2020; Zellars 2018).

U.S.-born black Americans have a high level of trust in their individual providers but have very low levels of trust in the United States healthcare system as a medical institution. When I asked them how much they trusted the United States healthcare system on a scale of 1 to 10, the average score was 8.5. Many participants indicated that they trusted their providers because they were more selective when deciding who their providers would be. Simply put, most participants were choosing providers who are racially concordant with their personal identity. Participants on the younger side pointed out that their parents, especially mothers, were more likely to seek out black providers or clinicians to give care. Since those providers shared the same background, it was easy for the participants to feel a higher level of trust because of the expectation that said caregivers could relate to their experiences and understand where they were coming from.

Terry, a 38-year-old U.S.-born black American, acknowledged that he really trusts his black provider because he saw her everywhere. She was a person in his community, and he also connected with her at church. Having an out-of-hospital relationship with his provider meant that he could view her as a trusted figure. It was easy for him to communicate and get care.

Having a black woman as my pediatrician up until I was 17 made a big difference. Man, it made a big difference. I went to school with her granddaughter, you know what I'm saying? She was the homie. I knew where she went to medical school, not that I understood that when I was eight or nine. It was definitely having Dr. [redacted], somebody that I saw all the time, like I saw her every Sunday in church, right. So, it wasn't foreign to - or to feel weird about going to see her and having to do like a finger prick or having her gimme shots and all that stuff.

One participant in the U.S.-born black American sample population did not have a high level of trust in the United States medical system. His reason for distrust related more to his “religious” background. During the interview, Devin did not want to use the word religious, but he said that it was the best way to convey his thoughts in a common language. This participant preferred to use traditional or “alternative,” means of treatment. He was very displeased at how the medical system overprescribes pharmaceutical drugs, especially when they are not essential. He was open about the fact that some of his providers have disrespected him, told him that his beliefs were incorrect, and he was endangering others by choosing not to follow their instructions. Devin had later found some providers who respected his beliefs. Thus, he started to have a higher level of trust in those providers.

Regarding black foreign-born African immigrants, they had a lower level of trust in the United States healthcare system. The average score for the sample population was 6.5. However, that number is misleading. To break down the data more clearly, West Africans have a higher level of trust in the United States medical system than other regions in Africa. In fact, the two people from western Africa had skewed the average score because they gave the ratings of a nine and ten. This differs significantly from other participants who reported scores that range from four to six. Those who have lower levels of trust in the United States medical system had also announced during the interview that the average person from their region had lower levels of trust than them.

I spent extra time during the interview sessions with black foreign-born African immigrants who had a higher level of trust in the United States healthcare system to see what provoked this increased level of trust. The two West Africans were reflective and said that it was because they had seen what resources were available in their home country compared to the

United States. From their answer, it was apparent that the United States had better resources and survival rates. Due to this disparity, the participants had more faith in what doctors and providers can do in the United States. Diane proclaimed that on a scale of one to ten, she trusted the United States healthcare system with a ten because

Being born in [West Africa] and having had some medical experience in [West Africa] and had some medical exposure in [West Africa], before I came to this country. I can definitely see the difference in the healthcare system in the two different countries. And the disparity is there. The difference is there. And obviously, the level at which medicine is being practiced in this country and the level of care that is given to people is quite different to what I'm used to, or what I saw in [West Africa].

The black foreign-born African immigrants who were not as trusting as those from the western regions of Africa mentioned that they do not trust the United States healthcare system due to the fact that there is a lack of respect for different or "alternative" medical practices.

Madeline, a 24-year-old black foreign-born African immigrant from the southern regions of Africa, said, "it's giving witch doctor," when referring to how others may characterize traditional medical practices. She also disclosed the experiences of her father.

I trust science and medicine more than my parents. Sometimes they're like 'ahhh.' There is also kind of a big thing in their culture just like [South Africans], or even in Africa, the whole use of traditional healers, witch doctors, juju, whatever you want to call it. So, a lot of people - and I think low key my dad, he just doesn't tell me, he kind of prefers doing things more traditional like I think he has his own traditional healer person, so he goes to [his home country] for his ailments and whatnot.

Even though the interviewee thinks misinformation spreads while using traditional medicine, she hopes more people take into account that western medicine is not the only treatment available in the world. There are other options, but they are portrayed negatively in the media and in medical encounters.

I suspected more of these concerns to come up in my cultural competency question, but it turns out that some participants have not had any issues regarding cultural competency. When probed about whether their background had been coming up in conversations while using health resources, some participants said it was of no importance since they just wanted to be treated for their disease. However, a few participants did indicate that they wished there were more conversations about diseases that are more common in black patients.

