

**THE EXPERIENCE OF ERITREAN IMMIGRANTS REGARDING UTILISATION OF  
HEALTHCARE SERVICES IN INDIANAPOLIS INDIANA USA**

by

MESGHANE GHIRMAI ASGEDOM

Submitted in accordance with the requirements

for the degree of

MASTER OF PUBLIC HEALTH

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF AH MAVHANDU-MUDZUSI

November 2015

## **DEDICATION**

I dedicate this research project to my beloved wife Melat and my baby Selam.

## DECLARATION

**Student Number: 44933398**

I declare that **THE EXPERIENCE OF ERITREAN IMMIGRANTS REGARDING UTILISATION OF HEALTHCARE SERVICES IN INDIANAPOLIS INDIANA USA:** is my own work, all the sources that I have used or quoted have been indicated and acknowledge by the means of complete references, this work has not been submitted before for any other degree, at any other institution.

Mesghane Ghirmai Asgedom (*GA Mesghane*)      25      November 2015

## ACKNOWLEDGEMENTS

First and foremost, thanks to the Almighty God, for He is with me during all my challenges of life, has brought me back to school life, and energized me with good faith to finish my research.

I would like to acknowledge the following people for their valuable contribution to all phases of my work:

- My supervisor, Professor Azwihangwisi Helen Mavhandu-Mudzusi for her great ability to shape me into becoming a professional person, her patience, kindness, endless help, advice, and thoughtful guidance which helped me to reach to the stage where I am now.
- My friends, Dr. Mulubrhan and Dr. Dawit, for their friendly and professional support and guidance regarding my studies.
- Doctor Rustom for his professional and fatherly advice, in helping me to choose resourceful research participants. He helped me to choose a set of resourceful research participants and identifying the agencies which were of use to me.
- My friends, Professor Aponte and Dr. Isaac, for their valuable advice, guidance and encouragement.
- My friend Muse, for his continuous help, thoughtful and endless encouragement in getting me back to school life. Their encouragement kept me going.
- My cousin Siyoum and his wife Letebrhan, for their advice and encouragement to resume my studies.
- All Eritrean immigrants who participated in this studies.
- Exodus refugee and Catholic charities in Indianapolis.
- Last but not least, my dear wife Melat for motivating me to continue with my education through her support, love and consideration. She keeps on energising me.

**ACROMYMS**

- **ACA** Affordable Care Act
- **ACP** American College of Physicians
- **ANA** American Nurse Association
- **ASPE** Assistant Secretary for Planning and Evaluation
- **CHIP** Children Health Insurance Program
- **CIPC** California Immigrant Policy Center
- **CMS** Centers for Medicare and Medicaid Services
- **EDHS** Eritrean Demographic and Health Survey
- **FSSA** Family and Social Service Administration
- **ICRMW** International Convention on the Protection of the Rights of all Migrant Workers and members of their family
- **MPI** Migration Policy Institute
- **PRWERA** Personal Responsibility and Work Opportunity Act
- **PTSD** Post Traumatic Stress Disorder
- **SNAP** Supplemental Nutrition Assistance Program
- **UNHCR** United Nation's High Commissioner for Refugees
- **USA** United States of America

**ABSTRACT****THE EXPERIENCE OF ERITREAN IMMIGRANTS REGARDING  
UTILISATION OF HEALTHCARE SERVICES IN INDIANAPOLIS  
INDIANA USA**

STUDENT NUMBER: 44933398  
STUDENT : Mesghane Ghirmai Asgedom  
DEGREE: Master of Public Health  
DEPARTMENT: Health Studies, University of South Africa  
SUPERVISOR: Professor AH Mavhandu-Mudzusi

**ABSTRACT**

This study explored and described the experiences of Eritrean immigrants regarding utilisation of healthcare services in Indianapolis. Qualitative descriptive phenomenological design was utilised. Data were collected using a semi-structured interview format, on eight conveniently selected Eritrean immigrants, living in Indianapolis. Data were analysed using Interpretive Phenomenological Analysis Framework for data analysis. Three superordinate themes emerged from data analysis: Healthcare financing system, Positive side of healthcare services and Challenges related to utilisation of healthcare service. All these factors have an impact on the utilisation of the Healthcare services by Eritrean immigrants. Recommendations have been put forward to advocate for policy change regarding financing of healthcare services for immigrants and improved healthcare services to accommodate cultural diversity. Further research should be conducted on ways of improving utilisation of healthcare services by Eritrean immigrants in Indianapolis.

**KEY CONCEPTS:** Eritrean immigrants, experience, healthcare services, immigrant, utilisation.

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## **CHAPTER 1: ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

This study explored and described the experiences of Eritrean immigrants regarding utilisation of healthcare services in Indianapolis. This chapter provides background, problem statement, purpose and objectives of the study. The chapter also offers an overview of the significance of the study, research questions and definitions of key concepts used in the study. An overview of research design and method employed in the study is also provided. Finally, the chapter outlined the organisation of the entire dissertation.

### **1.2 BACKGROUND OF THE RESEARCH PROBLEM**

United States of America (USA) is one of the countries with a lot of immigrants (Gur 2015:3). There are several reasons which make USA the favourite destination for most of immigrants. Some of the reasons identified are economic change, better life, better education, fleeing from persecution or conflicts from tyrant governments (Gur 2015:3). Most immigrants assume that USA is the ideal land of opportunities. Therefore, some of them come to USA with little psychological preparation, and virtually no knowledge or awareness of the reality of burdens of being a foreigner (Asana & Ngwa 2011:8). As they do not get enough orientation to face the burdens, high levels of expectation of what are in store for them develop due to their ignorance (Asana & Ngwa 2011:13). Immigrants are less aware of the different lifestyles and complexity of accessing public services in the USA (Swigart 2011:3).

This situation of challenges related to access public services is also experienced by Eritrean immigrants who are in USA. According to the reports by United Nations high commissioner for refugees (UNHCR 2010:14), Eritrea is among the top countries of asylum seekers in the various Western countries. In the past two years, it has been also among the top ten sources of refugee (UNHCR (2010:10) noted that the main constraint associated with Eritrean immigrants is the lack of access to medical care. This lack of

access to healthcare is compounded by the cultural beliefs and patterns of healthcare seeking behaviours among Eritrean (Mogos 2011:7). Chapman (2010:13) indicated that cultural background is the determinant deterring factor for Eritreans to access treatment as they mainly use natural traditional remedies before seeking Western medicinal help. Chapman (2010:13) further mentioned that Eritrean men prefer to be cared for by male healthcare providers while women strongly wish to be cared for by female providers. According to Cooper (2010:7), gender concordance with the healthcare provider is considered very important to many Eritreans.

Mogos (2011:7) further mentioned that Eritrean have a tendency of delay in seeking medical advice unless they are very sick. The Eritrean is also reluctant to discuss their health problems with other people including the fellow Eritreans and healthcare providers. This reluctance may be associated with stigma and discrimination which the Eritrean community attach to illnesses such as mental health and HIV/AIDS (Cooper. 2010:8). This leads to some Eritrean individuals who are living with HIV/AIDS not to disclose their HIV status. Some even refuse treatment, for fear of being known to be living with HIV/AIDS, while visiting a clinic that specializes in HIV/AIDS (Cooper 2010:8). Another challenge hindering discussion of health issues even to Healthcare practitioner is language barrier between the Eritrean immigrants and healthcare personnel (Mogos 2011:7).

Apart from the personal and cultural issues related to Eritrean immigrants, there are structural factors which hinder immigrant population including Eritrean immigrants to access healthcare in USA. The study conducted by Kaiser Commission on the key facts of the year 2008, found out that 47% of immigrants did not have health insurance, compared to only 15% of citizens (Centers for Medicare and Medicaid services [CMS] 2014:2). The same studies also indicated that immigrants utilise less emergency services, less healthcare services even if they are insured than the USA citizens. According to Centers for Medicare and Medicaid Services (CMS. 2010:2) Federal healthcare law excludes undocumented immigrants and some legally present immigrants in their first five years residency from federally funded health benefits. Examples of benefits which they are denied include Medicaid and children health

insurance. Moreover, it is also not easy to access complex federal and state health coverage even for immigrants who are legally eligible as they all are synchronized by modern paperless communication such as internet (CMS 2014:7). It is difficult to make proper decision regarding relevant healthcare insurance due to complex health insurance market place and thousands of menus of health insurance plans (Ku 2013:3). This complexity affect proper choice, resulting in losing existing health coverage, due to new law, huge co-pay payments, or out of pocket payments (Ku 2013:4). These lead to fear of debt by immigrants and resultant in non-use of healthcare service.

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

The researcher is part of the Eritrean community living in Indianapolis, and therefore, has had ample opportunity to observe day-to-day life style of the population under study. The researcher is also a professional nurse, working in one of the hospital. The researcher has realized that most Eritreans visit the hospital when they are already in critical conditions. This is also documented by Chapman (2010:13), mentioning that many Eritreans do not have health insurance, do not understand the healthcare system of USA, and many do not even bother to go for health screening at all. Some Eritreans arrive at the hospital after the disease become complicated (Cooper. 2010:8). The majority of the Eritrean immigrants, especially the aged, and those who are suspected to be living with HIV/AIDS die at their residential places. This poor utilisation of healthcare services may pose a threat to health of other citizens, especially if they are suffering from conditions like mental illness or some infectious medical conditions, such as HIV/AIDS and tuberculosis. Despite these possible health risks, there is no study conducted about the experiences of the Eritrean immigrants in Indiana, regarding the utilisation of healthcare services. These prompted the researcher to propose this study, in order to explore the experiences of the Eritrean immigrants regarding utilisation of healthcare services in Indiana.

## **1.4 AIM OF THE STUDY**

The aim of the study was to gain understanding about the experiences of the Eritrean immigrants in Indiana regarding the utilisation of healthcare services.

## **1.5 OBJECTIVES OF THE STUDY**

The objective of the study was to explore and describe the experiences of the Eritrean immigrants regarding the utilisation of healthcare services.

## **1.6 RESEARCH QUESTION**

A research question is a specific query that the researchers want to answer while addressing the research problem (Polit & Beck 2012:765). The researcher has generated the following research question to address the identified research problem: What are the experiences of Eritrean immigrants in Indiana regarding the utilisation of healthcare services?

## **1.7 DEFINITIONS OF KEY TERMS**

### **1.7.1 Eritrean immigrants**

Eritrean immigrants refers to the Eritrean people who were born in Eritrea, but living in another country outside Eritrea. For this study, it means Eritrean immigrants who are living in Indianapolis, Indiana: USA.

