

To Seek or Not to Seek:
Examining Health-Seeking Behaviors
among Ethiopian Immigrants in the United States

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ABSTRACT

Existing literature suggests that immigrants underutilize U.S. health care. Care utilization is associated with poor health for both patients and those around them. Current health care research lacks data specific to Ethiopian immigrants and the influences of their health-seeking behaviors. Such research is necessary, as the Trump Administration has made recent efforts in reforming health care and immigration policies. Therefore, the goal of this thesis is to investigate the reasons why Ethiopian immigrants choose and choose not to seek American health care. Past studies have identified (1) language differences with providers and (2) perceived discrimination from providers as barriers and (1) existing insurance coverage and (2) positive word-of-mouth testimonials from social networks as facilitators to health care use for immigrants. These identified factors served as the hypotheses for this thesis. Moreover, focus group methodology was applied to explore these hypotheses. Five focus groups were conducted with a total of 26 Ethiopian patients ($n = 26$) of *Learn and Live Wholistic Health Services*, a public clinic located in Northern Virginia, from July 2017 to August 2017.

The focus group discussions highlighted both hypothesized and emerging themes. Language was not a barrier to health care for participants, but there was variation on characterizing social discrimination as a barrier. Public insurance was a facilitator and private insurance was a barrier to utilization. Positive testimonials were strongly regarded as facilitators. In terms of emerging themes, one's attachment to Ethiopian traditionalism arose as a barrier, while professionalism of U.S. health care was branded a facilitator. This thesis concludes by providing the following policy implications: implementation of health advertisements in Ethiopian immigrant communities, development of tools to solicit Ethiopian ideas, improvement of language services in health facilities, and further health research on Ethiopians immigrants.

INTRODUCTION

The Trump administration has made health care and immigration central foci of U.S. policymaking debates. President Trump, in less than a year in office, initiated a repeal to the Affordable Care Act (Haberman & Pear, 2017), enacted Executive Order 13769 proposing to restrict U.S. entry for immigrants from seven countries (Calamur, 2017), and rescinded Deferred Action for Childhood Arrivals; a program that protects minor-aged undocumented immigrants from deportation (Shear & Davis, 2017). Understanding how these policy efforts may interact to affect life chances is absolutely essential.

Evidence suggests that members of immigrant communities seek health care less than resident populations of host countries. For example, it was found that non-U.S. citizens were less likely to use emergency department services than naturalized and U.S.-born citizens (Tarraf, Vega, & González, 2014). Chi and Handcock (2014) concluded that underutilization, for recent immigrants in California, was driven by underinsurance, financial difficulties, and unfamiliarity with the American health care system. This underutilization not only adversely affects immigrant health (Vaidya, Partha, & Howe, 2011), but also that of host country residents. These and a host of other phenomena have clear implications for public policy. Clark et al. (2011) reported that health care use was significantly correlated with the prevalence of infectious diseases in Azerbaijan. A person's failure to resolve an infectious health issue may leave others susceptible to the illness.

Increased utilization of health care is not universally associated with improved medical outcomes. While underutilization is generally present in immigrant populations, the diverse communities where immigrants reside have varying health outcomes contingent upon age, nativity, and time in the U.S. In 2009, researchers found that non-U.S.-born Mexican immigrants

had lower allostatic loads (a measure of exposure to repeated stressors) than the U.S.-born Mexican immigrant origin population, White Americans, and Black-Americans (Kaestner, Pearson, Keene, & Geronimus, 2009). In most cases, recent immigrants to the U.S. are healthier than native-born American residents (Kaestner et al., 2009). The authors hypothesized that exposure to stressors in the United States comprises immigrant health over time (Kaestner et al., 2009). This research suggests that factors, other than low health care utilization, degrades the health of members of immigrant communities given variation by time and across subsequent generations.

This current study focuses specifically on Ethiopian immigrants. The literature on health care utilization contains little about the experiences of East African immigrants, especially Ethiopians, though these populations are prominent in several metropolitan areas. As of 2015, Ethiopia is the second-leading country of birth for African immigrants in the United States (Anderson, 2017). Existing studies have explored health utilization patterns among Ethiopian immigrants in western countries. Fenta, Hyman, and Noh (2007) found that Ethiopian immigrants and refugees in Canada had poor rates of mental health care use. Chaumba (2011) revealed that underutilization of preventive services leads to poor self-reported health for Ethiopian immigrants in the U.S. However, few studies have analyzed potential contributors to these differences in health outcomes from the perspective of immigrants. This paper utilizes firsthand conversations to evaluate the mechanisms underlying Ethiopian immigrants' medical care utilization behaviors. As a first-generation Ethiopian immigrant, I hope to provide particular insights into this research and community and offer effective recommendations for policymakers and beyond.

DEFINITIONS

Health Care Utilization/Use - refers to one's use of health care services in any medical setting, such as in a hospital, pharmacy, or clinic

Health-Seeking Behaviors - actions that an individual takes to avoid or treat poor health outcomes; can lead to health care utilization/use; usually used interchangeably with *health care utilization/use*

RESEARCH QUESTION

The premise of this thesis research provides context for the following question: *what factors limit and promote health-seeking behaviors among non-American citizen Ethiopian immigrants in the United States?*

THEORETICAL FRAMEWORK

It is important to understand the underlying factors that influence health care utilization. Existing literature has clearly defined variation in utilization rates between migrant and non-migrant communities of host countries. Certain mechanisms affect an immigrant's ability to seek health care. Thus, while there are many reasons why an immigrant would not use health care, there are several reasons why an immigrant might exhibit opposite behaviors. These mechanisms are structural, cultural, and systematic. Researchers have varied on what should be identified as a barrier or a facilitator. However, many have agreed that language differences with providers and perceived discrimination from providers are primary barriers and existing insurance coverage

and positive testimonials from family or friends are primary facilitators of health care utilization for immigrants.

I. Identified Inhibitors to Health Care for Immigrant Populations

a. Language Differences with Providers Affect Immigrant Health Care Decision-Making

Past research suggests underutilization is more prominent in immigrant and minority communities due to language differences between providers and patients. Communication difficulties arise when an immigrant is not adept to a host country's native tongue. For instance, Ochieng (2013) noticed a lack of proficient health knowledge within Black African migrant communities in the United Kingdom due to their inability to converse with providers and their limited English proficiency. Ochineng (2013) administered a questionnaire to Black African migrants to study their health-promoting behaviors. They found that participants with "little" and "no understanding" of English were unsatisfied with translation services for health promotional material (Ochieng, 2013). Consequently, language barriers weakened Black African immigrants' ability to obtain health services (Ochieng, 2013). Though this study did not include a comparison group, these findings are compelling nonetheless. The existence of available translation services does not guarantee its usefulness for migrant patients.

In addition, language can influence patients' perceptions of illness. Maneze, DiGiacomo, Salamonson, Descallar, and Davidson (2015) discovered linguistic and cultural barriers to health care use in Australia. Maneze et al. (2015) found that Filipino immigrants underutilized health care in comparison to other ethnic groups. The study indicated such underutilization was due to language, cultural, and socioeconomic barriers (Maneze et al., 2015). According to Maneze et al. (2015), Filipino immigrants had dissimilar interpretations of medical diagnoses and pathology.

In Filipino native language, *hiya* translates to “personal shame” in relation to health and can hinder utilization, especially for those who are vulnerable (Maneze et al., 2015). In terms of pathology, these immigrants attributed unhealthy behaviors, such as smoking, to uncontrollable consequences from the stress of migration. Filipino immigrants may be less willing to link unhealthy habits to an illness and to seek health services (Maneze et al., 2015). Experts have seen this behavior illustrated in other literature. *The Spirit Catches You And You Fall Down* is a descriptive chronicle about the life of Hmong (an East Asian indigenous population) immigrant family, the Lees, in central California (Fadiman, 1997). The parents of the family have a severely epileptic daughter. Throughout the plot, the Lees fail to properly administer prescription medicine to their daughter even as her health deteriorates (Fadiman, 1997). Language primarily influences their behaviors. In Hmong culture, *qaug dab peg* translates to “epilepsy” and is considered a positive indicator of one’s leadership potential. Thus, Hmong tend to address epilepsy with ambivalence (Fadiman, 1997). Differences in disease interpretations impact how an individual regards their own health.

Studies have associated language dialect to preference for western health care. Research demonstrated that non-English-speaking immigrants are more likely to dislike western approaches to medicine (Alzubaidi, Mc Namara, Browning, & Marriott, 2015). Alzubaidi et al. (2015) explored the health-related decisions of both Arabic-speaking immigrants and Caucasian English-speaking patients in Australia. The researchers found that Arabic-speaking immigrants tended to prolong and purposely delay their access to health care. Several Arabic-speaking immigrants were religious and viewed diseases, such as diabetes, as “pre-determined” (Alzubaidi et al., 2015). As a result, these participants did not prefer to seek care since being ill was seen as being closer to God (Alzubaidi et al., 2015).