Gabriel, a biracial 22 -year-old, self-identified as a U.S.-born black American. He specified that his experiences closely align with a typical black man. When I inquired if his multicultural background affected the way he approached medical resources, the majority of the time, he said it did not. However, when providers make the assumption that he is only a black man, they fail to provide proper care for diseases that may be more common in his less visible racial background.

I'll say with skincare; skincare has been one of those things that has come up recently because my dad's parents and his brother were recently diagnosed with different cases of [redacted]. So that's something that's in the family, and I think because primary care physicians and dermatologists, you know, they see me as I'm black, so they just don't – nobody is screening me for [redacted], but that's actually very, very much a thing, that is in the family right now apparently. So that's not been something that I would say that has been addressed with cultural competency.

Despite the fact that providers were making assumptions, Gabriel did not see any issue with their actions. Once he revealed his biracial background, providers quickly adjusted and provided him with adequate care during his medical visits. Consequently, he never felt discouraged to utilize medical resources due to his background.

Furthermore, when I asked participants how historical events had impacted their level of trust, some were a little bit confused about whether I was referring to historical events in their

personal life or historical events that have happened on a national level. In the end, most people shared stories of historical events that happened on a national level in the United States, such as the Tuskegee Syphilis Study. On a similar note, the role of discrimination and racism on participants' level of trust did come up in the majority of interviews. Many people cited incidents of racism that have occurred to themselves, people they knew, or people they heard about in the media, all of which have affected their perception of the United States medical system.

I was curious to see how the level of trust has changed over time, and the general pattern for participants went one of two ways. The first category of participants said that their trust has only declined over time. The other group said that they had a high level of trust in the United States healthcare system when they were younger, it went down temporarily, but it has gone back up after having a positive personal encounter while utilizing resources in the healthcare system. Nearly all participants said they had a high level of trust in the United States healthcare system when they were younger because of ignorance. They were unaware of any problems or atrocities that other people were facing. Once they were able to understand the challenges people faced, their level of trust immediately started to decline.

Especially because I haven't had decades on decades of experience, but whenever I was younger, it was so much easier to just trust the healthcare system because it was just a thing that you did. It was only once I started learning more about the history of the healthcare system, and then knowing about what it was like to have social welfare programs, and then what it actually meant to be in those programs, and who benefited from the healthcare system, and also who's not getting health care too. Finding out the corruption as I got older, even though my experiences weren't really experiencing the corruption, but I could still read about it and see it happen. That's when my trust started to decrease from there.

Along with changes in the level of trust over time, the interviews highlighted the issues against minority patients or underserved communities that have yet to be resolved across many institutions in the United States. Within the medical system specifically, there has been an effort

to increase racial diversity, equity, and inclusion efforts in order to help reduce some challenges. When I asked my participants, “In recent years, there has been an increasing effort for racial inclusion and diversity within the medical system. Do you think your level of trust will change in the upcoming years? If so, how so? If not, why not?,” a good number of them said, “no,” or “I hope it does.” None of the participants confidently responded with a “yes, my level of trust will increase.” When explaining their choice, Devin declared,

That’s like a first step. Now, if you had asked me, ‘Am I happy?’ or ‘Do I think that’s moving in the right direction?’ It would be like, ‘Yes, I’m very happy that they’re becoming more diverse and inclusive, and I think that’s a wonderful step in the right direction. But trust is earned. There’s still stuff that has to happen. You gotta have a track record of - especially when... somebody is a liar, and you’ve known that they’ve lied multiple times, for you to believe them is not going to be after one situation, after they found a new mentor or after they converted to some faith. It’s going to take a while of you consistently speaking the truth and me verifying your information, right? I’m still not going to believe; it’s going to take a while of me verifying your information, seeing a difference in your character and culture, before I say this is a truthful person who used to be a liar, right? It just doesn’t happen because - even in that person, it might have happened, but you can’t expect the people around you to accept your new identity, without a track record, so that’s kind of how I feel. I pray this [is a] step in the right direction, but I think they should understand that it’s going to take a track record of honesty and transparency, before people trust like they want to.

For those who did have some hope that the system would improve, many of them did so with concern in their voices. To clarify, these participants responded in a way that translates to “for my sake as a black individual in this country, I hope it improves.”

Additional Findings

Related to both participants’ level of trust and the factors influencing their utilization of healthcare resources in the United States, I questioned my participants about whether they or anyone in their family had a connection to the healthcare field. Six of the participants indicated that they or an individual in their family worked in medicine. Many of those participants except one said that their ties to the system did not significantly impact their decision-making. For those

who did not have any relationship with the United States healthcare system, most interviewees revealed that they did not wish for a stronger connection because it does not affect a daily part of their lives.