### **1.7.2 Experience**

Experience is a skill obtained through accumulated knowledge and direct personal participation, that a person has undergone (Collins Online Dictionary 2014). This will deal with practical contact and observation of facts or events in line with the lifestyle of the Eritrean immigrants living in USA, regarding their health and health service experience by participants themselves.



### **1.7.3 Healthcare service**

Healthcare service is a public service that is responsible for providing medical care (Macmillan online Dictionary 2009). In this study, healthcare services refer to the healthcare services that are provided to the Eritrean immigrants living in USA.

### **1.7.4 Immigrant**

Immigrant is a person who lives permanently in a foreign country (Hornby 2010:750). In the USA, an immigrant is a person who is not a citizen of the United States, as defined by the Immigration and Nationality Act, section 101 (Chaudry & Fortuny 2011:7). In this study, immigrants refer to all people including the Eritrean immigrants residing in the United States, who are not USA citizens by birth.

### **1.7.5 Utilisation**

Utilisation refers to the use of resources at people's disposal (Hornby 2012:1646). In this study, the term utilisation refers to the use of the healthcare services by the Eritrean immigrants in Indianapolis.

## **1.8 SIGNIFICANCE OF THE STUDY**

Significance refers to the relevance of the research or study conveys the importance of the problem or the study results for different audiences that may profit from reading and using the study (Creswell 2014:248). There is scarcity of studies related to the experiences of the Eritrean immigrants living in Indianapolis regarding utilisation of healthcare services. The findings of the research is likely a starting point, or a building block for the interested researches, and would stimulate the need for similar studies, even in other immigrant groups. The findings of this study will contribute to the body of knowledge of the nursing profession regarding utilisation of healthcare services by immigrants. The study findings and recommendations will be used for providing

guidance regarding provision of healthcare services to the Eritrean immigrants. It is also envisaged that the findings may be utilised in formulating the guidelines for addressing healthcare issues of immigrants in Indianapolis.

## **1.9 FOUNDATIONS OF THE STUDY**

### **1.9.1 Research paradigm**

A paradigm is a basic and general organizing framework for theory and research which includes basic assumptions, key issues, models of quality research and methods for seeking answers (Neuman 2011:94). Creswell (2014:6) further defines paradigm as the world's view, which is set of beliefs that guide actions. The researcher used constructivist paradigm. This paradigm believes that individuals seek an understanding of the world in which they live, and works to develop the subjective meaning of their experience (Creswell 2014:8). This paradigm enabled the researcher to have in-depth understanding on how the Eritrean immigrants view and understand their experiences regarding utilisation of healthcare services.

### **1.9.2 Research approach**

Research approach is the plan and procedures for a research which spans the steps from broad assumption to detailed methods of data collection, analysis and interpretations (Creswell 2014:3). The researcher used a qualitative research approach. Qualitative research assist in answering research questions through provision of comprehensive information related to a phenomenon from the participants' viewpoints (Bryman 2012:35).

### **1.9.3 Research design**

Research design is an approach in a research that provides specific direction for the procedures in the research study (Creswell 2014:11). In this study, the researcher used

a descriptive phenomenological design. Phenomenological research design is an approach which enables the researcher to describe the lived experiences of the individuals about a phenomenon as described by the participants (Burns, Grove & Gray 2013: 693; Creswell 2014:15). The researcher used a descriptive phenomenological design to explore and describe the lived experiences of the Eritrean immigrants with regard to healthcare services access and its utilisation in Indianapolis, Indiana USA.

#### **1.9.4 Research Methodology**

Research methodology is the process or plan for conducting the specific steps of the study (Burns, Grove & Gray 2013:707). Research methodologies that are included in this study are the processes and procedures applied in population and sample selection, the procedures of data collection, and its subsequent analysis.

##### *1.9.4.1 Population and Sample Selection*

Population is a large group of many cases, from which, a researcher draws a sample, and, to which, the results from a sample are generalized (Neuman 2011:241). The research population here is the Eritrean immigrants of Indianapolis, the target population for this particular study are the Eritrean immigrants, aged 18 years and above. Sampling is a process of selecting a group of people, events, behaviours, or other elements, with which one should conduct a study (Burns, Grove & Gray 2013:708). The researcher used convenience non-probability purposive type of sampling, since no definite sampling frame was available. Non-probability sampling is a sampling technique or method, in which, every element of the population under study does not have equal opportunity to be included in the research (Burns & Grove 2009:353). Therefore, the researcher conducted the study with 8 purposively selected participants.

#### *1.9.4.2 Data Collection and an Analytical Approach*

Data were collected using a semi-structured interview, after arranging both time and place, according to the convenience of each of the study participant. Data analysis was conducted hand in hand with collection, using Smith's et al. (2009:234) interpretative phenomenological analytical framework, which is provided in details in Chapter Three.

### **1.10 MEASURES TO ENSURE TRUSTWORTHINESS**

Trustworthiness is a term used in the appraisal of qualitative research when describing credibility, dependability and transferability (Goodman & Moule 2009:395). The researcher followed the framework and criteria posited by Lincoln and Guba (1985) as cited in Polit & Beck 2012:584) as a measure to ensure the trustworthiness of the study. The criteria of this framework are presented in Chapter Three.

### **1.11 ETHICAL CONSIDERATIONS**

Ethics is a branch of philosophy that deals with morality (Burns & Grove 2009:61). According to Babbie (2013:32), ethics is concerned with the matters of right and wrong. The researcher was guided by ethical principles throughout all the process, and details are presented in Chapter Three.

### **1.12 SCOPE AND LIMITATION OF THE STUDY**

The study presented a detailed explanation of the participants' words, so as to develop the base theoretical foundation of further research, which will have an effect in the professionals and institutions that work with the immigrants, especially the Eritreans. The research findings will also act as a representation of the voice of the Eritrean immigrants, which has never been told or considered, considering their health experience. But, the scope of the study was limited, and was focused on only Eritrean Immigrants, who have utilized healthcare services at Indianapolis, Indiana, USA. The focus was only on the utilisation of healthcare services. Since the researcher is part of

the population, a concern is definitely the fact that the participants may not feel comfortable, or be willing to express the truth about their actual experiences to the researcher. In fact, the participants may tend to present themselves in the best possible way, while hiding their true behaviour. This introduces what is called a social desirability bias (Neuman 2011:322). To the maximum extent, this was, however, minimized, by the use of purposive sampling, that alleviated this limitation, and the individuals who were selected really understood the purpose of the research, based on the stipulated criteria of the selection criteria to the study. This was stimulated by the assurance towards the participants, that their information will be kept confidential.

### **1.13 STRUCTURE OF THE THESIS**

This thesis consists of five main chapters with subtopics. A short description of each of these is given below to guide the readers and help them follow and understand the discussions in an easy manner.

**Chapter one** gives a general introduction to the study, including the description of the research problem, the aim and objectives of the study. Key concepts used are defined. It also highlights the foundations of the study which covers the research paradigm, approach, design and method. Finally, ethical aspects and the measures to ensure trustworthiness are also highlighted.

**Chapter two** focuses on Literature reviewed. It highlights literature search strategy, appraisal of identified literature and themes which emerged from literature reviewed.

**Chapter three** provides a detailed description of the research approach used. Research design and the methodology implemented are fully discussed. The chapter also focused on the description of the measures taken to ensure trustworthiness of the studies. It also gives thorough description of the ethical issues adhered to in relation to the study.

**Chapter four** presents the results based on the super-ordinate themes, as well as the themes and sub-themes that emerged from data analysis, in terms of descriptive participant words. The presentation of results is also backed up by the excerpts from participants' interview transcripts.

**Chapter five** presents a set of discussions about the findings of the study, in relation to the existing literature and interpretation of findings. It also provided relevant conclusions and recommendations, based on the research findings.

## **1.14 CONCLUSION**

This chapter provides background to the research problem and also highlights the research problem. The purpose of study is provided together with the significance of the study. Foundation of the study which includes paradigm, approach, design and method is highlighted. Aspects of ethical issues and measures to ensure trustworthiness are also highlighted. The next chapter discusses literature reviewed in relation to immigrants and healthcare services.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

The previous chapter provided an overview of the study by highlighting the background to the research problem and the research problem. It also highlighted the purpose of study and foundation of the study. This chapter discusses the literature reviewed in relation to immigrants and utilisation of healthcare services. It provides the importance of conducting literature review and literature search strategy used for this study. The method used for appraisal of identified literature and themes which emerged from the appraisal process is presented.

### **2.2 THE IMPORTANCE OF CONDUCTING LITERATURE REVIEW**

Literature review is defined as an important source for providing detailed and relevant knowledge about the problem (Burns, Grove, & Gray 2013:707). As Newman (2011:124) described it, the purpose of conducting a literature review is to learn from others, to generate new ideas, to summarize what is known and to integrate what is found in the present, to identify the methodology in discovering what is missing and to initiate familiarity and establish credibility in the field of knowledge.

According to Yin (2012:64), literature review is conducted in order to find out what is already known about the topic of interest. Creswell (2014:29) explained, in qualitative research, the researchers use literature review in a manner that is consistent with the assumptions of exploring the new facets from the study participants' point of view or perception about the situation that is about to be studied.

For this particular study, literature review was done to enrich the basic knowledge about what the picture of health service access looks like to the immigrants, the package benefits that are accessible to them, the federal and state laws that administer healthcare, and the effect they have on the immigrants. To enrich the basic

understanding of the consumer, the researcher also included some unique information deemed to be important about Eritrea, Eritreans, and other related issues, especially about immigration and health orientation.

### **2.3 LITERATURE SEARCH STRATEGY**

A meticulous attempt was made to boost the literature review with comprehensive and relevant information, in order to reflect the related subject matter to the topic of study. Limited number of research books was used from the University of South Africa online, on E-library. The available and accessible public library at Wayne township branch in Marion County was used for the research books. Both sources enriched the study, and they were used to build academic knowledge about the research in general, and the qualitative research in particular. To explore the immigrant's healthcare access and utilisation, and the laws that govern it, electronic data or websites were extensively used, that included the government websites at both federal and state levels.

The following combination of words were used on Google to search related information such as: "immigrants in USA", "immigrants health utilisation" "immigrants health access", "refugees", "refugee and healthcare services", "African immigrants", "Eritrean immigrants in USA", "Medicaid and immigrants", "healthcare coverage of immigrants", and "undocumented immigrants".