Similarly, Whitley, Kirmayer, and Groleau (2006) found noticeable utilization differences between West Indian immigrants and native-born people in Canada. This study's researchers found that the following two factors contributed to their observations: (1) westerners' over-reliance on pharmaceutical medicine and (2) immigrants' saturated belief in the use of traditional and divine interventions. Drummond, Mizan, Brocx, and Wright (2011) discovered that refugee women sought substitutes to western care for addressing specific medical needs. In the study, West African refugees in Western Australia, especially those who were low-income and less-educated, visited outpatient clinics and desired health advice from community leaders, such as traditional healers and religious leaders (Drummond et al., 2011). Alternative providers of medical help, including traditional medicine, could be sources that are exclusively accessible to immigrant communities and augment utilization.

b. Perceived Discrimination from Providers Impacts Immigrant Health Care Decision-Making

Perceived discrimination derives from the opinions of immigrants and is difficult to measure or quantify. Perceived discrimination originates from xenophobia or racism within a host country. Also, such discrimination stems from immigrants' past experiences with a host country's providers and can lead to an avoidance of their health services. As previously mentioned, Alzubaidi et al. (2015) revealed that Arabic-speaking immigrants delayed their visits to health facilities. Arabic-speaking immigrants evaded visits to health clinics for diabetes management even when they had noticeable symptoms (Alzubaidi et al., 2015). According to Alzubaidi et al. (2015), "There appeared to be reluctance and fear among Arabic-speaking participants (immigrants) when they were referred to hospital-based diabetes services, particularly to specialists" (p. 8). Arabic-speaking immigrants believed providers would

intentionally blame them for their sicknesses and accuse them of medication non-adherence (Alzubaidi et al., 2015). Consequently, Arabic-speaking patients favored providers who shared the same race or ethnicity (Alzubaidi et al., 2015). Hacker, Anies, Folb, and Zallman (2015) learned that health system workers, in most countries, have unfairly treated undocumented immigrants due to their immigration status. The conjunction of providers' prejudice and fear of deportation worsens undocumented immigrants' perception about host country health care, which leads to underutilization (Hacker et al., 2015).

Drummond et al. (2011) found related findings even after controlling their analysis for socioeconomic class and educational attainment. Higher-educated refugee women, who had a notable understanding of etiology, concealed their health information from others (Drummond et al., 2011). They feared receiving discriminatory offenses not only from health care actors, but also from family members and friends. Last, discriminatory experiences in health facilities are valid barriers for Latina immigrants in the U.S. (Sheppard, Williams, Wang, Shavers, & Mandelblatt, 2014). Quality of their patient-provider relationships influenced Latina immigrants' view on discrimination in American health care (Sheppard et al., 2014). Therefore, researchers recommend for facilities to strengthen their communication with foreign patients, like hiring and working with multicultural staff (Sheppard et al., 2014).

II. Identified Facilitators to Health Care for Immigrant Populations

a. Existing Insurance Coverage Translates into Health-Seeking Behaviors among Immigrants

Affordability of health services is a facilitator for care use. Access to affordable health insurance positively influences an immigrant's ability to seek health care. Derose, Escarce, and Lurie (2007) emphasized health insurance's monumental impact in stipulating opportunity to

health care. The researchers of this paper highlighted how health insurance scarcity in immigrant communities is largely influenced by one's inability to obtain legal status in the host country. In nations, like the United States, private and public insurers rarely offer non-citizens with health insurance. Suphanchaimat, Kantamaturapoj, Putthasri, and Prakongsai (2015) recognized that immigrants, especially undocumented ones, might choose to not utilize or pay for health services due to their lack of proper insurance. Insurers face a dilemma when denying coverage to uninsured immigrants. Such dilemma is "between ethics and laws that limited immigrants' right to health care" (Suphanchaimat et al., 2015). Immigrants are likely vulnerable yet are more restricted in terms obtaining insurance coverage. In some situations, existing insurance coverage does not promote health-seeking behaviors. Zuckerman, Haley, Roubideaux, and Lillie-Blanton (2004) observed that American Indians/Alaska Natives (AIANs) and Whites had similar rates of utilization and levels of access to health services, regardless of insurance coverage. Health insurance has an indirect relation to utilization if other factors, such as fear or perceived discrimination, outweigh its effect.

b. *Word-of-Mouth about Providers from Networks Impacts Immigrants' Health Actions*

Social networks craft opinions on a variety of subjects regardless of immigrant status. If an immigrant is uninformed about a host country's care, testimonials from friends and family can serve as unique sources of knowledge. The *social network theory* is an underlying concept for these observations. According to this theory, strong ties are relationships in which one can extract useful resources and information while weak ties exhibit less of this pressure (Kim, Kreps, & Shin, 2015). Kim et al. (2015) concluded that strong social networks are facilitators for obtaining health information especially when language barriers deter immigrants' care use.

Social networks are important when they are entwined with foreigners' health care decisions. Deri (2005) contended that social networks are especially useful if an individual is not familiar with the native language(s) of a country. Deri focused on how individuals, who do not speak the Canadian native languages of French or English, gain information about the Canadian health care system. Deri (2005) discovered that social networks positively influenced health-service utilization. According to Deri (2005), "My results show that one's behaviour is affected by the behaviour of others around him for measures of utilization that reflect visits primarily instigated by patients themselves, measures that reflect initial contact with the health care system" (p.1100). Devillanova (2008) determined that an individual's connection to strong social ties reduces the duration of time between their arrival to a new country and their first use of that country's health care by 30 percent. Language diversity of immigrant communities determines how influential social networks are in promoting the significance of health services. Deri (2005) concluded that immigrants' residency in an area where there is one primary language spoken, specifically their native language, promotes these health-seeking behaviors, but only if neighborhood residents have previously used health care. If such residents are not known to utilize care, an area with a high concentration of one primary language discourages health-seeking behaviors.

The information presented highlights a need to explore this topic in-depth and across different immigrant populations. The purpose of this thesis is to investigate and explain health-seeking behaviors among Ethiopian immigrants. In addition, I will compare this thesis's results to the literature.

HYPOTHESES AND OBSERVABLE IMPLICATIONS

Since this research is exploratory and previously unexplored, the hypotheses were drawn from the theoretical framework. Therefore, I hypothesized Ethiopian immigrants would identify insurance coverage and positive word-of-mouth testimonials from social networks as their primary facilitators to seeking health care. Also, they would identify language differences with providers and perceived discrimination from providers as their primary barriers to health care use. Last, I expected un-hypothesized themes to emerge from focus group discussions. A noticeable agreement from a majority of research participants indicated a confirmation of each hypothesis. This subjective approach has limitations.

METHODS

The results of the thesis stem from five focus group discussions conducted from July 2017 to August 2017 with a total of 26 research participants. In addition, the methodology for all analysis was qualitative.

I. Justification for Focus Group Methodology

Focus group methodology promotes a range of opinions from participants on a broad topic. As opposed to interviews and case studies, focus groups allow for data collection in the absence of an expectation for respondents' answers. Focus discussions additionally provide respondents an opportunity to use others' ideas in crafting an individual response. This method forces researchers to consider novel ideas unobserved in existing literature. Focus group methodology is appropriate because this topic has been previously unexplored by scholars.

II. Recruitment Logistics

Recruitment occurred during May 2017 in a clinic within the D.C Metropolitan area (Northern Virginia, Southern-Central Maryland, and Washington D.C.). Samples from the D.C. Metropolitan area were pertinent since it hosts the largest concentration of Ethiopians in the non-African world. Cases from D.C. may have more experiences to share than others. Also, Ethiopians in the D.C. Metro area are concentrated within a small region as opposed to in other cities, like in New York, where Ethiopians are scattered across greater vicinities (see *picture 1* in Appendix).

Participants were recruited at the medical center for *Learn and Live Wholestic Health Services* (abbreviated to *Wholestic Health Services* or *Wholestic*). With two locations in Alexandria, Virginia. *Wholestic Health Services* provides Ethiopians with multi-faceted health services through structural and social means. This clinic attracts many newly-arrived Ethiopian immigrants in the D.C. community. I had prior ties with the co-founder and primary physician of this clinic, Dr. Lishan Kassa. Thus, I had familiarity with *Wholestic's* role in the region. Throughout recruitment, I used a family member as my point of contact because they were a clinic employee and provided me with any necessary resources.

Beginning in May, I visited the clinic and sat in the waiting room of the clinic, where patients were located before and after appointments. I approached patients in the waiting room and introduced myself as according to an oral script (see *script 1* in Appendix). If a patient showed interest, I administered a background introductory form to them. If a participant did not have time to fill out the form, they were free to take my contact information and contact me on their own. Questions on this form (see *form 1* in Appendix) determined a person's eligibility to participate in this study. For eligibility, a participant had to be: (1) a majority of Ethiopian

heritage or descent, (2) over the age of 18, (3) a non-citizen of the United States, but a current or temporary American resident, (4) a previous user of the services provided by *Wholestic Health Services*, and (5) a previous user of the American health care system outside of *Wholestic Health Services*, at least two times in the last five years. There was a non-citizenship requirement because one's ability to receive health care may be augmented or deteriorated by their citizenship status. American citizens are eligible to receive public and private health insurance, which is a recognizable contributor of health-seeking behaviors. The Duke University Institutional Review Board (IRB) [E0131] approved methodology and recruitment tasks on 05 May 2017. An amendment to this IRB protocol was approved on 22 May 2017. The amendment proposed changing the background questionnaire from an electronic to a paper format.

a. Background on “Learn and Live Wholestic Health Services” Clinic

Ethiopian-Americans, Lishan Kassa, MD and Lemlem Tsegaw, MPA, BSN, founded *Learn and Live Wholestic Health Services* as a non-profit in 2012. According to Tsegaw, both established the clinic to help those, in the Ethiopian community who need affordable health care. This facility aims to serve two types of patients, those who are: (1) uninsured and (2) unfamiliar with the American health care system. Thus, all provided services are free. Their mission is to address the physical, psychological, and social features of patient health. Kassa and Tsegaw believe a holistic approach to health is more sustainable and leads to better outcomes. Tsegaw stated, “There's more to physical health and mental health than only diagnosing. If their [patients'] social needs are met, they are less likely to develop long-term health problems.” *Wholestic* not only offers subsidized preventive medical care, but also access to life coaching, family conflict mediations, addiction counseling, parent support groups, and health education

(“Services”, n.d.). Despite lack of external donations, word-of-mouth and local radio advertisements spread awareness about *Wholestic Health Services*. Kassa and Tsegaw consider their work rewarding and look forward to a promising future.