Probably because the only time we're utilizing it or interfacing with it is when there is a situation that arises, so yeah, it's not a part of my life/everyday lexicon.

On the other hand, Lance suggested that it might have been nice to have a stronger connection to be more aware of what is going on and what to look out for when going into medical situations.

I'd say, maybe - I guess just like be more informed or just like a direct source like, 'Oh, I feel like this is going on.'

Notably, participants in both populations perceived a higher level of trust in the United States healthcare system when comparing themselves to those who share the same cultural or racial background. There were very few who could accurately elaborate on this discrepancy, but one participant believed that the media played a big part in her understanding of trust in black communities. Based on what was shown in the news and widely shared journal articles, she believed that distrust was an issue for black communities. Then again, she had not seen any of these challenges in real life.

Discussion and Conclusion

Based on the results of the interviews, the role of trust in health care utilization between U.S.-born black Americans and black foreign-born African immigrants is complex. There was not a definitive conclusion for each sample population, but at least half of the interviewees stated that it did not matter to them or was not a part of the top three factors listed as affecting their utilization of health care resources. This lack of consensus when responding to questions of whether trust had any impact on the participants' health care utilization is telling. For example, U.S.-born black Americans had higher levels of distrust of the United States healthcare system overall, however, not of their individual providers. Given the data, it is possible that trust plays a more nuanced role than what the participants expressed and the current literature indicates.

The finding, of which there is nearly complete agreement, is that financial costs and affordability played the most considerable role in impacting how both study populations interacted with the United States healthcare system. The two low-income participants in the study ranked financial costs and affordability as their number one factor. Many of the participants explained that if they cannot afford the care they need, it would bring about more concerns when trying to access treatments.

Moreover, exploring levels of trust in both the U.S.-born black American and black foreign-born African immigrant population was not the leading goal of this project. I chose to analyze this aspect because of the limited and conflicting information that was publicly available. Several discoveries can be extracted from the data. First, it was most apparent that U.S.-born black Americans have a higher level of trust in the United States healthcare system than black foreign-born African immigrants. The data revealed no obvious reason why one group was more trusting than another, but the interviews hinted that it could be due to cultural differences or

communication challenges. The black foreign-born African immigrant population had an overall trust level of 6.5 in the United States healthcare system. Nonetheless, West Africans' responses skewed the level of trust reported for this group of participants. Thus, the average level of trust for black foreign-born African immigrants should be around a 4 instead of a 6.5. It is possible the level of trust of black foreign-born African immigrants could be even lower if the participants' perceptions of their compatriots' levels of trust are accurate.

While the U.S.-born black American population had an overall higher level of trust in the United States healthcare system, it was mainly caused by significantly higher trust levels in their chosen providers. The majority of participants said their providers were racially concordant or had frequently interacted with their family/personal community to a point where the provider was able to build trust over time. Considering what other factors may have influenced levels of trust, most people shared stories of historical events that happened on a national level in the United States, such as the Tuskegee Syphilis Study. The Tuskegee Syphilis Study is a frequently used example in literature when explaining how the distrust started in black communities, mainly among U.S.-born black Americans (Scharff et al. 2010; Thomas and Quinn 1991). To my surprise, this study was referenced by both sample populations. A handful of other historical events were mentioned, but participants could only talk about the Tuskegee Syphilis Study with detail and accuracy.

Research participants made several suggestions for health systems, but the main three recommendations they reported that the United States healthcare system should urgently try to focus on are (1) increasing staff diversity, (2) improving cultural competency surrounding different medical practices, (3) expanding accessibility to quality care, especially in low-income

communities. By doing this, there may be a better relationship between black communities and the United States health care system in the future.

The study had five limitations that may have impacted the results. First, as I was recruiting participants, it was a struggle to get black foreign-born African immigrant adults over the age of 50; and as a result, their perspective is missing from the data. The two main reasons there is a lack of representation from this group are language barriers and inaccessibility issues. Many older black foreign-born African immigrants have limited English proficiency; thus, it would have been difficult to conduct my interviews without a translator (Okafor et al. 2013). Some questions may not have made sense even with a translator since there may not be a direct translation of the words. Hence, the participant may not have fully understood what the interview was asking of them, making it unethical to collect their opinions. Furthermore, there was difficulty in getting access to this community. With minimal technological usage, it was easier to get the child of someone who was 50 and older to participate (Chen, Frennert, and Östlund 2021).