Each of the search terms were initially used individually, and then combined using Boolean operators (AND, OR). The researcher highlighted and summarized related sources to prevent duplication of literature sources. Due to the bulkiness of the information obtained from the websites, using the above search words, the researcher formulated and used the following inclusion criteria to guide and focus the search for literature sources:

- Documents published from 2010 to 2015
- Only documents related to immigrants and healthcare services
- Documents published only in English



However, in case of documents specifically related to healthcare services and the Eritrean immigrants, all the relevant documents were utilised regardless of time. This was because of limited documents to this regard.

## **2.4 APPRAISAL OF IDENTIFIED STUDIES**

As not much has been found about the Eritrean immigrants in the study site, every literature has been critically examined. The process of reviewing each study was based on established and validated models of critical appraisal, such as those offered by Polit & Beck (2012:342). The studies were evaluated in terms of their rigor, validity, reliability, dependability, and transferability (Polit & Beck 2012:342). The following were the stages of appraising the research articles used in this study:

- Stage 1: reading the articles
- Stage 2: Initial note-making
- Stage 3: Development of themes
- Stage 4: Searching for connections across the emerged themes
- Stage 5: Development of final themes

## **2.5 RESULTS OF APPRAISAL PROCESS**

Based on the appraisal process of relevant literature, four major themes and subthemes emerged. The results are summarised in table 2.1

Table 2.1: Summary of findings from literature review

| <b>Themes</b>   | <b>Sub-themes</b>   |
|---|---|
| <b>Global overview regarding immigrants</b>                                   | <i>Statistics of immigrants</i>   |
|   | <i>Trends of Eritrean immigrants</i>  |
|   | <i>Challenges experienced by immigrants</i>   |
|   | <i>Protection of immigrants</i>   |
| <b>Immigrants in USA</b>  | <i>General overview of immigrants in USA</i>  |
|   | <i>Eritrean immigrants in USA</i>   |
| <b>Health and immigrants in USA</b>   | <i>Laws and policies governing the utilisation of healthcare services by immigrants</i> |
|   | <i>Healthcare benefits and coverage for immigrants in USA</i>                           |
| <b>Healthcare status and utilisation of Healthcare services by immigrants</b> |   |

### **2.5.1 Global overview regarding immigrants**

This theme highlights the statistics of immigrants, trends of Eritrean immigrants, Challenges experienced by immigrants and protection of refugees.

#### **2.5.1.1 Statistics of immigrants**

According to the UNHCR (2014:17) report, in the year 2013 the number of international migrants reached 232 million, of whom 46 million resided in USA. This number included both legal and illegal immigrants of different status. Refugee as one form of status accounted for a small proportion of the global migrant stock, which is 15.7 million. By the end of 2014, of the total 15.7 million refugees, 10.4 million were residing in Asia,

followed by 2.9 million in Africa. A small number of developing countries hosted the majority of refugees' worldwide (UNHCR 2014:21). With 659500 numbers of refugees, Ethiopia is among the top six refugee hostellers for Eritreans ; by the end of the year 2014, there were 123800 Eritrean refugees who were registered in Ethiopia, of whom, 40000 arrived in 2014 to the refugee camps present in Ethiopia (UNHCR 2014:9-10).

### ***2.5.1.2 Trends of Eritrean immigrants***

According to the United Nations High Commissioner for Refugees' online reports (UNHCR 2014:1-2), initially, Eritrean refugee immigrants were destined to be refugee in neighbouring countries for years, mainly in Ethiopia and Sudan. They started to resettle as refugees, beginning in the 80s in Sudan, Kenya, and Italy. After the ignition of the 1998 Ethio-Eritrea war, followed by more than a decade of no war peace condition between the two countries, and repressive action of the current Eritrean government, mass migration of Eritrean citizens to Ethiopia and Sudan was noted (Mogos 2011:3; UNHCR 2014:2).. So, Ethiopia has become the number one source of Eritrean refugee immigrants, followed by Malta and Israel.

### ***2.5.1.3 Challenges experienced by immigrants***

As newcomers to an unfamiliar place, the immigrants were confronted by language and communication barriers, cultural issues, unfamiliar environment and weather, new regulations and rules, as a result of which, it may have lead to discrimination, abuse, exploitation, torture, forced labour, and deprivation of basic human rights, including the right to health (Pace 2009:8).

### ***2.5.1.4 Protection of immigrants***

Considering all that the immigrants face in hosting countries, to protect and respect their rights as basic human right instrument, the United Nations developed three complimentary universal instruments, which provided a legal framework to protect

migrants as a component of human and labour rights (Bingham 2010:7). The purpose of developing the universal instruments was to protect and respect the immigrants' rights as basic human rights. The instruments developed are as follows:

- The 1990 International Convention on the Protection of the Right of all Migrant Workers and members of their families (ICRMW),
- International Labour Organisation (ILO) migration for employment convention, 1949 (C-97), and
- International Labour Organization for migrant workers (supplementary provisions) convention 1975 (C-143).

As it is reported by the international steering committee for the campaign for the ratification of the migrant rights convention in 2010 (Bingham 2010:11), the ICRMW is entered into force since 2003, and it explicitly applied the rights which are elaborated in the international Bill of Rights, to the specific situation of the migrant workers and members of their families, including their rights to health. The rights include their right to health which is stated as follows in article 12(1) of the international covenant on economic, social and cultural rights (ICESCR) *The "right of every one to the enjoyment of the highest attainable standard of physical and mental health"* (Pace 2009:9). The ICRMW included the right of the migrants to health in the articles 28, 43/1/e, 45/1/c and article 70 (Pace 2009:159-162). Article 28 of the convention mainly focused on the emergency medical treatment, and is written as follows:

- *"Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment"*.

Articles 43 and 45 stress upon the general access of the migrant workers to health rights, and Article 70 reminds the responsibility of the state to undertake them. Article 43/1/e states:

- *“Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to: Access to social and health services, provided that the requirements for participation in the respective schemes are met”.*

Article 45/1/c, which is mainly concerned with the families of migrant workers, states:

*“Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to: Access to social and health services, provided that requirements for participation in the respective schemes are met”.*

Article 70 reminds one of the responsibilities of member states, to ensure the right to health of the migrant workers, and their families, and mentions:

*“States Parties shall take measures not less favourable than those applied to nationals to ensure that working and living conditions of migrant workers and members of their families in a regular situation are in keeping with the standards of fitness, safety, health and principles of human dignity”.*

However, according to the 2011 report, prepared by the international steering committee for the campaign, for the ratification of the immigrants’ rights convention, only 82 member states ratified to one of the three components of the international treaties, with regards to the migrants, and none of the main immigrant-hosting countries in the western world ratified it (Benedict, Deville, Mckee, Mladovsky, Rechel & Rijks 2011:54). As a result, the occurrence of consequences of denial of the basic rights of immigrants is seen in many corners of the world, as reported by Benedict et al (2011:55).

## **2.5.2 Immigrants in USA**

This theme is about the general overview of immigrants in USA specifically Eritrean immigrants in USA.

### ***2.5.2.1 General overview of immigrants in USA,***

Historically, USA is a country of migrants. According to Kandel (2014:9) in the year 2013; there were 41.3 million foreign born or immigrants of all categories living in USA. Broadly, immigrants in USA can be categorized as legal or illegal (undocumented) immigrant (Marouf 2012:4). The illegal immigrants are those who enter without permission of the government, or, once entering the country, stay beyond the termination date of the temporary visa (Marouf 2012:6). In another report, according to the most recent estimates by the department of homeland security in 2011, where there were 11.5 million unauthorized immigrants living in the USA (Bruno, 2014).

### ***2.5.2.2 Eritrean immigrants in USA***

Eritrean immigrants came to USA the same way as other immigrants do from different countries of the world; they come to USA and get entry, both legally and illegally. (Mogos 2011:12). Illegal Eritrean immigrants finally cross the Mexico border and become asylees for further immigration status determination. Mogos (2011:12) the main categories of legal immigrants for Eritreans are refugees and asylees. Refugees are immigrants who were granted legal status, because of the persecution in their homeland, and Asylees are granted the status after they enter United States, legally or illegally, based on the claim they present to immigration officer (Phillips 2013:2; Fortuny & Chaudry 2011:7).

Illegal entry of Eritrean immigrants is complex; the migrants pass through many countries before they get into Mexico, then, after they have crossed the border in between the two countries, they apply for asylum (Vedantam 2011:30). Besides Eritreans coming to USA as either refugees or Asylees, some Eritrean immigrants also

came to USA as students and diversity visa winners, starting 1990. The other type of immigration is family reunification where the family left in Eritrea join their relatives in USA after they are granted legal status or USA citizenship (Mogos 2011:15).

### **2. 5.3 Health and immigrants in USA**

This theme covers the Laws and policies governing the utilisation of healthcare services by immigrants and Healthcare benefits and coverage for immigrants in USA

#### ***2.5.3.1 Laws and policies governing the utilisation of healthcare services by immigrants***

In USA, several studies have been conducted with regards to immigrants. Some of them, such as those by Migration Policy Institute (MPI) focus on the demographic characteristics of immigrants, and specifically mentioned about immigrants health (Capps, Fix; & McCabe 2012:10-12; McCabe 2011:13; MPI 2013:15).

The American College of Physicians (ACP 2011:14-15) and the American Nurse Association (ANA 2010:4) described the current situation of access of healthcare of documented and undocumented immigrants, in relation to the state and federal health laws, with respect to ethical and professional policies and obligations. There are also a number of researches comparing the immigrants' use of healthcare and health coverage, in relation to the native born, to prove that health expenditure by the immigrants are less than native born, and to substantiate it with facts, to disprove the accusations of the immigrants using healthcare services for which they are not eligible, or use more often than everyone else (Medalia & Smith 2014:24). These researches include that of Anderzejewski, Fuentes, Luke and Reed (2011:14).

American College of Physicians (ACP 2011:4) documented that there is severe challenge regarding access of healthcare, utilisation and health insurance coverage by immigrants, The challenges are caused by strict federal and state health laws towards immigrants. Based on the findings of ACP studies, a proposal was put forward for

stating that immigrants' access to healthcare should be addressed at a national level, rather than as a patchwork of state laws. This was made to avert some discriminatory policies, which lead into conflict with physicians' ethical responsibility to treat patients without regard to their legal documentation status.