III. Focus Group Participation and Data Collection Logistics

Over 30 people expressed interest in focus group participation. After recruitment, eligible respondents were contacted for time availability. I originally planned to conduct five focus groups, with six individuals in each group (30 participants; $n = 30$). In actuality, I conducted five focus groups, but with varying participant amounts (26 participants; $n = 26$). Before participating, each of the 26 participants signed a consent form (see *consent 1* in Appendix). The 26 participants were compensated with 45 USD in cash for successful completion of the focus group discussion.

Demographic Characteristics of Focus Group Participants

	Group 1 (n = 3)	Group 2 (n = 4)	Group 3 (n = 6)	Group 4 (n = 6)	Group 5 (n = 7)
Age (median)	48	55.5	43	34	58
Age (mean)	55	53.25	43.5	43	56
Age (range)	45-72	35-67	18-76	25-45	33-82
Gender Composition (M = Men) (W = Women)	M: 2 W: 1	M: 3 W: 1	M: 4 W: 2	M: 2 W: 4	M: 3 W: 4

As mentioned previously, I moderated discussions from July 2017 to August 2017. Each session was approximately 1 hour long and conducted in English. Three focus groups occurred at *Wholestic's* medical center in Alexandria, Virginia. The remaining two were conducted in Silver Spring, Maryland. All discussion was audio-recorded and transcribed verbatim. Focus group methodology was semi-structured: there was a predetermined set of questions, but discussion was allowed to fluctuate. The questions asked are located in the Appendix (see *form 2* in Appendix). There were two introductory questions, followed by six core questions.



(Picture of Focus Group Set-Up at *Wholestic* Medical Center in Alexandria, Virginia)



(Picture of Refreshments for Participants in the Waiting Room of *Wholestic* Medical Center in Alexandria, Virginia)

IV. Data Analysis

Analysis consisted of importing transcription data into *NVivo* (an application for qualitative analysis) and developing coding schemes. No specific coding schemes were adapted or used. The various discussion points were organized into major themes and the most common

were highlighted. The eight following themes were acknowledged (*in alphabetical order*): (1) Attachment to Traditional Ethiopian Culture, (2) Family and Friend Networks, (3) Insurance Coverage, (4) Language Compatibility with Providers, (5) Life of Ethiopians in the U.S., (6) Nature of American Health System, (7) Perceived Discrimination from Providers, (8) Personal Factors. Six of these themes will be further examined in the next section. All names of participants were changed for anonymity. In each discussion group, participants were identified with one unique number. These identifiers were changed again after all data collection was completed. Each participant was randomly assigned with two numbers from 1 to 7 and one letter from a to d. These new identifiers are unknown by research participants.

RESULTS

A number of compelling, previously unknown themes pertaining to health-seeking behaviors for Ethiopian immigrants emerged from the five focus groups. These generally fell into five categories. First, participants classified public insurance as a promoter for health care utilization. Second, there was no consensus in terms of Ethiopian immigrants' experience with discrimination from providers. Third, most participants had no prior difficulty in communicating with non-Ethiopian medical staff. Fourth, group members valued social acquaintances' experiences with health care. Fifth, the focus group discussions introduced unexpected and non-theorized factors. Last, though "[sic]" is absent in quotes, all quotes were directly extracted and grammar was unchanged from discussion recordings.

I. Insurance Coverage: *Public Insurance as a Facilitator, Private Insurance as a Barrier*

One central emerging theme discussed in the focus groups was insurance coverage as an influencer of health care decision-making and utilization. This was exhibited in four out of the five focus groups. However, as Participant 73a brought up, it is important to differentiate between the two main types of insurance: (1) public insurance, which is subsidized by the government, such as Medicare (“What is Medicare?”, n.d.), or by third parties, such as *Kaiser Permanente’s Medical Financial Assistance Program* (“Subsidized Care and”, n.d.), and (2) private insurance offered through employers or the health care exchanges. The majority of focus group participants communicated satisfaction with public insurance. Participants who use Kaiser cited the following as benefits of this public service: flexibility in clinic and doctor decision-making, ease in receiving proper health care, subsidized or free coverage of health services, high quantity of Kaiser facilities in the D.C. Metro Area, confidence in visiting health services due to financial assistance in medical expenses, and opportunity of providing coverage for family members. These findings suggest public insurance coverage is a facilitator for these participants and the broader population of Ethiopian immigrants.

Not surprisingly, private insurance coverage produced the opposite effect and posed as a barrier. In these discussions, participants noted their frustrations with and disdain for costly expenses of private insurance. This was particularly the case for unemployed participants whom co-pays were not available. Some noted a preference for no insurance coverage over private insurance coverage due to a fear of debt, especially if they were from a low-socioeconomic status. According to Participant 54b, “I don’t want to get any insurance at all because I have a bad experience, kind of, lot of bills coming all the time.” Participant 43c noted, “...the fear of debt, medical debt has pushed many people to opt out of being without insurance.” Participant

73a hypothesized why this would be the case in Ethiopian immigrant communities. They linked this situation to the universal nature of health care in Ethiopia, where health services allegedly are subsidized or provided for free to all citizens. According to this Participant 73a, newly-arrived immigrants to the U.S. likely have not adjusted to the free market features of health care in the United States. This participant also noted how Ethiopians immigrants might view private insurance as a bad investment, specifically if one is healthy and is paying for unused health services. Participant 73a offered, “Insurance, unless otherwise you're sick, there's nothing that you get, but you are paying more on monthly basis.” They described private insurance as “money, which you don't get money, something out of it, or even return.” This set of finding infers cost and more specifically private insurance may be barriers to health care for Ethiopian immigrants.

Several additional insurance-related factors emerged from these discussions. Chief among these was incurring health care expenses without insurance coverage. This was interpreted as a likely by-product of participants’ preference for no insurance versus private insurance. Despite this general trend, Participant 43a explained how frustrations with uncovered expenses influenced their decision to apply for public insurance through Medicaid. They discussed the impact of periodic visits to the emergency room and how the high costs of these visits illustrated the security that insurance can provide. Though not all were insured, few participants seemed to underestimate the importance of insurance. Most individuals agreed on the vital necessity of insurance coverage, especially in the United States. These participants argued that insurance provides a buffer for the unknown. Participant 66b stated:

And, I have seen this saying somewhere that the purpose of a checkup is to prevent the preventable and to delay the inevitable. So, I see the importance of having health insurance not only for the cure side, but from the preventive side.

Thus, even though much of the conversation discussed the differences between public and private insurance, groups debated on whether people should pay for American health care. The lack of awareness on what one's insurance covers was acknowledged as another barrier in one group. Participant 14c noted that this unawareness could cause a patient to unknowingly forgo using certain medical services. However, more discussion on health care awareness in immigrant communities is needed.

a. Summary of Key Findings: Insurance Coverage

- Public Insurance is a Promoter of Health-Seeking Behaviors
- Common, Public Insurance Option is *Kaiser Permanente's Medical Financial Assistance Program* because it...
 - Allows for Autonomy in Clinic and Doctor Decision-Making
 - Provides Sufficient Health Care at an Affordable Price
 - Is Greatly Accessible and Available in D.C. Metro Area
 - Covers Family Members with Health Insurance
- Private Insurance is a Barrier to Health Care Use
- Many Participants Preferred No Insurance Coverage to Private Insurance Coverage

II. Perceived Discrimination from Providers: *Unclear if a Barrier for Ethiopians*

I observed three types of responses to this discussion on discriminatory experiences in health care: (1) the impossibility of experiencing discrimination in American health care, (2) differences in providers' interactions with patients due to implicit prejudice and cultural clashes, and (3) factors unrelated to ethnicity or language.

a. *Ethiopians Do Not Experience Discrimination in American Health Care*

The focus groups highlighted that Ethiopian immigrants do not readily perceive discrimination in the health care setting for several reasons: (1) they have not personally experienced it, (2) they are not familiar with American racism and categorizations by race, and/or (3) they believe strongly in America's unique tradition to uphold equality.

First, the majority of participants had not experienced any discrimination in the health care setting. In two groups, discussion around this topic was brief because participants had not experienced discrimination. For the remaining groups, regardless of their personal experiences, participants shared narratives of family and friends being mistreated. Also, I suspect people were unwilling to express their true opinions about American health care since they were being audio-recorded. Thus, I cannot conclude these participants do not believe discriminatory actions occur in health care since beliefs are not only crafted from personal experience. I can only conclude that they did not choose to speak about such experiences in this setting. Researchers will need to focus on this phenomenon more closely in the future.

Second, some Ethiopian immigrants perceived discrimination and racism as foreign to their culture; this influenced their responses. Immigrants' experience with discrimination in their home country shaped these responses. According to Participant 73a, there is no racism in Ethiopia due to the absence of European colonization in the country's history. As a result, this absence supposedly blurs racial differentiation and promotes national pride. This participant contended that imbedded pride serves as a so-called "shield" for Ethiopian immigrants because they do not expect to experience racism or discrimination in the U.S., let alone in health care. For example, Participant 73a explained how some Ethiopians immigrants used to racially identify themselves as "Other" as opposed to "Black" in government surveys because of this

inexperience with being a minority. In response, I argue there are similar acts of prejudice in Ethiopia's history, such as colorism (discrimination based on one's color shade), income inequality, and tensions between various tribes. Therefore, researchers must further dissect why some may think discrimination is unique to the United States, how different communities define discrimination in unique ways, and how this mindset shapes their behaviors.

Third, some participants reasoned health care discrimination was not present because the United States was founded on the principles of equality. Participant 45b mentioned, "There is no discrimination especially when you go to the medical treatment, you know, no matter what. If you are a foreigner or American, every peoples they are equal." They also said, "But, I like America. There is no discrimination if you are foreigner, white. They [the U.S.] treating like egg, I can say, you know, it's my word. God bless America. I like it and I love it." Two underlying variables help explain these observed sentiments.