Next, the language barrier was not only an issue in populations 50 and older but also in the entire sample population of black foreign-born African immigrants. Participants were aware that the conversations would be happening in English, but for some of them who had recently immigrated in the last ten years, several of the questions had to be rephrased in order to help with understanding. Eventually, all questions were answered, but there were some challenges in making sure that the participant was able to accurately respond to what they were being asked.

Another complication with the black foreign-born African community was that there was no representation of North Africa. This region was the hardest to connect with during the recruitment process for several reasons. Firstly, the United States government classifies those

from North Africa as white. However, some individuals from that region may not perceive themselves as part of the white racial category (Maghbouleh, Schachter, and Flores 2022). Some self-identify as black North Africans, so it is possible that there was some confusion in eligibility when I required my participants to be black. Furthermore, there is also a perception that North Africa is not considered African (Egbunike et al. 2018). Publicly available literature has sometimes referred to Sub-Saharan Africa as the “true” Africa. Everything north of the Sahara is the Middle East or North Africa, which most closely aligns with the Arabic and Muslim world (Egbunike et al. 2018). Therefore, the sample population of “black foreign-born African immigrants” may not have been seen as applicable to those in North Africa. In the future, the terminology used in recruitment forms should be adjusted to clarify any discrepancies.

The fourth limitation was seen after the first couple of interviews. It became evident that many of my participants had regularly interacted with the United States medical system or had done so prior to the COVID-19 pandemic. The participants who have not seen a physician in a while said they wished they had gone more frequently, but they just have not because of lack of time and fear of the hospital during a pandemic. As a result, some admitted that the accuracy of their reflections might be off due to their inability to remember events past a certain point.

Lastly, due to financial and time restraints, the study population had to be limited to only U.S.-born black Americans and black foreign-born African immigrants. When the idea was initially proposed, my goal was to study the entire African diaspora, including black individuals living in predominantly white countries, black Caribbeans, and black Latinx-identifying individuals. Given that there were so many distinct backgrounds, it would have been hard to navigate all the identities in this short qualitative project.

Henceforth, if more research is done in this area, it needs to target the main limitations of this study. Future research should diversify the target populations and study different ethnic and cultural backgrounds within black communities. Projects should also focus on older adults, especially those over the age of 50. Their perspective will show how their trust has evolved. It would be especially remarkable to hear from those who have lived in the United States during times of de jure racial segregation. In addition, if resources allow, a translator should be available during interviews to collect the perspectives of those with limited English proficiency. I want to emphasize the importance of having a translator or other communication tools because of the complex relationship between foreign-born African immigrants, limited English proficiency, and low socioeconomic status. It is necessary to collect their perspectives to help support those who may need it most. These individuals are less likely to seek out and use medical resources, even when they might need them (Graham et al. 2008; Okafor et al. 2013).

All in all, this work has uncovered some new findings on the use and the unequal access of medical resources across two populations within the African diaspora. Although there is still much work that needs to be done to improve the relationship between the United States healthcare system and black communities, it is imperative that this matter receives more attention in order to better support our underserved communities.

Appendices

Appendix A: Interview Participant List

Participant ID Number	Pseudonym	Sample Population Group	Represented Region	Age	Gender
1	Mike	Black Foreign-Born African Immigrant	Africa - West	18	Male
4	Madeline	Black Foreign-Born African Immigrant	Africa - South	21	Female
6	Kelly	Black Foreign-Born African Immigrant	Africa - East	20	Female
8	Lance	U.S.-Born Black American	United States - West	21	Male
9	Emily	U.S.-Born Black American	United States - West	33	Female
10	Devin	U.S.-Born Black American	United States - Midwest	48	Male
11	Terry	U.S.-Born Black American	United States - South	37	Male
14	Cecelia	U.S.-Born Black American	United States - South	21	Female
17	Diane	Black Foreign-Born African Immigrant	Africa - West	47	Female
18	Eric	Black Foreign-Born African Immigrant	Africa - Central	20	Male
19	Gabriel	U.S.-Born Black American	United States - North	22	Male

Appendix B: Interview Guide

Do you have any questions before we start the interview?

1. *(Demographic Questions)* First, to start this discussion, I just want to learn a little bit more about you. Again, I want to remind you that all your responses are confidential, but please say “I prefer not to answer” if you would like to skip the question.
 - a. What state or country were you born in?
 - i. *[If born outside of the United States]* How long have you been in the United States?
 - b. How old are you?
 - c. What is the highest level of education you have completed?
 - d. What socioeconomic class do you consider yourself a part of? Low-, Middle-, or High-income?
 - e. It is not my intention to delve into your beliefs. However, for research purposes, do you consider yourself to be a religious or spiritual person?
2. *(Current Utilization of the Healthcare System)* Now, I would like for you to think about your utilization of health care system in the United States.:
 - a. How long has it been since your last doctor’s visit or since you have last met with a medical provider?
 - b. In general, what do you usually go to a doctor or medical professional for? Please select one or more options from the choices I am about to read out to you: (a) routine check-ups, (b) follow-ups, (c) lab work, (d) chronic illnesses, and/or (e) acute illnesses.