Under the law of affordable care act (ACA), those naturalized (immigrants who have gained USA citizenship) residents have the same access and requirements like US-born citizens (Ku 2013:3). However, the existing federal immigrant eligibility restriction for Medicaid remains in effect, including for the immigrants with five year or more waiting period, meant for most of the adult resident immigrants with a low income class (ACP 2011:6). Under the federal law, the undocumented immigrants are only eligible for emergency care, and under the ACA, they may be able to purchase health coverage outside the exchanges, through the open market, and thus, it will give them a chance of coverage, with fewer options, but they are not mandated to be covered by the ACA law (ACP 2011:6).

According to federal laws, Undocumented immigrants are not eligible for Medicare, non-emergency Medicaid and Children health insurance program (CHIP). For that, the American College of Physicians For that reason, ACP (2011:7) and American nurse association (ANA 2010:7) both recommended the appropriate strategies to handle the health issues of the immigrants, and expressed their concern that hindering them from using health infrastructure would jeopardize the public health of the country, and, when a person, whether documented or undocumented immigrant, can get non-emergency illness, which could be a public concern in its natural course, and thus, may also increase the healthcare cost (ANA 2010:8).

### ***2.5.3.2 Healthcare benefits and coverage for immigrants in USA***

In USA, the way healthcare is delivered to the beneficiaries is health insurance-based and more complex than anyone would think or expect. The way it is accessed is very confusing. Moreover, being an immigrant also makes it more challenging, by raising



plenty of issues of eligibility criteria, which are governed by the state and federal policies. These are one of the major barriers to healthcare and public benefits of immigrants (Chaudry & Fortuny 2011:10). At the federal low level, there are a set of eligibility criteria based on immigration status for healthcare and public benefits access, such as Medicaid, Medicare, and Children Health Insurance Program (CHIP) and Supplemental Nutrition Assistance Program (SNAP). Public benefits are mainly for the low income families; despite their greater proportions of low income societies, immigrants have lower rates of benefits than the native born (Chaudry & Fortuny 2011:2). According to Chaudry & Fortuny (2011:3), legal or authorized immigrants used to get public benefits same as citizens, with same eligibility criteria till 1996. Restrictions to federally tested public benefits to lawfully present the immigrants started in 1996, after the Personal Responsibility and Work Opportunity Act (PRWORA) was enacted. The 1996 PRWORA enacted some policies, which categorised immigrants for eligibility based on their immigration status. Therefore, starting that year, some of the categories of lawfully present immigrants were excluded from public benefits. The eligibility to public benefits is not guaranteed. There are many criteria which an individually must meet to be eligible, and they are not limited just to immigration status and income level. The office of the Assistant Secretary for Planning and Evaluation (ASPE 2012:13), summarises the barriers of immigrants to get health coverage as the component of public benefits which includes immigration status and family composition, age, present health status (such as disability, pregnancy and chronic disease) income level, and family size.

The eligibility criteria for public benefits include health insurance coverage and health advantage, which differ from state to state, and even from one local area to another. It affects every individual dweller of the country. The complexity of federal and state eligibility criteria for health and other public benefits program and immigration status are the two policy-based factors, which contribute to a low rate of participation by the immigrants in the program. Furthermore, the factors which contribute to low access of healthcare coverage and utilization of immigrants includes the confusion of eligibility criteria, fear of adverse immigration consequences, language barriers, literacy problems, cultural backgrounds and sensitivity, transportation problems, climate

misinformation, mistrust and fear, and other aspects (ASPE 2012:6). To sum up, due to a number of reasons at any time, the percentage of population with health insurance coverage was lower for the people who were not citizens, than those who were native born and naturalized. For example, in 2013, the overall uninsured rate was 11.2% for the native born, 15.9% for naturalized citizens and 38.1% for non-citizens. Thus, they had the chance of being uninsured three times more than the native born (Medalia & Smith 2014:12). The rate of being uninsured in 2012 for low income residents of USA also showed in the statistics, where immigrants with low income had almost twice the chance of being uninsured, with 35% for native born, and 62% for immigrants. Children of this group had 12% and 38% uninsured respectively in the same year (Jewers & Ku 2013:8).

#### **2.5.4 Healthcare status and utilisation of Healthcare services by immigrants**

This theme addresses the general health status of immigrants and their utilisation of healthcare service. Despite the challenges in the path for accessing healthcare, different researchers proved that the immigrants are healthier than their native born counterparts at the first years of their immigration period, and deteriorates more than the native born through time (Giuntella 2013:33; ANA 2010:11). Study conducted by Medalia and Smith (2014:24) compared immigrants' use of healthcare and health coverage in relation to native born. The findings of the study was in contrast with studies by Anderzejewski et al. (2011:14) who documented that health expenditure by immigrants are higher than native born citizens. Regardless of all challenges of access, the fact that immigrants use healthcare less than the native born may be due to their primary aim, of immigrating, not for healthcare but for economic change (Anderzejewski et al. 2011:3; ANA 2010:4).

However, with time, the health status of immigrants deteriorates. The health status of the immigrants deteriorated with time, due to a number of reasons, such as poor health access, negative acculturation, language barriers, and confusion of eligibility for the

government-funded programs, such as Medicaid, Medicare, and CHIP, where generally, immigrants use healthcare less than the citizens (ANA 2010:5; ASPE 2012:6).

## **2.7 Implications of the results of literature review**

Findings thus far suggest that the immigrants are facing challenges regarding utilisation of healthcare services. Issues such as difficulty to access healthcare services were also raised. Some of the issues mentioned are cost of healthcare services, lack of medical health insurance and some legislation which prevent utilisation of healthcare services by certain types of the legislations. However, those issues were mentioned for general immigrants in the USA. None of the studies were focusing specifically on the experiences of the Eritrean immigrants regarding utilisation of the healthcare services. This is a gap which the researcher would like to cover through conducting this study.

## **2.6 CONCLUSION**

In this chapter, the importance of conducting the literature review was presented. The literature search strategy used for this study was also highlighted. The identified literatures were appraised using critical appraisal model described in Polit & Beck (2012:342). The summarized of themes gave the reflection of the Global overview regarding immigrants, Immigrants in USA, Health and immigrants in USA, and Healthcare status and utilisation of Healthcare services by the immigrants. The next chapter will address research approach, research design and methodology, measures to ensure trustworthiness and ethical issues employed in this study.

## **CHAPTER 3: RESEARCH DESIGN AND METHODS**

### **3.1 INTRODUCTION**

This chapter describes the research design and the methods used to explore the experience of the Eritrean immigrants, regarding the utilisation of healthcare services in Indianapolis. It includes the descriptions of the sampling process and sample size, research settings, data collection, data analysis, and ethical issues of the research.

### **3.2 RESEARCH APPROACH**

This study followed qualitative research approach. Qualitative research is a systematic, subjective approach used to describe lived experiences and situation in order to give them meanings (Grove, Gray & Burns 2015:20). The researcher has used this approach because of the following characteristics:

- Use of the methods that gives participants a certain degree of freedom.
- Permission of spontaneity regarding responses among both the participants and the researcher.
- Ability to create a conducive environment which allows the participants to freely express themselves.
- Permits the participants to share their views, experiences and opinions freely without being channelled by the closed ended questions and structured questions used in quantitative approach.
- Offering the research an opportunity to gain deeper understanding of participants' experience.
- Believing on attribution of meanings to experiences by participants.
- Offering freedom to the researcher to use probes and prompts to gain more information or to get clarification rather than just sticking on initial participants' response.

- Using smaller number of participants to gain in-depths understanding (Grove, Gray & Burns 2015:19)

The researcher has used qualitative research approach in order to gain in-depth understanding of the experiences of Eritrean immigrant regarding utilisation of healthcare services through allowing the participants to share those experiences in their own voice in an environment where the participants are comfortable and free.

### **3.3 RESEARCH DESIGN**

Research design is an approach in a research, which provides specific direction for procedures in research study (Creswell 2014:11). As Burns and Grove (2013:225) describe a study design as a guider or blue print, which the researchers plan and implement in a way that will enable them to reach the desired goal or purpose. It helps them to get the study results, which reflect the reality on the ground. In this study, a phenomenological research design was implemented. Phenomenological research design is an approach which enables the researcher to describe the lived experiences of the individuals about a phenomenon, as described by the participants (Creswell 2014:15). A specific phenomenological design which was used was the descriptive phenomenology. This design enabled the researchers to explore and describe the lived experiences of the study participants. Participants' information was interpreted by the researcher (Burns, Grove & Gray 2013:693).The researcher used this design in order to explore and describe the experiences of the Eritrean immigrants, with regards to their utilization of healthcare services. The researcher used this design to gain more understanding, with regards to the lived experiences of the Eritrean immigrants' about their healthcare utilization in Indianapolis, Indiana, USA

### **3.3 RESEARCH METHODOLOGY**

Research methodology is the process or plan for conducting a set of specific steps of the study (Burns, Grove, & Gray 2013:707). In this section, research site, population and sampling, data collection, and data analysis is discussed.

#### **3.4.1 Study Setting**

The study was conducted in Indianapolis, which is the capital and one of the largest metropolitan cities in the state of Indiana. As a capital city, Indianapolis is inhabited not only by American citizens, but also by immigrants from other countries of the world including Eritrea. Indianapolis also has many health centers and private clinics to serve both USA citizens and immigrants.

#### **3.4.2 Population**

Population is a large group of many cases, from which a researcher draws a sample and the results are generalized (Neuman 2011:241). Population includes all elements, such as individuals, events, objects, or substances that meet the criteria to be included in the study (Burns, Grove, & Gray 2013:703). The population in this study is the Eritrean immigrants living in Indianapolis, Indiana, who have been treated in one of the health services of Indianapolis.

#### **3. 4.3 Sampling and Sample size**

Sampling is a process of selecting a group of people, events, behaviours, or other elements with which to conduct a study (Burns, Grove & Gray 2013:708). The researcher used a non-probability criterion purposive sampling technique. Non-probability sampling is a particular technique or method, in which the element of the population under study has not got equal opportunity to be included in the study or research (Burns & Grove 2009:353). Purposive sampling involved the researcher

making judgement about the site and the participants for the study (Polit & Beck 2012:279). The researcher purposely selects the Eritrean immigrants who are judged to be typical of the population or particularly knowledgeable about the issues under study. Only participants who met the pre-set criteria were selected to participate in the study.