The first factor is that the D.C. Metropolitan Area is a hub of diversity in the United States. Its demography is composed of foreigners from many countries, which may generate cultural acceptance amongst its residents. Participant 35c noted, "You experience racists when you go to predominantly white areas. But, when you live around this area, because there's a diverse group of people, even the doctors are diverse. So, I don't think you will have that [discriminatory] issues." The second factor is that health facilities in the United States are more efficient than those in Ethiopia. Participant 45b mentioned differences in providers' approach towards incoming patients, "If you don't have money, you can't get treatment [in Ethiopia]." Though this contradicts others' claims on subsidized health care in Ethiopia, it nonetheless highlights immigrants' satisfaction with the American system. I noticed many individuals who have resided in the U.S. for less than seven years expressed more happiness with American

providers. It is probable that one's satisfaction with service at American health facilities negatively correlates with their amount of time resided in the United States.

b. Providers Discriminate Ethiopians Based on Race, Ethnicity, or Language

A second response suggests that health care providers discriminate based on race and culture. Some members agreed racial and ethnic discrimination exists in American health care. Participants related past and current racial tensions in United States as primary explanations for this perception. To them, such treatment is expected since hierarchical prejudice is engrained in the history of the U.S. Also, this type of discrimination is inevitable since it is disseminated in American culture. Nevertheless, one mentioned a “harmless” instance of prejudice from providers would not cause them to stop using their services. Participant 54c stated:

I don't know if his [the provider's] bias would affect his knowledge or his treatment. If it does then, I do not want to go to him. But if he's socially biased towards me, but treatment-wise, he's perfectly sound, I wouldn't mind it.

This individual justified their claims by asserting how previous generations in the U.S. underwent torment from others and survived. Participant 35c provided context to America's past role in combatting global incidences of HIV/AIDs. They responded, “The system in general [is racist]. No, even the health care. I mean, how can you send expired [HIV/AIDs] medication to Africa, specifically African countries? So, it's black. Did you get me? Yeah, so it's really in the system.” Though these were authentic sentiments, none of these two participants personally experienced any acts of racial or ethnic discrimination from health providers.

In addition, a patient's race or ethnicity affects how providers not only approach them, but also medically diagnose them. Participant 73a argued most discrimination in America is subtly distributed and observed through the indirect actions of the oppressor. They stated:

So, there is an implicit way of discriminating people. They show you their teeth - no doubt. The Americans, they know how to do it. They giggle and then they give you what they want to give you. That's how they discriminate. They don't tell you in front, I mean, in front of you.

In the case of health care, providers can relinquish their bias in the form of misdiagnosis and over-prescription of unnecessary drugs. The same participant provided an example of doctors prescribing morphine to black patients and not to white patients. With morphine prescriptions, this person claimed racist providers prefer quickly alleviating the symptoms of hospitalized black patients than taking time to analyze the cause of the medical diagnosis. Participant 43a noticed how providers stereotype patients based on their ethnicity or race. They recalled a visit to the hospital in order to address body pain issues. This participant explained:

And, I addressed the nurse what my problem is. And, I don't think they ask to every person, but she [the nurse] asked me if I, if I do hard drugs, street drugs and such things like that. And, I say no of course. But, you know, I don't think they ask that to each patient.

I imagine such stereotyping leads to misdiagnosis and deterioration of patient health as a result of the misdiagnosis. For that reason, researchers need to consider how race intersects with health-seeking behaviors and utilization rates

Lastly, discrimination based on language proficiency was highlighted as barrier. Participant 16c shared their difficulties in communicating with a nurse to explain their discomfort with a given treatment. This led the nurse to gossip openly to others about the participant, who later refused further treatment and left the facility. They believed this would not have happened if they were not a minority or proficient in the English language. According to them, “I feel like that because I'm an Ethiopian or something. Yeah, I feel like that because yeah. If a person who speak your language is, I think, they have a heart to helping you.” Participant 43a had a similar sentiment. They said:

It doesn't matter if you're black, white, or foreigner, but if you speak English and you go to the hospital and you talk to them, to the nurse or to the doctor, they'll, you know, they'll try to help you out as much as they can. But, if you don't speak English and you try to tell them [providers] whatever the problem you have, they're not going to take you seriously unless they see something going on. Unless you like bleeding or, you know, you're on the floor just like panicking.

As I will examine later, miscommunication from language differences affects the accuracy of a medical diagnosis and a patient's preference for Ethiopian providers.

c. Providers Discriminate Ethiopians Not Based on Race, Ethnicity, or Language

Providers discriminate patients based on their insurance coverage. Many people claimed providers offer better health services to patients who have insurance than to those who do not. Participants expressed concern with providers' obsession for maximizing their own wealth.

According to Participant 35c:

...when you go to any clinic or hospital, the first thing they ask you is what? – “Do you have insurance?” That's how they start your treatment. So, based on that, they can bill the insurance company. If you have a better one [insurance], they will do a better testing because the insurance can afford it, to pay for you. If not, you're doomed.

As a person without insurance coverage, this participant conveyed sadness with this reality. These results imply uninsured Ethiopian immigrants may forgo visiting health facilities because of some providers' inability to equally treat all patients.

Second, several participants revealed their unfamiliarity with the U.S. health care system has resulted in maltreatment from American providers. Participant 66b argued this type of discrimination is not a product of racism, but a lack of Ethiopian immigrants' experience with American health care. They spoke, “But, since they [Ethiopian immigrants] are not familiar with the system, they may not sue them [providers who have malpracticed]. But, I take it, you know, not as racism, but lack of experience, lack of skill.” Participant 16c proposed for D.C.-area health facilities to give awareness about the medical system in Ethiopian communities. This group member explained, “And, those health places, they don't give enough awareness for it. We don't

have Amharic magazines and something like that to, like Ethiopian people. We don't have like to, like information, full information about health care and something like that.” They theorized improvements in awareness would combat their own and some Ethiopians’ fear with visiting medical facilities. These findings imply such discrimination is a barrier, but can be alleviated with effective awareness campaigns catered towards Ethiopians immigrants.

As a result of the response variety, I am hesitant to characterize this factor as an explicit barrier to health care use. To more clearly identify whether this a factor would require further research on Ethiopians’ personal history with discrimination. Researchers need to specifically study how an immigrant’s degree of association with the Black race impacts their opinion on discrimination existing in American health care.

d. Summary of Key Findings: Perceived Discrimination from Providers

- Participants Varied on Characterizing Discrimination as a Barrier to Health Care
- Some Participants Denied Existence of Provider Discrimination in U.S. because...
 - America was Founded on Principles of Equality and Acceptance
 - Ethiopians are Not Categorized by Race in their Home Country
 - Certain Ethiopians have Problems Identifying as Black when Arriving to U.S.
- Participants Experienced Discrimination from Providers based on their Insurance Coverage and Unfamiliarity with American Health Care
- Certain Group Members Believed Racial Discrimination is Inevitable in U.S.

III. Language Differences with Providers: *Not A Barrier, Preference for Ethiopian Doctors*

Most group members did not perceive language differences with providers as barriers. Translators and interpreters are available in hospitals and clinics for patients. However, most participants believed these services could be more efficient. Ethiopian immigrant communities strongly prefer doctors who speak Amharic, the national language of Ethiopia.

a. *Participants Can Communicate to American Providers in English*

Participants highlighted the ease in conversing with English-speaking doctors and nurses. Having a non-Ethiopian provider was not a deterrent in seeking health care. Sample responses included:

Anyone who want to go to hospital anytime, we can go and we can communicate with the doctors or somebody or - it's not a problem for us. (Participant 64d)

But, if there isn't anybody around here who doesn't speak Amharic, I would go to the English-speaking doctor and that wouldn't matter for me. I can understand him [the doctor] and he can understand me. There is no difference. (Participant 52d)

Two factors underscore this perception. First, most participants understand English enough to express themselves. Second, translators and interpreters are widely available in the United States. Translators help patients with written material and interpreters help patients with oral communication. Providers are willing to call interpreters and translators over-the-phone if language services are not available in-person. Participant 45b noted, “When I'm here in Virginia, there is a translator in California. They [provider and translator] speak together like that [on the phone].” Two participants recollected non-Ethiopian doctors speaking Amharic. Participant 14c thought language differences were not deterrents to a proper diagnosis. They believed doctors have enough advanced skills to discover a health issue without communicating with the patient. In total, few mentioned difficulty in properly expressing symptoms to English-speaking doctors.

b. *Translator and Interpreter Services Need to be Improved for Ethiopian Community*

Though translators and interpreters are present in health facilities, many deemed improvement of these services as necessary. Participants believed both the quantity and quality of D.C.-area translators and interpreters should increase. In terms of quantity, Participant 73a argued the amount of Amharic interpreters in clinics is smaller than that of interpreters in government settings. This person claimed, “D.C. government has already started interpreter, I mean, interpreting Amharic into English in different government offices. That should work all over.” Participant 43a believed these quantity improvements will be easy to implement since there is rich diversity in the D.C. area and said, “...there's a lot of different races and different backgrounds so I'm sure there's a lot of Ethiopian nurses and doctors in each hospital. Same as any other races.” In terms of quality, Participant 16c noticed the frequency of mistranslation among translators and interpreters. They stated, “And those translators, sometimes, there is mistranslating, a mistranslation. Like, I hear some English and the translator say different.” Inadequate language services were barriers to health care use for participants who had apparent difficulties speaking English.

c. *Ethiopians have a Strong Preference for Amharic-Speaking Ethiopian Providers*

The Ethiopian immigrant community clearly prefers Amharic-speaking Ethiopian doctors or nurses. Two reasons illustrate this phenomenon: (1) ability to express one's symptoms more accurately and (2) embedded ethnic trust and solidarity towards other Ethiopians.