- i. *[If they do not usually go to a doctor]*, Under what circumstances would you most likely seek out medical help? Your answers can be related to the examples I provided earlier or can be entirely new.
 - a. Do you or anyone in your family have any connection to the health care field?
 - ii. If yes, do you think your perception of the United States Health Care System is affected by this connection?
- 3. *(Current Beliefs Surrounding the Trust in the U.S. Healthcare System)* Next, I will ask you a few questions regarding your trust in the United States healthcare system and how it impacts how you use medical resources. Again, I would like to remind you that if you feel uncomfortable answering any of these questions, you can say you do not know or ask me to skip the question.:
 - a. Although the definition of cultural competency varies, the Health Resources and Services Administration under the U.S. Department of Health and Human Services asserts that “Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations.”
(<https://nccc.georgetown.edu/curricula/culturalcompetence.html>)
 - i. Do you think your provider(s) have lived up to the standard of cultural competency described in the quotation I just read to you?
 - b. Based on your experiences, do you trust medical professionals in the United States healthcare system?
 - i. Does your current level of trust increase or decrease your use of medical services?

- c. Do you think you have the same or different level of trust compared to individuals with similar racial/cultural backgrounds?
 - d. Has your level of trust in medical providers and the U.S. health care system varied over time? Would you please share how your trust has changed?
 - e. What factors influence your level of trust in health care services?
 - i. Do you think anything about your personal identity has influenced your level of trust?
 - ii. Do you think historical events have impacted your level of trust?
 - iii. Do you think discrimination or racism against you or others has affected your trust in the United States health care system?
 - f. In recent years, there has been an increasing effort for racial inclusion and diversity within the medical system. Do you think your level of trust will change in the upcoming years? If so, how so? If not, why not?
4. (*Weight of Influential Factors on Healthcare Utilization*) My next set of questions also deals with some of your perspectives or beliefs on the United States healthcare system, but these next set of questions are only asking about how important you consider these factors related to health care services to be. Again, there are no right or wrong answers.:
- a. Do you think the amount of money you have could affect your usage of health care resources? Please explain your reasoning.
 - b. Do you think other people have trouble using health care services because of their income? If so, which ones, and elaborate on why you believe that.
 - c. To what extent do you think gender plays an impact on using health care services?
 - d. To what extent do you think race plays an impact on using health care services?

- e. To what extent do you think having insurance coverage impacts the usage of healthcare-related services?
 - f. Are there other factors I did not mention that would affect your use of the health care system in the United States?
 - g. If you had to rank your top three factors influencing how you utilize health care resources, what would they be?
 - i. Can you explain why you picked those three factors?
5. (*Suggestions for Areas of Improvement*) Thank you for all the responses that you have provided up until this point. My final question is looking at areas of improvement for the United States health care system.
- a. Without considering any limitations, what would medical providers or healthcare systems need to do to increase your level of trust?
6. Is there anything else you would like to add to our conversation?

Appendix C: NVivo Codebook

Themes	Sub-Nodes	Description
Connection to the Health Care Field		Responses that discussed any relationships to the United States healthcare system in their personal networks.
Cultural Competence	<ul style="list-style-type: none"> • Traditional or Alternative Medical Practices 	Discussions around behaviors, attitudes, and policies that enable effective work in cross-cultural situations during medical encounters.
Current Level of Trust	<ul style="list-style-type: none"> • Change in Trust Over Time • Trust compared to individuals with similar racial or cultural backgrounds • Trust Level in the Upcoming Years 	Discussions referring to participants' level of trust.
Demographic Information	<ul style="list-style-type: none"> • Country or State of Origin • Highest Level of Education • Religious or Spiritual Identification • Socioeconomic Class 	Any references that described the participant's demographic background.
Examples or Personal Anecdotes		Any references brought up by participants while responding to interview questions that related to their personal life or seen in the real world.
Factors Affecting Health Care Utilization	<ul style="list-style-type: none"> • Costs or Income • Discrimination or Racism • Historical Events • Insurance Coverage • Other Factors <ul style="list-style-type: none"> ○ Accessibility ○ Severity of Illness • Personal Identity 	Any references that influenced participants' usage of health care resources.
Future Improvements		Responses that mentioned any suggestions or areas of improvement for the United States healthcare system.

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