**Inclusion criteria:**

- Being an Eritrean immigrants
- Having stayed in Indianapolis for at least 6 months
- Having utilized one of the healthcare facilities in Indianapolis
- Being 18 years old and above

**Exclusion criteria**

- Being non Eritrean immigrants
- Having stayed in Indianapolis for less than 6 months
- Never utilized one of the healthcare facilities Indianapolis
- Below 18 years of age

The researcher accessed participants through various Eritrean social or traditional gatherings. The researcher informed the participants about the study, he is conducting. The researcher further explained the purpose of the studies, and all the information related to the ethical aspects. The researcher also outlined the following inclusion and exclusion criteria

All participants were also given information pamphlets with all the relevant aspects about the studies, including the researcher's contact details. Participants who met the eligibility criteria, and willing to participate, were advised to contact the researcher for an appointment to conduct interviews.

At the beginning, the researcher was aiming to interview 12 participants. More participants were considered ahead of time, to get the maximum amount of data, and to avoid the consequences of dropouts in the process. However, only 8 participants were

interviewed in the end, and the experience was quite similar between the participants, meaning, data saturation was reached. The number was determined through data saturation. According to Polit and Beck (2012:521), there are no stringent rules for the sample size in qualitative research, as the size of the sample is determined by data saturation or redundancy. Grove, Burns and Gray (2013:691) defined data saturation to be a state, when additional sampling and interviewing provided no new information, only the redundancy of the previously collected data. Only eight participants were interviewed based on data saturation was reached.

#### **3.4.4 Data Collection**

Data collection is a systemic gathering of information, which is relevant to the research purpose or the specific objectives, questions, or hypothesis of the study (Burns, Grove & Gray 2013:708). Data collection methods commonly used in qualitative research includes interviews, observations, and document analysis (Creswell 2014:190). For this study, the researcher used individual face-to-face semi structured interviews.

Data collections was commenced after receiving the ethical clearance from the University of South Africa's ethics committee, and also, after receiving a go-ahead permission from the relevant structures, such as the Exodus Refugee and immigration. After obtaining the informed consent from the participants, an individual face-to-face semi structured interview was conducted in a participant-selected, comfortable, secure and private place, to ensure confidentiality with each study participant. Each of the interviews was initiated through an informal discussion, to make the participants feel more relaxed. This was followed by the following first question in the interview schedule, *"Kindly tell me about your experience regarding utilization of healthcare services in Indiana."*

Other questions in the interview schedule were used as probes and prompt, to guide the researcher during the data collection process, and to elucidate in-depth-information from the participants. Audio-tape was utilised, to capture the interview process. Field notes were also taken, to describe some non-verbal cues which were observed from the



participants' body language and environment. After interviewing the sixth participants, the researcher realised that no new information was coming out, however, the researcher continued to interview two more participants, to really confirm that saturation was reached. Each interview lasted from 45 minutes to an hour, depending upon the participants' flow of relevant information, related to unique experience.

### **3.4.5 Data Analysis**

Data analysis is an activity that is conducted to reduce, organize and give meaning to the data collected. (Burns & Grove 2013:691). According to Neuman (2011:507), data analysis refers to the breaking up of data into manageable themes, patterns, trends, and relationships. The aim of the analysis is to understand the various constitution elements of a study data, and to see whether there are any patterns or trends that can be identified, isolated or establish themes in interpretation (Mouton 2010:108). As Creswell (2014:195) explained, qualitative research data analysis goes hand in hand with the other activities to complete the study. In this research, each and every participant's audio-recorded data were transcribed verbatim within 48 hours of each interview. The transcripts were analysed manually together with field notes using the following Interpretative Phenomenological Analysis framework of analysis (Smith 2005:11) provided below:

**Stage 1:** Reading and reading transcript to familiarize with participant's account,

**Stage 2:** Making notes of the interesting issues about participant's account,

**Stage 3:** Development of emergent themes that capture the meaning of participant's account,

**Stage 4:** Searching for connections across the emergent themes. and.

**Stage 5:** Development of a master table of themes containing super ordinate themes, sub-themes and quotes from transcript

The analysis was carried out in parallel with the interviews, and was conducted iteratively throughout the interview period, until data saturation stage was reached. Five

themes emerged from the above process. These steps were followed to analyse each transcript. An independent coder was also given all eight transcripts, to analyse them independently, and after the analysis of all eight transcripts by both the researcher and an independent coder, all the master list of themes were compared to check their similarities and differences. This process led to the development of a single master table of themes for all the transcripts. The emergent themes will be discussed in the result section of the next chapter, which is Chapter Four.

### **3.5 ETHICAL CONSIDERATIONS**

Ethics is associated with moral values that are concerned with the adherence to legal, professional and ethical conduct of a given profession or group (Polit & Beck 2014:381). Researchers have moral and professional obligation to be ethical for the research participants (Neumann 2011:143). Creswell (2014:95) emphasised upon the need of ethical issues of a research in all its processes; thus, even before it was proposed, during proposal, data collection and analysis, reporting, sharing and storing the data, the research was in harmony with the ethical issues in all its stages.

The researcher followed relevant ethical aspects described in Polit and Beck (2012:54). The aspects include permissions to conduct a study, autonomy, confidentiality and anonymity, protecting the integrity of the study, providing privacy and fair treatment.

#### **3.5.1 Permission to conduct the study**

The researcher obtained ethical clearance to conduct the study from the University of South Africa (UNISA) Health Studies Higher Degree Committee. Permissions to interview the refugees were provided by the Catholic charities of Indianapolis, Exodus Refugee and Immigrant Services. Study participants also gave their informed consent to participate in the studies after the researcher has explained of all relevant ethical issues related to the studies such as confidentiality, respects, rights to withdraw and voluntary participation.

### **3.5.2 Autonomy**

Autonomy in a research refers to individual's decision to participate or not in a study (Creswell 2014:97). Therefore, the individual's determination to participate in a research or any kind of study is one of the basic ethical principles (Burns & Grove 2013:171). This kind of qualitative study demands a deep understanding of the subject matter by the participants, before they would decide to participate or not, and whether to continue up to the end or not. In this study, the participants exercised their full autonomy. In the process, each participant was initially sensitized to the matter by raising the issue of health, general purpose, and specific objectives were clarified in a way that the study participant could fully understand the subject matter, then, each participant was asked to sign a consent form to participate, and they were all informed that they could withdraw from the study at any time.

### **3.5.3 Informed consent**

Relevant information concerning the study was explained to all the participants. Information given included the purpose of the study, specific objectives, their rights as participants which include: voluntary participation, confidentiality, benefits, potential harm and their rights to withdraw. Each participant was asked to sign the consent form to participate and they were all informed that they could withdraw from the study at any time without giving any reason.

### **3.5.4 Confidentiality and Anonymity**

According to Burns and Grove (2013:686-690), anonymity is the condition, in which, the participants' identity cannot be linked or mentioned in his/her individual response, even by the researcher, and confidentiality is the protection of the study participants so that the information provided are never publicly revealed. Confidentiality and anonymity are the two basic strategies or principles to protect individual's privacy in a study (Neuman 2011:155). Under this ethical principle, in the final presentation of the research report, no specific information or name is ascribed to an individual participant or a group of

known participants. To do so, no names are included in the research report: names were not recorded in the data collection process; rather, codes were used for data collection control and for the organization of the information. The audio recorded interviews were kept under lock and key, to prevent them from being in the wrong hands.

### **3.5.5 Protection and Privacy**

According to Burns and Gray (2013:705), protection refers to the right of research subjects under the ethical principle beneficence that this is for a good cause, and, above all, does not cause harm. Privacy is the freedom of an individual to determine the private information provided either to share or withhold from others. To assure privacy, each research participant was given a chance to select the time, place, and means of communication, according to their preference, and every participant was clearly explained the purpose of the research to ensure they understood and were protected.

### **3.5.6 Fair Treatment**

Fair treatment is an ethical principle that promotes fair selection and good treatment of participants during the course of the study (Burns & Gray 2013:694). Participants were approached with respect, according to their own culture and standard of knowledge, in their own language and way of cultural communication. Selection of participants was purposive, and participation was voluntary, which, after all, was the purpose of study, and this was made clear to each participant, where the right to withdraw at any time during the course of study was made clear to each participant.

### **3.5.7 Scientific Integrity of the Researcher**

Research is an activity to make science practical, based on evidence. Such kind of qualitative study is for the development of further research and policy designing, which significantly affects the experience of healthcare utilisation by the immigrants.

Therefore, considering the entire mentioned facts, the researcher acted professionally, by implementing ethical and scientific manner throughout the study.

### **3.6 MEASURES TO ENSURE TRUSTWORTHINESS**

Burns and Grove (2009:132) stated that trustworthiness is a means of demonstrating the plausibility, credibility and integrity of the qualitative research process Polit and Beck (2012:745) define trustworthiness as the degree of confidence the qualitative researchers have in their data. In this study, trustworthiness was ensured through adherence to Lincoln and Guba (1985) framework of trustworthiness cited in Polit and Beck (2012:175). The framework consists of the following five criteria: credibility, transferability, dependability, confirmability and authenticity.

#### **3.6.1 Conformability**

Conformability refers to the objectivity, which is important for the congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck 2012:585). This criterion is concerned with the establishment of the fact that the data represents the information which the participants provided, and that the interpretations of the data is not invented by the inquirer (Polit & Beck 2012:723). To assure this criterion, all face-to-face interviews with the participants were audio taped, and transcribed verbatim. The researcher counterchecked the data content and its interpretations with all participants, and invited them individually for further explanation of the study findings, to check and delete or add further ideas if necessary. An independent coder was given the entire transcript for recoding. Findings from the independent coder were discussed with the researcher, before finalizing the master list. Audiotapes were then kept safe, in case the supervisor or any other authorized person would need to listen to them.

### **3.6.2 Credibility**

Credibility refers to the confidence in the truth of the data and its interpretations (Polit & Beck 2012:724). It is also a criterion for evaluating the integrity and quality in qualitative studies, referring to the confidence in the truth of the data which is analogous, to its internal validity in quantitative research. To ensure this, the researcher had to contact the study participants all through the study process, to countercheck if their ideas were interpreted and presented well, without changing the sole meaning, according to their understanding, and was read to them, to check if it sounded right and reflected what they thought, or their experience.

### **3.6.3 Transferability**

According to Polit and Beck (2012:745), this refers to the ability of generalizing data, to an extent where the findings from it can be appropriately transferred or extrapolated to other settings or groups. To comply with this criterion, the researcher fully described the research sites, participants, and the data collection methods. The researcher conducted detailed and necessary description of findings from the study participants about their experience of healthcare utilization.