Regarding the first reason, a majority of participants acknowledged Ethiopians' unique descriptions for medical symptoms. Many medical terms in Amharic are not directly translatable in English. Some responses included:

But, you know, when you are telling someone with other language, you may struggle sometimes to describe what you are feeling. I heard, you know, somebody was feeling a constant needling effect, but you cannot say that one in English. Or “the house is going round”, when you say it like that, you know. It is very difficult for us. (Participant 14c)

I used to go to universal clinic where an Ethiopian, Amharic-speaking doctor treats me. And, to be honest, I feel confident and I can express myself and whatever he [the doctor] says, you know, I can easily grasp it. (Participant 66b)

Ethiopian immigrants desire the sense of familiarity in the unfamiliar setting of U.S. health care. In addition to proper expression, patients can ask more questions and be more attentive when utilizing care medical services under an Amharic-speaking doctor. This ethnic preference could decrease incidences of misdiagnosis and mistreatment for Ethiopian patients. Also, group members instilled more trust in Ethiopian providers than any other type of providers. Participant 31d explained, “But, I trust an Amharic speaker more than I trust an English speaker cause I'm comfortable with that part and I can communicate with cause it's my health and it matters more and it's important.” Several agreed with this sentiment; the absence of Amharic-speaking doctors was not a hindrance to seeking care, but its availability was preferred.

One unexpected theme that emerged was some participants' preference for Amharic doctors regardless of provider expertise. Group members recognized that a provider's Amharic-speaking ability does not determine their medical skill. Ethiopian doctors are not always the appropriate providers for Ethiopian patients. Nevertheless, this acknowledgement did not affect the general preference. Participant 16c said, “Sometimes, yeah, we going to wrong doctors to get our language speakers.” Participant 46b claimed, “Sometimes, you know, when we get Ethiopian doctor, now we feel that we are in our country maybe. So, we might think that we are, I will be getting inferior quality treatment.” As I previously noted, Ethiopian immigrants believe Amharic speakers keep their best interests in mind.

d. Summary of Key Findings: Language Differences with Providers

- Language Differences are Not Barriers to Health Care Utilization
- All Participants can Speak and Communicate in English
- Strong Preference for Amharic-Speaking Providers because...
 - Ability to Express Symptoms More Confidently and Accurately
 - Ethiopians Confide in Those from their Culture
- Group Members Unsatisfied with Existing Translator and Interpreter Services

IV. People Networks: Friend or Family's Positive Experience with Care as a Facilitator

Participants highly valued the opinions of others in their Ethiopian community. A friend or family's positive experience with a health facility determines one's decision-making. More than half of all participants prioritized word-of-mouth reviews from acquaintances over professional or online reviews. Two factors explain this preference: (1) family and friends know more about an individual than professionals and (2) collectivist culture ensures trust in others' testimonials.

a. Friends or Family Know and Care about Others More than Professionals

Ethiopian immigrants favor personal recommendations since family and friends better understand their interests. Participants believed professional reviews cater towards patients generically. Such reviews do not incorporate the diversity of patient health statuses. Thus, Participant 72b mentioned, "I would prefer my friend's suggestion. Yeah. Because there are many different reviews, different kinds of reviews." Participant 54c similarly noted:

So, like a Google or Yelp review would be just [for], you know, any person, random person. But, at the very least, this friend knows about me to give a suggestion one way or another. So, that added knowledge for me gives his [a friend's] recommendation more weight.

Health care recommendations from others of the same religion are well appreciated. Some participants preferred to have a care provider with similar beliefs. Though most favored personal opinions, two to three group members looked at professional reviews as supplements to family or friend testimonials. Participant 66b explained:

I will go for the [online] reviews because, you know, my friend is just one person. So, I can only get, you know, one person's opinion. But, when I see the [online] reviews, there are diverse people, different people, different genders, different colors, different races, different experiences. So, I would prefer to follow what the [online] reviews says, not just one review, but I will summarize the reviews.

On the opposite side, Participant 35c believed testimonials were supplements to professional reviews. If they received any expert information about a health facility, this participant would ask for a friend's suggestion. Two participants shared negative experiences with providers who were recommended by family and friends. Nonetheless, group members were still willing to visit a provider at least once based on an acquaintance's opinion.

b. Collectivist Characteristic of Ethiopian Culture Promotes Trust

Moreover, the collectivist nature of Ethiopian communities was a fundamental cause for this preference. Group members explained that Ethiopians are accustomed to incorporating others into their lifestyles. Participant 72b voiced, "In our culture, I think we are more family-oriented, friend-oriented people and that's why we trust with each other in everything that we discuss, especially the health issue. No joke about that." For medical advice, Ethiopian immigrants trust their personal network because they want to better the well-being of others. Participant 52d insisted their family and friends tell them the truth about health care facilities. According to them, "That's what accepted in our [Ethiopian] society and I would take it [medical

advice from acquaintances].” Because of this collectivism, the influence of testimonials on health-seeking behaviors can work in the opposite way. Some mentioned that a friend or family’s negative experience with a certain facility would deter them from visiting it. Participant 52d and 54c would not even attempt using medical services from a place disregarded by friends. As I will discuss later, Ethiopians may focus more on their community’s health-related perceptions than on their own perceptions.

c. Summary of Key Findings: People Networks

- Word-of-Mouth Reviews about Providers are Facilitators to Care Utilization because...
 - Family and Friends Know More about Acquaintances than Providers
 - Ethiopians Highly Value and Trust the Opinions of their Community
- Many Participants Ask Family or Friends for Provider or Clinic Recommendations
- Testimonials from Friends and Family can be Supplements to Professional Reviews
- Two Group Members Only Go to Providers Approved by Family or Friends

IV. Emerging Themes Not Highlighted in Hypotheses

There were numerous subjects that I did not hypothesize or include in my theoretical framework. Near the end of each discussion, I allowed participants to provide any other factors of health-seeking behaviors that they believed were prevalent in the Ethiopian community. Attachment to traditional Ethiopian culture was introduced as a barrier and the positive nature of the American health system was introduced as a promoter. These two themes were organized into two to three subthemes.

a. Attachment to Traditional Ethiopian Culture as a Barrier

The degree to which one adheres to traditional Ethiopian values can negatively determine their health care perceptions and rates of utilization. Adherence to traditional culture comes in three main forms: (1) privacy within the Ethiopian community, (2) alternatives to American technical medicine, and (3) satisfaction with not knowing one's current health status. The more attuned an Ethiopian immigrant is to their traditional culture, the less likely they are to adopt western practices in health care.

i. Privacy and Confidentiality Exists in Ethiopian Immigrant Community

The confidentiality culture in Ethiopia has carried over to the U.S. and impacted how immigrants view the importance of health care. All focus groups highlighted this factor. Its influence intertwines with a multitude of other subjects, such as national pride and mental health. For context, confidentiality refers to an individual's preference to keep personal information to themselves regardless of the situation. Though participants contended privacy is more common in Ethiopia, it exists in immigrant societies of the U.S. Several reasons illustrate this secrecy. First, certain illnesses are more stigmatized than others. Participants noted mental disorders and sexually transmitted diseases (STDs) as the most taboo. Sample responses included:

Mental health in our culture is not sickness. It's not disease or mental disorder. It's really you going wild, you're going crazy. So, just because of that name, perception, they [Ethiopians with mental illnesses] don't say it. They don't even want to take medication. They don't even want to admit that they're sick. (Participant 35c)

For example, if it's a sexually transmitted disease that you have. For Ethiopian person to go to another Ethiopian doctor or another doctor, there's a big shame, guiltiness going on and they [Ethiopians] don't want to go through all that process. (Participant 43a)

As I will analyze in the next section, mental health disorders are typically treated with spiritual alternatives to medicine in Ethiopia. As Participant 16c noted, less stigmatized or severe illnesses

can be addressed by going to the pharmacy and obtaining over-the-counter medicine. People fear isolation from others if disclosing a STD or mental health diagnosis.

Second, some Ethiopians hold national pride, which makes it difficult to admit health weaknesses to others. Participant 35c stated, “We're very proud people by the way. In our culture, - even how can you not tell? You have a doctor, wife, and you can't even tell, you know, tell her [a spouse/wife] about your sickness?” Two group members also shared how American doctors are noticing these behaviors in the Ethiopian community. Participant 46b referred to a situation when their friend visited a health facility. This friend, who was also Ethiopian, refused examination by an American provider. After the refusal, the doctor asked the patient if they were Ethiopian. Participant 35c indicated some doctors in the D.C. area are concerned about the medication adherence of Ethiopian immigrants. This participant said, “They're even, among the American doctors, they're really worried about Ethiopians not taking their medicine. And, they [Ethiopian immigrant patients] lie, seriously. They will come literally and lie.” It may be the case that American providers have been exposed to such privacy culture.

Last, group members blamed their upbringing as a result of confidentiality. These actions are what Ethiopian immigrants are used to. Participant 45b explained, “We [Ethiopians] are ashamed people when grown up, you know. [Parents say] ‘Don't like that!’, ‘Don't tell every people like this!’, ‘Don't open up!’. We grown up like that. But, what can we do? It is culture.” On the same subject, Participant 73a mentioned, “We are not detached from our culture. Our culture has its own limitations like we are not - I mean the way we are grown up, the way we grow up, doesn't push us to go to a doctor.” Therefore, participants acknowledged the disadvantages of secrecy, but some perceived it to be uncontrollable and innate to their identities. One solution highlighted in two groups was the ethnic diversity of American providers. Not

evident in Ethiopia, immigrants have the ability to visit non-Ethiopian doctors in the U.S. Participant 67b thought Ethiopians with highly stigmatized diseases would prefer going to a non-Ethiopian doctor to properly treat their illness. This allows an immigrant to be comfortable in seeking help that may be seen as unacceptable in the Ethiopian community. Communal privacy issues should be explored further.

ii. Alternatives to American Health Care and Medicine are Accessible to Ethiopians

Cultural substitutes to American medicine affect health-seeking behaviors in the Ethiopian community. Spirituality, specifically Christianity, was identified as a possible alternative to health care. Though two mentioned witchcraft as a possible option for Ethiopians, almost all participants were of Christian faith. According to group members, Christian holy water is commonly used for addressing mental health illnesses in Ethiopia. Participant 66b revealed:

It [mental health disorder] is directly connected with spirit, you know, evil spirit and whatever. That's why even people [providers in Ethiopia] do not take their patients, back home [in Ethiopia], to the hospital. They take them to a place where there is holy water. I mean, you find hundreds of mental sick people in that place, where they pour water down and then upon them than the mental hospital.

Though it is unclear if these actions are as severe in U.S. immigrant communities, Participant 35c believed spirituality affects the perceived normalcy of mental health. Participant 35c advised for mental health awareness in immigrant societies so more can accept this reality. They said, “So, I believe we need to be educated and we need to accept, like, it's ok, it's normal being sick. Sickness is normal.” Additional research on the intersection of spirituality and health care use in Ethiopian immigrant populations is necessary.

Group members identified traditional medicine as a more prevalent alternative to health care in immigrant communities than Christian or divine approaches. Participants defined

traditional medication as Ethiopian herbs or home remedies for treating diseases. According to Participant 73a, "...everything [traditional medicine] is coming from Ethiopia and we are not detached for our culture. So, that's makes us refrained from having insurance and from going to hospital for each and every treatment." Participant 16c was not shy in offering insight on their personal use of this alternative. They explained, "Yeah. I use, like, like home medication and I'm not comfortable even to go to hospital because they [providers] ask me a lot of questions and I don't understand what they say." Participant 54b argued their use of home remedies depended on the severity of the illness. For example, this group member had traditional solutions for alleviating slight headaches. Participant 43a reasoned dry mud was an ailment for treating broken bones in Ethiopia. Participants used traditional alternatives, especially for mild diseases, because they are inexpensive. Traditional medicine is not only less expensive, but also less stressful in its utilization than typical medical care.

iii. Ethiopians are Satisfied with Not Knowing the "Unknown"

Some Ethiopian immigrants prefer not knowing their current health status for two reasons. First, disclosure of a medical diagnosis is costly to an individual and their society. As previously discussed, Ethiopian immigrants value collectivism in their communities. Having a disease, especially one that is stigmatized, can counteract personal pride. Participant 66b had plenty of experience with seeing these kinds of behaviors in Ethiopia. They inferred Ethiopians would rather die from an illness than addressing their symptoms. Specifically for HIV/AIDs, the toll of diagnosis awareness is higher than its consequences on one's health. Participant 66b explained, "Whenever we [others] tell them [patients about their HIV/AIDs diagnosis], they will die with worry earlier. Yeah. I've seen this in a lot of people. If you don't tell them, even without

picking the medicine, they can stay [live] longer.” This group member talked about how the social pressure from a HIV/AIDs diagnosis can actually worsen the health of that individual. They continued, “They'll [diagnosed patient will] be sick psychologically and they'll be sick emotionally. They will, you know, stop taking care of their body. I mean it [HIV/AIDs diagnosis] is a death statement.” Some believed this fear has channeled from Ethiopia into immigrant communities in U.S. Participant 54c added that the potential physical pain from medical treatment deters Ethiopian immigrants in seeking health care. Participant 72b talked about how their sick relatives have continued to work and adhere to their regular lives even with noticeable disease symptoms. Experts must investigate and analyze this phenomenon in the context of Ethiopian immigrant communities.

Periodic visits to health facilities are uncommon practices in Ethiopia. Certain participants expressed their unfamiliarity with a “general check-up” when they arrived to the U.S. Participant 54b stated, “So, after we [Ethiopian immigrants] get here [in the U.S.], it's just like, you know, a new experience from scratch. And, if you just tell me, you know, to check-up. I can say, ‘What's a check-up?’” Participant 73a contended the absence of a “check-up” culture leads to a cycle of negative health outcomes in Ethiopian immigrants. Because of this chain reaction, this group member demanded more health care awareness in the Ethiopian community.

Participant 73a said:

OK - so you don't go for general check-up. Ok - since you don't have general check-up, you don't know your status. If you don't know your status, an easy thing that could be protected by food could be a bigger disease tomorrow and will let you go to the hospital and you'll be on bed. You see, that's the problem. So, I insist on changing the perception.

Participants also mentioned some Ethiopians' preference for no insurance lessens the necessity for preventive care and general check-ups. Participant 73a blamed Ethiopia's insufficient supply of effective health facilities. This group member inferred Ethiopians rather visit churches for

medical illnesses. Last, Participant 54b presumed most newly-arrived Ethiopian immigrants are in blue-collar professions. They shared, “And, I think for most cases, most Habeshas [people of Ethiopian or Eritrean descent] work more hours, just 16/7. No time. I mean, they don't give time for that checkup or for medication.” Immigrants possibly don't have disposable time to receive preventive care. Both financial and cultural themes influence health-seeking actions for periodic medical examinations.

b. Positive Nature of the American Health System as a Facilitator

An Ethiopian immigrant's experience with health care is widely affected by the positive outcomes derived from the American health system. Participants were pleased with the level of respect showcased by providers. The advantageous nature of U.S. health care is categorized into the following themes: (1) the professionalism exhibited by American providers and (2) the noticeable efficiency of health care facilities in comparison to those in Ethiopia.

i. Americans Health Care Providers are Professional

The politeness and competency of doctors was a positive contributor of health care use. Participants who admitted to an absence of discrimination in the health system had pleasant experiences with providers. These group members commended medical staff for their knowledge and skills. Participant 27b revealed they had criteria for evaluating providers' character. For this participant, eye contact is necessary and all providers should call patients by their proper name. Participant 43a preferred doctors who were genuinely concerned about patient health. They accounted, “That's a good trust. But, if he [a provider] looks like it doesn't care, then I'll have to

change my doctor.” As introduced in a previous section, participants believed Amharic competency was not correlated with provider skill and professionalism.

Participants believed professionalism derives from a provider’s history with other patients and medical school education. Participant 57b said, “So, it [professionalism] depends on the doctor, how good he is, and how well he was trained in school. So, I don't really think it has something to do with language.” Participant 67b similarly alleged, “So, if that doctor is a certified doctor, he's [that doctor is] able to do anything that he's done. He has done other people as well.” Ethiopian immigrants prefer using health services where medical staff is both hospitable and capable of addressing patient needs.

ii. Health Facilities in U.S. are More Efficient than Those in Ethiopia

Participants identified advancement in American medicine as a reason for seeking medical care. Ethiopian health facilities are deprived of basic resources and unsatisfactory to patients. Participant 46b commented on the scarcity of kidney dialysis services in Ethiopia. This participant shared, “...I think [there is] one [dialysis] machine [in Ethiopia]. And then [in Ethiopia], people are waiting for that [machine] in queue. Maybe six months or one year or more than that, they [Ethiopians] die. They die, literally they die.” They were amazed by the plentiful variety of dialysis care in America. This member continued, “...twenty [dialysis] machines there [in a certain U.S. clinic]. There are a lot of dialysis, I know of other, other dialysis centers [in the U.S.]. Many of them.” Group members also admired the organization of American services. Participant 46b was also captivated during a visit to a Kaiser Permanente facility. This participant appreciated the ease in receiving a variation of care since all their Kaiser amenities were offered in one building. Last, people proudly recognized heightened efficiency for elderly

care in the United States. Participant 52d expressed, “I found it here that seniors are regarded highly. And so, are considered very, I mean, nicely wherever they go. That's why I say it is quite pleasing for everything.” Participant 65b acknowledged the financial security Medicaid provides elderly patients. Participant 46b observed the higher life expectancy of Americans in comparison to that of Ethiopians. In reaction to seeing elderly aged 90 to 95 years old, this participant explained:

...they [American elderly] are still alive because of the treatment they are getting. Then I said, somebody [elderly] in Ethiopia, if he was Ethiopian, he would have died before 10 years [10 years earlier], he would have died before 20 years [20 years earlier].

Ethiopian immigrants may choose to seek care solely as a result of receiving more efficient care than what is provided in Ethiopia.

c. Summary of Key Findings: Emerging Themes

- A Participant’s Association with Ethiopian Traditional Culture as a Barrier to Utilization
 - Ethiopians are Private and Prefer to Not Disclose Health Information to Others
 - Participants have Alternative Forms of Medicine and Health Care
 - Ethiopians are Satisfied with Not Knowing Current Health Status
- The Positive Nature of Current American Health Care as a Facilitator
 - Providers in the U.S. are Professional and Care about All Patients
 - American Health Facilities are More Efficient than Ethiopian Health Facilities

V. Summary Table of Research Findings

Themes Introduced in Hypotheses	Themes NOT Introduced in Hypotheses
Public Insurance as a Facilitator to Case Use	Attachment to Traditional Ethiopian Culture as a Barrier to Utilization
Private Insurance as a Barrier to Utilization	Privacy in Ethiopian Community as a Barrier to Health Care Use
Varied Responses on Social Discrimination as a Barrier	Alternatives to American Health Care as Barriers
Some Experienced Discrimination Based on Factors Unrelated to their Race and Culture	Some Ethiopians are Content with Not Knowing Current Health Status
Language Differences with Providers are Not Barriers	Relative Deprivation of Ethiopian Health Care as a Facilitator to Utilization
Need for Improvement of Translation and Interpretation Services Available to Ethiopians	Health Facilities in the U.S. are Seen as More Efficient than Those in Ethiopia
Strong Preference for Amharic-Speaking Providers	Professionalism of American Providers as a Facilitator

CONCLUSION

This thesis's results varied from the hypothesized factors introduced in the theoretical framework. First, language differences did not limit participants' health-seeking behaviors. This finding has some likely limitations, which will be later discussed. Second, public insurance was deemed a facilitator, which lies in accordance with existing literature. However, private insurance was surprisingly viewed as a barrier. Third, few participants' perceptions of health care discrimination agreed with the themes identified in past literature. Fourth, the hypothesis regarding positive testimonials was verified in discussions. Group members strongly valued others' opinions. Last, the emerging themes provided additional factors for researchers to consider in their future work.