### **3.6.4 Dependability**

According to Polit and Beck (2012:725), dependability referred to a criterion for evaluating integrity over time and conditions, analogous to the reliability in research. The study was reliable and transparent, both with the study participants, and the supervisor about the research, where the research process and its findings were important. From the beginning of the study, the researcher maintained a close personal relationship and continuous contact with the study participants, all through the process of the research over time, to assure that the final results included and presented the truthful representations of what the subjects had experienced, and what they have explained from their own points of view or understanding. Therefore, they were updated continuously through different means of communication, according to the preference of

each individual. The researcher maintained a close contact, continuous follow-ups, and benefited from the constant input of guidance from the supervisor.

### **3.6.5 Authenticity**

Authenticity is about the truthful means, which offer a fair, honest, and balanced account of one's social life, from the viewpoint of the people who live it every day (Newman 2011:214). In this research, it refers to the genuine nature of the information which was provided by the study participants about their healthcare utilization experience, regardless of other factors, and the data collected, as well as the research findings presented, are also from the real study participants, the Eritrean immigrants, and by the sole author or researcher of this study. This was also maintained through the communications with my study supervisor, the members of the ethical committee, and the study participants, starting from the inception of the study, till right up to final point.

## **3.7 CONCLUSION**

This chapter presented detailed description of the research approach used. Research design and the methodology implemented are fully discussed. The chapter also described the measures taken to ensure trustworthiness of the study. It also gave thorough description of the ethical issues adhered to in relation to the study. The next chapter will presents the results based on the experiences of the Eritrean immigrants regarding the utilisation of Healthcare services in Indianapolis.

## **CHAPTER 4: RESULTS**

### **4.1 INTRODUCTION**

The previous chapter highlighted the research design and the methods used in this study. This chapter presents the study findings that emerged from the data analysis, based on the Eritrean immigrants' experiences of healthcare utilisation. The data were obtained through individual face-to-face interviews. Transcripts from these interviews were analysed thematically, using the IPA framework of data analysis. Three super-ordinate themes emerged from this. Verbatim excerpts of the participants, indicated in italics, were used in this chapter, to support or substantiate the discussions of the themes. The first section of this chapter highlighted the demographic data of the participants, while the second section was about the thematic presentation of results.

### **4.2 DEMOGRAPHIC DATA OF THE PARTICIPANTS**

Description of demographic data of the participants is necessary for qualitative research. It helps to ensure the trustworthiness of the study, as it assists in meeting the criteria of transferability (Bryman, Bell, Hirschsohn, Dos Santos, Du Toit, Masenge, Van Aardt, & Wagne 2014:45). Demographic data enable the readers to understand the sources of data, and also assist in interpretation of the findings. The following table (Table 4.1) is the summary of the demographic data of the participants.



Table 4.1 Demographic characteristics of participants

| <b>Participant</b> | <b>Age</b> | <b>Marital status</b> | <b>Family size</b> | <b>Immigration status</b> | <b>Number of years in USA</b> | <b>Educational status</b> |
|--------------------|------------|-----------------------|--------------------|---------------------------|-------------------------------|---------------------------|
| <b>IRMU</b>        | 30-40      | Married               | 5                  | Refugee                   | 8                             | MA                        |
| <b>IADA</b>        | 30-40      | Married               | 4                  | Asylee                    | 9                             | BSc                       |
| <b>IUFI</b>        | 50-60      | Married               | 4                  | Undocumented              | 10                            | 8 <sup>th</sup> grade     |
| <b>IDVKI</b>       | 40-50      | Married               | 6                  | Diversity Visa            | 11                            | BSc                       |
| <b>IRYO</b>        | 50-60      | Single                | 2                  | Refugee                   | 7                             | None                      |
| <b>IRSI</b>        | 60-70      | Married               | 8                  | Refugee                   | 26                            | BSc                       |
| <b>IRMO</b>        | 40-50      | Single                | 1                  | Refugee                   | 5                             | 12 <sup>th</sup>          |
| <b>IDVYO</b>       | 40-50      | Married               | 4                  | Diversity Visa            | 5                             | BSc                       |

In this study, all participants are from Indianapolis, and they lived there at least for five years, and with the highest time of 26 years. It is one of the findings where the more years the participants lived in USA, the more they become suited to the system of healthcare seeking behaviour or culture, and the less they become apprehensive to the challenges they faced throughout time, to get access to healthcare, which affects their utilisation.

Out of the eight participants, six are married, so that they shared their healthcare experience and their families, as the head of their households. The study included two single participants as well, of whom, one is living alone, who is less privileged, with federal and state-funded health coverage, in which, experience of healthcare utilisation was different. The immigration status of the immigrants changed throughout the time of their stay. For example, one may enter USA illegally, then she/he would be an illegal immigrant; after applying for asylum, she or he may become asylee, and so on, up to the time when he/she may be naturalized and become a citizen. Throughout these times, an immigrant's access and utilisation of healthcare is affected by his/her status of immigration. Participants were categorized, depending upon how they got into USA at the beginning of their entry, and it has an impact upon their access and utilisation of healthcare. Therefore, to assess the effect of immigration status upon the access of healthcare, the study included four refugees, two diversity visa immigrants, one

unauthorized, and one asylee immigrant, who initially got into USA illegally through the Mexico border.

Study participants' educational backgrounds ranged from zero level to masters' degree. This condition helped the researcher to know the perspective of healthcare utilisation from a wide range of level of knowledge, and the subjective explanation of the situation at different understanding levels of the participants.

### **4.3 PRESENTATION OF FINDINGS**

This section presents an overview of the super-ordinate themes, themes, and sub-themes that emerged from data analysis of the experience of Eritrean immigrants, regarding the utilization of healthcare services in Indianapolis. Summary of the emerged themes is presented in the study below in table 4.2, which show the relationship between the super-ordinate themes, the themes, and their sub-theme, or the illustrated phrases of explanation.

Table 4.2: Summary of emerged themes or results

| <b>Supper-ordinate theme</b>                                    | <b>Theme</b>  | <b>Sub-theme</b>   |
|---|---|--|
| <b>Healthcare financing systems</b>                             | <b><i>Compulsory Healthcare insurance.</i></b>          | <i>Free health insurance</i>                                   |
|   |   | <i>Healthcare coverage of illegal immigrants</i>               |
|   |   | <i>Fluctuation of insurance status</i>                         |
| <b>Positive side of healthcare services</b>                     | <b>Efficient healthcare services</b>                    | <i>Advanced technology</i>                                     |
|   |   | <i>Successful emergency care</i>                               |
|   |   | <i>Comprehensive screening and immunisations</i>               |
|   | <b>Attitude of healthcare professionals</b>             |  |
| <b>Challenges related to utilisation of Healthcare services</b> | <b><i>Personal factors</i></b>                          | <i>Cultural believe</i>  |
|   |   | <i>Language barrier</i>  |
|   |   | <i>Attitudes towards medical insurance</i>                     |
|   | <b><i>Structural factors</i></b>                        | <i>limited eligibility of immigrants</i>                       |
|   |   | <i>Limited choice of services for immigrants</i>               |
|   |   | <i>Requirement to continuously use the healthcare services</i> |
|   | <b><i>Interaction with healthcare professionals</i></b> | <i>Compulsory Use of interpreters</i>                          |
|   |   | <i>Use of multiple disciplinary teams</i>                      |
|   |   | <i>Blanket approach to provision of healthcare</i>             |
|   |   | <i>Delays in receiving healthcare service</i>                  |
| <i>Attitudes of healthcare professionals</i>                    |   |  |

Three super-ordinate themes emerged from the data analysis, and were presented with detailed description and interpretation of their sub-themes, to reflect the real word account and understanding of the study participants as follows:

1. Healthcare financing system
2. Positive side of healthcare services
3. Challenges related to the utilisation of healthcare services

#### **4.3.1 Healthcare financing systems**

Healthcare is financed in the form of health insurance, which is different from what participants know back home, where one is treated when they are sick, and payments are made on spot. This theme is about the financing system which is used, which has a massive impact on the utilisation of healthcare services by the Eritrean migrants. The real life healthcare accesses and utilization experience is different from person to person. Some of the factors are the immigration status, thus, Eritrean immigrants enter the country through different means of immigration, and this creates disparities upon the individual access and utilization to healthcare. In any way, it is compulsory to have health insurance, in order to access healthcare services.

##### ***4.3.1.1 Compulsory Healthcare insurance.***

The healthcare system of USA works through health insurance. It can be gained by either paid health insurance, that is job based, privately purchased or public benefits, in the form of Medicaid, Medicare, or other forms of health coverage. This theme is about the different health financing systems that an individual need to utilise in Indiana. As it is known, the ACA is in its implementation phase, and based on that, every legal resident need to have health insurance. Participants mentioned that they experienced problems related to the new health law, which proclaimed compulsory health insurance for every legal resident. The following statement by IRYO attests to this:

*“I am expected to join the health insurance, despite my health status. For me, I rarely get sick, so paying such large amount of money for health insurance is like a waste to me. I would have used that money for something else. But because I*

*am paying, it makes me visit the healthcare facilities even for minor things which do not need treatment, just to use my money.”*

Under compulsory health financing, different systems of financing were experienced by different refugees, depending on their status. This included free health insurance, healthcare coverage of illegal immigrants, and fluctuation of insurance status. All this have an impact on the utilisation of healthcare services by the Eritrean immigrants.

#### *4.3.1.1.1 Free health insurance*

When an immigrant is legal and within a certain group of immigration status, such as refugee, and still has a low income with a considerable family size, he/she may be eligible for Medicaid. Although some participants complain of healthcare insurance, some participants, like IADA, are happy about the system and insurances, because they are still using health insurance due to their pregnancy status, and eligible immigration status.