I. Limitations and Observations

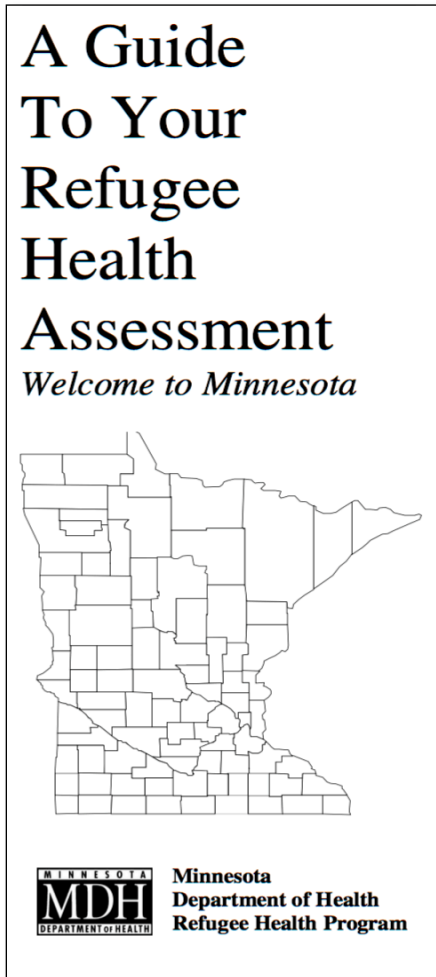
This study had four primary limitations. First, all discussion was in English. Participants noticeably preferred to speak in native Ethiopian languages. Thus, the amount of information and experiences discussed may have been limited. Second, as a result of the first limitation, I am hesitant to fully disregard language differences as barriers. It is likely participants were more proficient in English than a representative sample of Ethiopian immigrants. Third, there were no checks or mechanisms to confirm group members were truthful when completing the background questionnaire during recruitment. I suspected some participants had little to no experience with non-American health care outside of *Wholistic Health Services*. Fourth, certain group members spoke more than other participants. One group member out of the 26 chose to not speak at all. The findings are unlikely representative of all group participants' views. Last, all observations from these discussions are specific to the D.C. Metropolitan Area and are non-generalizable. Additional studies in other locations are encouraged.

II. Discussion and Implications for Future Policymaking

The experiences discussed in the focus groups illustrate the need for Ethiopian community advocacy and policymaking. It is necessary to: (1) implement effective awareness campaigns about the importance of health care utilization in immigrant communities, (2) develop mechanisms to incorporate Ethiopian ideas and opinions, (3) improve current translation and interpretation services available to Ethiopians, and (4) research further on Ethiopians' perceptions of discrimination and health care in the U.S.

Participants were disappointed with health care advocacy in their communities. Participant 16c argued that they would be willing to seek care if local health facilities and

governments advertised more in Amharic. For example, the Minnesota Department of Health provides online access to multilingual health education materials for refugees (“Health Education Materials”, n.d.). The department’s materials include a guide to refugee health assessments and resources for receiving proper health care (“Health Education Materials”, n.d.). This guide is available in several East African languages, including Amharic, Somali, and Arabic (“Health Education Materials”, n.d.). Similarly, many web pages from the D.C. Department of Health Care Finance contain reports and forms translated in Amharic (“DHCF Policies and”, n.d.).



(Minnesota Department of Health’s *Guide for Refugee Health Assessment* in English (*left*) and Amharic (*right*) (“Health Education Materials”, n.d.))

Public organizations are capable of creating these promotional materials. Therefore, these organizations need to offer more awareness in Ethiopian immigrant communities. Existing literature also demonstrates the importance of community-based strategies in health promotion. Flores et al. (2005) found that uninsured Latino children who were exposed to Medicaid advocacy programs, received help on insurance applications, and had family assistance, applied for insurance more than those who were not exposed to these actions. Researchers believe community-based case managers better approach minority populations than traditional public insurance outreach workers (Flores et al., 2005). A health insurance case manager is a social worker that advises patients on receiving appropriate health care for their needs (Davis, 2017). Local health departments must advertise not only the importance of care utilization, but also the importance of community-based health programs to immigrants.

Sustainable advocacy does not only stem from local organizations, but also stem from Ethiopians themselves. As observed, participants trusted other Ethiopian acquaintances more than American providers in service recommendations. This phenomenon likely exists in health education and awareness. The inclusion of more Ethiopian representatives in American political office is one solution. At the national level, Ethiopians or Americans of Ethiopian descent have never held legislative positions. However, political participation and office-holding among African immigrants has been recently increasing. Mohammed Tahiro was the first Ethiopian-American to run in a U.S. Senate election, in 2014 (“Mohammed Tahiro Interview”, 2014). In 2016, Ilhan Omar became the first Somali-American legislator in the U.S as a Minnesota State Representative (Samuelson, 2016). Internal solutions from Ethiopian community members can be non-political as well. *Learn and Live Wholistic Health Services* was established by Ethiopians for underserved and uninsured Ethiopians. *The Ethiopian Community Center, Inc.* in the D.C.

area offers resources about health care access by hosting discussions on nutrition and HIV/AIDs and health fairs (“Healthcare”, n.d.). Additional production of grassroots organizations has the potential to minimize cultural taboos associated with seeking health care.

Third, translation and interpretation services in health care settings have to be improved. Federal law mandates the current implementation of these services. According to Juckett and Unger (2014), “Title VI of the Civil Rights Act mandates that interpreter services be provided for patients with limited English proficiency who need this service, despite the lack of reimbursement in most states” (p. 476). Yet, there is empirical evidence that medical facilities have failed to uphold this national standard for translation and interpretation services. For instance, interpretation services are unfunded in most states since insurance companies do not cover it (Juckett & Unger, 2014). Thus, providers are not incentivized to hire adequate interpreters and rely on the interpretations of a patient’s friend or family member (Juckett & Unger, 2014). Policymakers must establish accountability systems in states where translators and interpreters are not reimbursed for their work. Providers should be accountable for patient negative health outcomes that stem from insufficient language services.

Fourth, researchers and policymakers alike need to analyze the relationship among duration of immigration residency, one’s association with American “blackness”, and perception on discrimination existence in the U.S. Previous studies suggest that duration of residence in the United States is positively associated with negative health (Kaestner et al., 2008). Kaestner et al. (2008) coined this scenario *unhealthy assimilation* for immigrants to the U.S. In the focus groups, I observed another effect. Older focus group participants were less willing to express discriminatory experiences from providers. But, some of these participants had similar residency durations to others who had differing opinions. As Participant 73a mentioned, the Ethiopian

identity operates as a shield for immigrants. According to this participant, “shielded immigrants” are more likely to dissociate themselves from the black race in U.S. Researchers must uncover how Ethiopian pride and black dissociation influence immigrants’ so-called health advantage, which Kaestner et al. (2008) coined, over other ethnic groups. Further studies should investigate how the degree of one’s black dissociation impacts the rate at which immigrants’ health advantage decreases.

Therefore, race and ethnicity are not synonymous. Policymakers should address the intersection of race and ethnicity with caution. Ethnicity has important implications in health outcomes, as different ethnic groups are exposed to various stressors and have access to unique resources (Ford & Harawa, 2010). Current approaches to health equity research are dominated by racialization and ignore ethnic categorizations (Ford & Harawa, 2010). Providers’ ignorance in adopting ethnicity concepts in health practice can lead to improper diagnosis and a worsening of patient health (Ford & Harawa, 2010).

Further research on Ethiopian and other East African immigrants is necessary for experts to better understand how ethnic identity impacts health-seeking behaviors and care utilization. It is important for future researchers to disregard universality in actions and health outcomes within a race and acknowledge the counteracting influence of immigration status.

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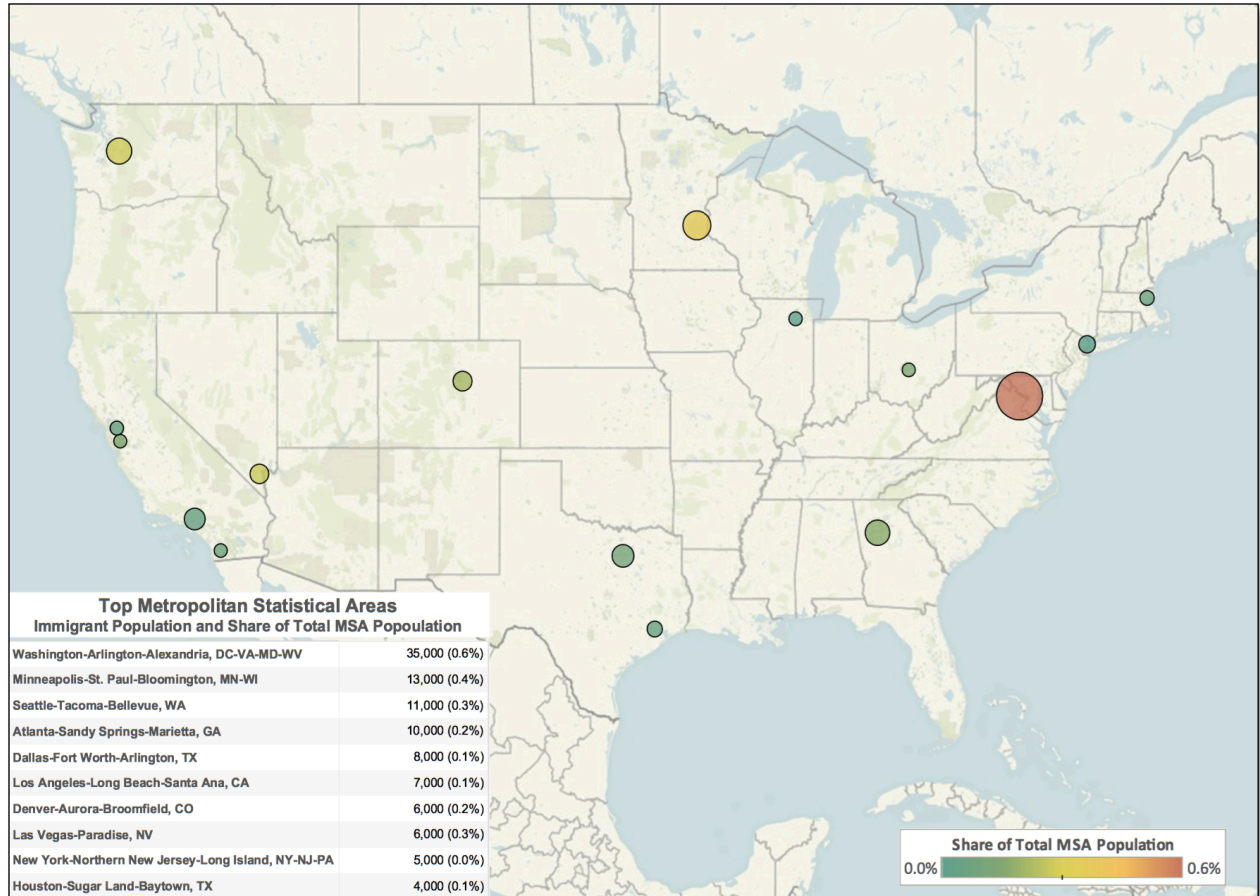
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APPENDIX