*“For me, I am enjoying free access and utilisation of healthcare service. I am now pregnant, and my children are also receiving free services. Medicaid is very helpful. I do not know what I would do if there was no free insurance. I can take my child to the hospital anytime, free of charge, as long as I present my card.”*

Apart from healthcare insurance, which allowed participants free access to healthcare service, there is also different health advantage for the participants who hold diversity visa and other immigration status. Eritrean immigrants still need to be the residents of Marion County. Luckily, for those types of Eritrean immigrants with low income status and considerable family size, advantages are available. One of the study participants, IDVYO, shared experiences as follows:

*“I and my family, my two daughters, and my wife have Wishard health advantage. My daughters are not born here, so they are not eligible for*

*Medicaid. I was told if my wife gets pregnant, she can be eligible for Medicaid, and we all are eligible for emergency health problem Medicaid coverage. Anyway, I am very grateful that we are covered by health advantage, they always refer us which health center or hospital to go to get treated with our health advantage card. The good thing is, we do not pay monthly premium like those who purchase health insurance, and/or we do not have deduction from our pay checks, because I am a taxi driver. We get treated any time we feel sick, both myself and my family. With the health advantage that we have, we are only required to see the specific health centers or hospitals, but that is ok, it only minimizes confusion and we like it.”*

#### *4.3.1.1.2 Healthcare coverage of illegal immigrants*

The healthcare access and utilization experience of illegally entered immigrants was also found different. For them, as public benefit, only emergency care is allowed, and only if they complete other eligibility requirements, such as income. Two of the study participants were in the same condition, and, one of them, IADA, who by now is naturalized, described the healthcare access and utilization experience at the beginning of his arrival in the following words:

*“I had to apply to get asylum, and while I was on the middle of my process of getting asylum, I had pneumonia, so, as I had no insurance I was confused on what to do, but as an illegal immigrant, I got emergency service, and that’s how I could be saved, because I am in America and I am grateful for it.”*

For unauthorized or legally undocumented immigrants, the healthcare coverage depends on the employer’s capability to pay, or subsidise the insurance. IUPI described the situation as follows:

*“At the beginning, I tried many jobs, and all of them had no insurance. The situation was so frustrating. But currently, I have insurance from my job. This*

*time I am well covered by the insurance. I pay Biweekly less than 38 dollars from every pay check, that's 76 dollars per month. I am very grateful and I get treated every time I feel sick."*

#### *4.3.1.1.3 Fluctuation of insurance status*

The health insurance system is unpredictable, difficult to manage or understand, according to all study participants. They described it as unstable, and can fluctuate from one insurance status to another depending on employment, age, pregnancy status, and birth rights of children. The same variables also make a family end up with different insurances for different family members. So, it has great impact on the access and utilisation of healthcare. For example, one of the study participants, IDVKI, described the experience as follows:

*"I had to include my family with me on my job-based health insurance; it was very expensive, more than 400 dollars a month. Later, when my wife got pregnant, she got Medicaid coverage until she delivered, after that my baby, born in the USA got Medicaid, and I do not need to worry about him. In such situation, after all, my wife had to start work, and there she was having her own job-based insurance. I had to include my other three children with me, and the monthly payment become 215 dollars. While we were living in such a situation, my wife had to quit her job, and she lost everything. It was stressful moment with the must-have insurance or the policy of the new healthcare law. Lastly, my wife became eligible for health Indiana plan (HIP), thus, I pay 10 dollars a month as premium for her, which is very good deal. So, this time I and my three children are under my job-based insurance, my youngest son who is born in USA is eligible for CHIP of Indiana, and my wife is under HIP. The health insurance issue is not only affecting my health, it is also affecting my career. I graduated one year ago from college, but I just started my profession-based job recently, and I needed to not lose my health insurance coverage, especially because I do not want to take a risk for my family situation, leaving them even for a week*

*without health insurance. Recently, my children and my wife got naturalized, so I am hoping that all my children would be eligible for Medicaid coverage, and that will give me a relief relatively”.*

Different types of health insurance among the Eritrean immigrants determine the access and utilisation of healthcare service by this population.

#### **4.3.2 Positive Side of Healthcare Services**

This theme focuses on the good experiences with regards to the utilisation of healthcare services in Indianapolis by the study participants. Themes under this super-ordinate theme are efficient healthcare services, and the attitude of healthcare professionals.

##### **4.3.2.1. Efficient healthcare services**

Efficient healthcare services were discussed under advanced technology, successful emergency care, as well as comprehensive screening and immunisations.

###### *4.3.2.1.1 Advanced Technology*

Participants found that the healthcare services are better, and the utilisation of the services improves the quality of life. One of the study participants, IRMO, who came to USA as a refugee, described it in the following words:

*“It is a blessing to find yourself in a land of possibility to solve every health problem which is not possible back home; especially the complicated surgical and medical conditions, which can be managed by modern medical services, and talented, well-educated health professionals”.*



#### 4.3.2.1.2 Successful emergency care

Participants were grateful about the type of care they received when utilising healthcare services for emergency conditions. One of the study participants, IRSI, who went through complicated and life threatening condition in life, described it as follows:

*“In 2006, I had a heart-block. I had to undergo an emergency surgery. The doctors had to operate on my heart in order to remove whatever was blocking the blood to go in or out of my heart. I was admitted in one of the best hospitals of Indiana, which I did not even deserve, based on my income. I stayed in that hospital for two weeks. When I was showed the bill, it was bigger than all my assets in Eritrea and here. However, I was shocked to hear that there were sponsors who paid all my bills, which was hundreds and thousands of dollars, which were all paid by my sponsors, or I think Medicaid. The hospital professionals, under almighty God, saved my life. Had it been in Eritrea, I may not be survived”.*

One of the study participants, IADA, also mentioned a time, especially at the beginning of their life in USA, and when he had nothing, and described the good part of life to get his health issue solved:-

*“Soon after I got in to USA and while I was illegal immigrant, I got sick of pneumonia. I was very sick. They considered me as an emergency case, and admitted me to the hospital. I did not have any required papers as a migrant or refugee. But they treated me very well, until I regained my health. They discharged me, and did not require for me to pay. The hospital staff were very good to me.”*

#### 4.3.2.1.3 Comprehensive screening and immunisations

The other issue that was presented to the study participants was specifically raised as good opportunity regarding healthcare service, and it was the experience and utilization

of the free service given to the refugees on their arrival to Indiana. Four of the study participants who were included were refugees, and had a good opportunity to start their life, which can be exemplified by the account of one of them, IRMO:

*“There we had comprehensive examination and laboratory check-ups for blood, faeces and urine. They gave me six shots of vaccination and one flu vaccine through my nose. I was surprised by this many shots at one time, which I never expected to happen. I realised that the country is so advanced in modern medical practice. After three days, I got a letter that I am positive for Giardiasis, and it ordered me to report to the hospital as soon as possible for treatment. I did and I was treated good”.*

#### **4.3.2.2 Attitude of healthcare professionals**

Participants mentioned that the attitudes of some healthcare professionals towards migrants were good, as mentioned by IRSI:

*“Majority of them has good attitude, kindness, they were humble, knowledgeable and respecting. I enjoyed my stay in the hospital. During visiting time, because I did not have anyone visiting me, some nurses would come and talk to me, they were all very kind”.*

Though some of participants have positive experiences regarding the utilisation of healthcare services, other participants had experienced several challenges in the process.

#### **4.3.3 Challenges Related to the Utilisation of Healthcare Services**

This section highlights the challenges related to the utilisation of healthcare services while living in Indianapolis. The factors are either personal or structural. Both factors are interrelated, and go hand in hand to create cumulative effect of the immigrant’s poor healthcare utilisation.

#### **4.3.3.1 Personal factors**

Personal factors are those which are directly related with the immigrant's self-characteristics or behaviour.

##### *4.3.3.1.1 Cultural belief*

One of the personal factors raised is the cultural practices of the Eritrean immigrants. Culture determines their health seeking behaviour. Participants expressed this issue by saying that there was no need to take medication while not being sick, no need to come to the doctors, and they prioritized other life activities. The following quotation from IRMU attests to this:

*"We do not have the culture of seeking medical help for minor illnesses. It should be really serious for one to go to the hospital. One needs to be really sick. I mean we do not really care about what we are supposed to do concerning our individual health, until we experience a health crisis. The problem is, now, when you go to the hospital, you already have complications, and the healthcare worker becomes very rude and complain that if you came in time, we should not be doing all the unnecessary work. I went with a toe which was very septic, and they ended up amputating it, because they said I should have come when the wound started. They also said that I have Diabetes Mellitus. And I know that it might have started a year ago, because when I checked the signs of Diabetes from the pamphlet they gave me, I realised that I had started feeling most of the symptoms last year, but just ignored them. Even when I first got to Indianapolis, I was told that I have some signs that indicate that I am going to develop diabetic, but I ignored it".*

From the findings, generally, the healthcare seeking behaviour or culture of the individuals back home, and even here as immigrants, is poor, when compared to the native residents.

#### 4.3.3.1.2 Language barrier

Another issue raised is the inability to speak and understand English language which is used by the healthcare practitioner. This challenge makes some participants stop using treatment prematurely, or fail to make follow-up visits to the health facilities. Study participant IRYO shared his own experience of interaction and misunderstanding because of language barrier in the following words:

*“They gave me packages of tablets to take without interruption for two months. I think I did not understand the instruction, and even the purpose of doing that. I tried them for one week, and then I concluded that I am well. I threw the rest of the pills away. After three weeks, I was very sick. When I went back to the hospital, they were furious about me, saying that I did not follow their instructions. They told me that I should visit the clinic daily for injection. So, if I have understood their language, I would not have stopped. Now, the daily injection was too much for me.”*

#### 4.3.3.1.3 Attitudes towards medical insurance

Another factor raised is the attitude of Eritrean immigrants towards payment of medical insurance. According to them, the health insurance system is just throwing away money to a third party, and neither to the provider, nor to the patient. Thus, even those who are insured under the employer-based coverage find it unsatisfactory, due to the co-payment and out-of-pocket payments every time they avail the services. For example, the study participant, IADA, described it in the following words, for job-based insurance.

*“The healthcare facilities and the insurance companies try get better profit from the customer (patient); at the same time, the healthcare facilities try their best to charge a lot of money from the patient, and the insurance company tries their best to pay less, by putting restriction on the insurance plan.”*

### **4.3.3.2 Structural factors**

Structural factors are those that are out of control of the immigrant. Participants mentioned about their complexity, and how it works, when you get service under the health insurance coverage.