picture 1: This picture shows a visual representation of the various Ethiopian Diaspora concentrations in the United States (“Immigration Population from”, 2014).



script 1:

Duke University Sanford School of Public Policy – Study Recruitment (Oral Script)

Blaine Elias – Brief Oral Script: Hello, my name is Blaine Elias and I am a junior at Duke University, who is studying Public Policy and Global Health. I am conducting a study for my senior thesis on the reasons why or why not Ethiopian immigrants in the D.C. area choose to seek American health care (such as visiting a clinic or a hospital for a check-up). I am conducting focus group discussions for this research, which are discussions that will include 3 to 5 other people in the Ethiopian community. All participants will receive money if they participate. If you have time and are interested in this, please feel out this form right here. If you are interested, but don't have time to fill this out or have questions, feel free to contact me at 540-522-9799 or be36@duke.edu. If you are not interested at all, thank you for your time and have a great day!

form 1:

BACKGROUND QUESTIONNAIRE
Duke University Sanford School of Public Policy – Study Recruitment

Please read this form in its entirety. Thank you!

Hello, my name is Blaine Elias and I am a junior at Duke University, who is studying Public Policy and Global Health. You may have seen me around the clinic but I am not approaching you as a clinic worker or volunteer.

I am conducting a study for my senior thesis on the reasons why or why not Ethiopian migrants in the D.C. area choose to seek American healthcare (such as visiting a clinic or a hospital for a check-up). My study is not connected to Wholestic but is for my school requirement.

As you know, I am recruiting participants for focus group discussions in the summer. Focus groups are discussions with usually 3 to 5 other people, where general topics are talked about. These focus groups will **be audio recorded**. All recordings will be destroyed after a transcription of the discussion is completed.

If you are interested in participation, please complete the following form. The form asks basic background questions about you, which will only be known by me. I will be the only person collecting these responses. I will use this information to schedule a focus group. People who successfully attend their assigned focus group discussion will receive some money for their participation. After I have completed my research, all of the information collected on this form will be destroyed.

No participant **will be identified by his or her name**. Instead, each participant will be assigned a number of identification.

NOTE: Completion of this form does not guarantee participation in this research study.

For now, the focus group discussions will take place at one of Wholestic's offices in Alexandria, Virginia. **Location is subject to change**. Date and time details will come soon.

If there are any questions, please feel free to call/text me at: 540-522-9799. My email is be36@duke.edu. Thank you for your help!

Background:

1. What is your full name?
2. What is your age?
3. What is your gender?
4. Are you an American citizen? (Y/N)
5. Do you identify as an Ethiopian or is the majority of your ethnicity Ethiopian? (Y/N)
6. What is your preferred method of communication (best way I can contact/reach you)? (email, telephone, both)
7. What is your email? (if a respondent preferred email or both in Q6)
8. What is your telephone number? (if a respondent preferred telephone or both in Q6)
9. Does this telephone number allow for text messages? (Y/N)

More Questions:

10. Have you ever visited/used the services at *Wholestic Health Services*? (Y/N)
11. Have you used services from the U.S. healthcare system (doctor visit, pharmacy visit, dentist visit, clinic visit, etc.) other than at *Wholestic Health Services*, at least 2-3 times in the last 5 years? (Y/N)

Thank you for completing this form! If chosen for the study, I will contact you immediately with the next steps.

consent 1:

CONSENT MATERIALS

Duke University Sanford School of Public Policy – Informed Consent

Introduction: Hello! As you know, my name is Blaine Elias and I am a junior at Duke University, who is studying Public Policy and Global Health. Thank you for your interest in my research study.

Purpose of the research: As I already explained, the purpose of my research is to understand reasons why or why not Ethiopian migrants in the D.C. area choose to seek American healthcare (such as visiting a clinic or a hospital for a check-up) or show health-seeking behaviors (such as going to the pharmacy to pick up medication).

I am conducting this research for my own purposes. I am not carrying out this study on behalf of Wholistic Health Services.

Procedures: If you agree to be in the study, you participate in a focus group discussion with other Ethiopian migrants who also live in the D.C. area. I will ask you questions about your general experiences with the U.S healthcare system. You do not have to share any specific experiences to be shared.

Audio recording: The focus groups will be **audio recorded**. All recordings will be destroyed after a transcription of the discussion is completed. If you are not comfortable with being recorded, please refrain from agreeing to participate.

Confidentiality: **You will not be identified by your full name in the focus groups/recordings.** Each participant will be assigned a number of identification. I will not identify you in the research paper either.

Voluntariness: Participation is not a requirement. If you agree to participate in this study, you can choose to withdraw or cancel your participation, and leave the group, at any time for any reason. You can skip any question you do not want to answer. It is **not** a requirement to answer each question in the focus groups.

Please consider: It is completely up to you to decide how much you want to share during the focus group. While I hope you feel comfortable to answer all of my questions, **please do not feel obligated to share things in the group that you would not want others to know about your or repeat outside the group.**

Compensation: If you who successfully attend your assigned focus group discussion, you will receive \$45 for your participation.

Contact: You can contact me at any time if you have additional questions. If you would like to speak with someone else about the research, you can contact my advisor, Jay Pearson, at jay.pearson@duke.edu or 919 613 7327, or if you have any questions about your rights as a participant, you may contact the Duke University IRB Office at (919) 684-3030 or campusirb@duke.edu.

If you agree to be in the research, please sign below. You will be given a copy of the form for your records.

Signature of Research Participant: _____ Date: _____

Printed Name of Research Participant: _____

form 2:

Duke University Sanford School of Public Policy – Focus Group Guide

Blaine Elias – Introduction:

Audio recording will begin now. Hello, my name is Blaine Elias and I am a junior at Duke University, who is studying Public Policy and Global Health. I am the researcher who is conducting a study for today's focus group. Welcome everyone! For context, I am conducting a study on the reasons why or why not Ethiopian migrants in the D.C. area choose to seek American healthcare (such as visiting a clinic or a hospital for a check-up) or show health-seeking behaviors (such as going to the pharmacy to pick up medication). So, today's focus group is to get a sense about these factors and reasons..

Here are some logistics for today's discussion. First, all discussion is and will be audio recorded. You will be notified once recording stops. This audio recording will be destroyed once the discussion is transcribed. Second, if you are not comfortable, you are free to leave at any time. Third, you are not required to answer any question today if you do not feel comfortable. Fourth, all identifiable information (such as your name) you shared with me will be destroyed and discarded after data collection is over. Fifth, all discussion must be spoken in English for the purpose of complacency. Sixth, I will identify you by your assigned number during today's discussion. Please refrain from using your or another participant's real name when speaking. Also, when a question is given, please raise your hand and ONLY start speaking when I call your assigned number. BEFORE SPEAKING, please repeat your assigned number ALOUD. Please refrain from interrupting others while they are speaking. It is not necessary to give specific information about your personal experiences. You are fine with giving general ideas or information. Also, do not feel obligated to share any information that you do not want others to repeat outside this group discussion. Last, for attending, all of you will receive \$45 compensation. This discussion will be approximately 1 to 2 hours. Let's begin.

Introductory/Neutral Questions:

1. What brings everyone to today's discussion?
2. How would you describe your experiences with the American healthcare system?

Core Questions:

1. In the past 2-3 years, how many times have you sought healthcare?
2. How has having health insurance or not having health insurance influenced your ability to seek health care?
 - a. Can you provide me an example?
3. Do you feel that speaking a different language than healthcare providers has influenced your desire to seek medical care?
 - a. Why?
 - b. How?
 - c. Can you provide me with an example?
4. Have you ever felt discriminated against from American providers, such as from nurses or doctors?
 - a. Why or how?
 - b. Can you provide me with an example?
5. Has a friend or family's positive experience with American healthcare influenced your decision to seek health care?
 - a. How?
 - b. Can you provide me with an example?
6. What are some other factors that you think have influenced your ability to seek health care?
 - a. How have these factors influenced this ability?
 - b. Can you provide me with an example?

Blaine Elias – Conclusion:

That is our discussion. Thank you for participating! Please do not discuss today's discussion outside of this room. All information reported today is confidential! Feel free to ask me or Blaine any questions or hesitations before you leave! And, do not forget to pick up your monetary compensation from Blaine before you leave today. Thank you again for all your help! **Audio recording will end now.**