#### *4.3.3.2.1 Limited eligibility of immigrants*

One of the structural factors that hinder the utilisation of healthcare is the limited eligibility of the immigrants to federal and state tested public benefits, such as Medicaid. The effect of this is also seen and described by the study participants, especially those who are of mixed status, and the immigrants of less than five years in USA. The following excerpts from IRMO attest to this:

*“I really want to use the heathcare service. But, it is so frustrating, because, before you get care, especially if it is not an emergency. one has to complete a lot of forms, making requests for authorization. Sometimes, they return the form, saying that it is incomplete, or authorisation is not granted, based on the type of medical aid you asked for, and you get different wait times before you are approved.”*

#### *4.3.3.2.2 Limited choice of services for immigrants*

The other structural challenge mentioned is the specification regarding the services which are supposed to be use by the migrants. Some of medical insurance do not allow specific services, or just restrict access to a few facilities, as indicated by IRSI' statement:

*“The health system is so frustrating. There is a healthcare facility next to where I stay, it is just a five minutes' walk. But, my medical insurance does not allow me to use that facility. Everytime when I am sick, or my family member is sick, I have to hire a car, or call an ambulance to take the person to the hospital, which*

*is 25km from where I stay. It is also difficult to visit the patient there. So, we end up not using the healthcare services unless the condition is very serious.”*

#### *4.3.3.2.3 Requirement to continuously use the healthcare services*

From the study participants' word account, it can be generalized that, all health professionals try to implement the idea of good customer service, and they want the participants to visit the healthcare services continuously, so that, they will be able to get adequate profit and income. Participants mentioned that they are not treated to get rid of the illness, but to visit the healthcare facilities as a client, and this is a part of American healthcare seeking behaviour or culture, for the sake of money. Participants explained this in many ways, but, more or less, they have some descriptive message and understanding. Immigrant IRMO summarized it as follows:

*“Even though it seems that patient care comes first, but, technically, the issue of money comes first, before the patient, because the system makes the healthcare workers and other involved individuals to run after money in the name of the client or patient. The services that you get temporarily are good, but, generally, the idea and mentality of the health workers do not reflect true humanity, rather, it reflects towards making more money out of us. Because whatever they give you, it is billed.”*

This completely contradicts with the idea of 'get treated to get free of the disease' ideology and the expectation of the Eritrean immigrants, and is on opposite direction with their poor healthcare seeking behaviour. IUF1 described the situation as follows:

*“You can go to church at least every week, but you cannot visit a clinic weekly or more often; but technically, that looks like what the physicians want you to do.”*

The imagination behind to that point is, according the study participants' ideology, there is no need to oscillate to and from health facilities frequently, and there is no fun that one gets out of it.

#### **4.3.3.3 Interaction with healthcare professionals**

Results indicated that the participants experienced challenges in relation to interacting with the healthcare professionals. Issues were raised, including the use of interpreters, and were accompanied by misunderstandings.

##### *4.3.3.3.1 Compulsory use of interpreters*

According to the study participants, the first issue that was mentioned and discussed as a factor that affects the communication between the participants and providers is the language barrier. Even though one speaks English initially, the use of an interpreter is a norm for them with the healthcare professionals, just to avoid the accent disparities and misunderstanding. As his initial encounter, one of the study participants, IADA, puts the experience in the following words:-

*“Accent (language barrier), accompanied by cultural and social barriers for nonverbal communication, such as maintaining eye contact (which is sign of respect according to Americans and disrespect and rude according to Eritrean), was a major challenge. Some of the providers try to consider you as if you don't have enough English knowledge to explain your problem, just because of accent and body motions that you show, based on your cultural background. Some of them don't want to talk to you directly, but the real world of privacy and confidentiality, accompanied by difference in conceptual health knowledge between the patient and provider is a big barrier, and it creates discomfort, which bothers you more than your actual health problem. Some of the facilities use a phone interpreter, in which, the interaction you have with your healthcare provider completely depends up on verbal communication, excluding the vital*

*meaning of your message through body language, which is mainly clear to the person who is similar to you, and understands what it means and conveys it to the physician.”*

#### **4.3.3.4 Attitudes of healthcare professionals**

Though some participants mentioned that they have very good experience when interacting with the healthcare professional, other participants have negative experience with them. IRMO attests it in the following words:

*“I do not wish to go to the hospital again. The healthcare professionals were very rude and disrespectful. Some were just talking to me like a child. They do not try to understand what I mean, I remember the other day when two nurses were talking about me while I was in bed saying that “people have just left their country and they do not know nothing, no education no English, no knowledge”. They continued saying a lot of unnecessary things in English, thinking that I do not understand them. I felt so angry, but there was nothing I could do. All in all, they are too ignorant to know how much you know, they just judge you from the scientific knowledge that they have, they do not consider the health understanding that you have about yourself, based on your own culture and belief.”*

##### **4.3.3.4.1 Use of multiple disciplinary teams**

The other structural problem raised was the use of plenty of healthcare professionals for only one minor problem. IDVKI described it in the following words:

*“If you visit the healthcare centre for headache, you will end up seeing more than 5 healthcare professionals, all making money out of you, and also wasting one’s time. You will see the doctor, then laboratory technician, then a nurse, a dietician, then you go to X-ray. Practically, you encounter many physician specialists,*



*laboratory, which creates confusion, wastage of time, and they end up asking too many personal questions, which is unrelated to your problem. The professionals seem to have a similar concept. They are governed by one rule for every patient; irrespective of background, prescribing too much, which is boring. I do not even think about taking it all, or buying all, even if it is free. They are not convinced by the idea of taking medicine as prescribed, except those who have been longer in the USA, and are better situated with the system.”*

#### **4.3.3.5 Blanket approach to provision of healthcare**

According to the participants' explanation, use of same healthcare approach to all patients, regardless of whether the person is immigrant or not, is a problem. This is described by one of the study participants IRMU:-

*“When I share my health problem with the healthcare professionals of different health concept, language, and culture, it greatly affects the continuation and outcome of care we receive as immigrants. Health professionals have no clue on how to approach immigrant patients and deal with them, according to the health concept he/she has, based on cultural and religious background, but their method of approach is universal, the same as they would approach any American resident, which is not meeting the cultural needs of the Eritrean immigrants.”*

#### **4.3.3.6 Delays in receiving healthcare service**

Participants mentioned that they were not expecting that, because the country is advanced, thus, they expected that it would take minimum time to receive service, if one visited the healthcare facility. But, the participants found it unclear why they were always full of patients, and the time spent in getting service involves unacceptably long waiting hours, despite the fact that many professionals move in between the patients. One of the study participants, IUFI, described it this way:

*“Once I remember I went to emergency by my own car feeling terribly sick, there I waited four hours. Healthcare professionals were just passing me. Others will just look at my card and say, this is not an emergency, we shall see you later. I came back home without anything, since I got frustrated from waiting. I decided to get back home, and be treated in my own way.”*

#### **4.4 CONCLUSION**

The chapter presented a summary of the findings of the study that emerged from the data of the individual interviews conducted on the Eritrean immigrants living in Indianapolis. The next chapter of the research focuses on the discussions of the study findings, including the limitation of the study, and the recommendations based on the findings, for the professionals, agencies, or any policymakers dealing with the immigrants.

## **CHAPTER 5: DISCUSSION, LIMITATION, CONCLUSION AND RECOMMENDATION**

### **5.1 INTRODUCTION**

Based on the data obtained from the study participants, the study findings were presented in the previous chapter. This chapter presents the discussions of the research findings, within the perspective of the literature reviewed. It includes the limitations, and the contributions to the study. It summarizes the study, and gives recommendations based on findings.

### **5.2 RESEARCH DESIGN AND METHOD**

The study used qualitative descriptive phenomenological design to explore and describe the experiences of the Eritrean immigrants regarding the utilisation of healthcare services in Indianapolis. Data collection was done from eight purposely selected participants using semi-structured interview. The researcher used the interpretive phenomenological analysis framework of data analysis. Researcher maintained the trustworthiness of the research by following Lincoln and Guba criteria of credibility, transferability, dependability, conformability and authenticity so as to insure the rigor of the study. Ethical issues were adhered to throughout the studies. Three superordinate themes resulted from data analysis namely: (i) Healthcare financing systems, (ii) Positive side of healthcare services and (iii) Challenges related to utilisation of Healthcare services

### **5.3 DISCUSSION OF THE RESEARCH FINDINGS**

This section is about the discussion of the results based on three super-ordinate themes and themes as presented in the previous chapter.

### **5.3.1 Healthcare financing systems**

Under this super-ordinate theme, the issue of compulsory health insurance system to access healthcare service is raised. Three themes identified under this superordinate theme are free health coverage, healthcare coverage of illegal immigrants and fluctuation of health insurance. The findings indicate that there are several health financing ranging from free health financing, paid health insurance that's Job based, or privately purchased or public benefit in the form of Medicaid, Medicare or other forms of health coverage. These findings attest to the report by Chaudry and Fortuny (2011:2) and ACP (2011:6) mentioning that immigrants to varied healthcare coverage.

There are different factors which have impact on the type of healthcare financing which can be accessed by the immigrants. Some of the factors include immigration and citizenship status, length of stay in Indianapolis, Health status, family composition, sex, age, occupational status, income level, educational status and other individual factors. The factors identified in this studies are congruent with the study conducted by Medalia and Smith (2015: 6-7) who mentioned that there are several criteria an immigrant has to meet before accessing healthcare finance.

Different financing systems have an impact on utilisation of healthcare services as there are other immigrants who are not eligible for health financing. They are only cared for in case of emergency. Same was documented by (ANA 2010:8) mentioning that, according to federal laws, un-documented immigrants are not eligible for Medicare, non-emergency Medicaid and Children health insurance program (CHIP).

Limited access to the healthcare financing lead some of the immigrants not to utilise healthcare service due to fear that they will not be able to afford payment. Other Eritrean immigrants even gave the report of refusing to be hospitalised, or demanding premature discharge thus putting the doctors and other healthcare professional in dilemma of not knowing whether to keep the client or not. The results attest to report ANA (2010:8) reporting that denying access to healthcare by the immigrants would jeopardize the public health of the country, especially when an undocumented

immigrant is suffering from non-emergency illness which can pose health threat to other individuals (ANA 2010:8).

The results also indicate that there is lack of sustainability in health financing status which makes some immigrants to find themselves in and out of medical cover, or moving from one medical cover to another one with limited benefit or cover. The findings attest to findings by Campbell et al (2015:9) mentioning that utilisation and access to healthcare finance varies from time to time depending on time of stay as an immigrant, and passing through different immigration status.

Lack of sustainability of the health cover makes some immigrants to become reluctant to utilise healthcare service due to fear of being expected to make co-payment or to be expected to pay huge amount of fund to cover medical expenses. Lower utilisation of healthcare services by immigrants due to inability to pay health expenditure attest to findings by Medalia and Smith (2014:24) mentioning that there is lower usage of healthcare services by immigrants compared to native born Americans.

Though the healthcare financing system in Indianapolis seems to have negative impact on the utilisation of healthcare services by Eritrean immigrants, results indicate that there are some positive side of healthcare services in Indianapolis.

### **5.3.2 Positive side of healthcare services**

Findings indicate that some participants were impressed by the services they received in the healthcare facilities in Indianapolis. Most of them were impressed with high medical technology utilised in Indianapolis healthcare services. This finding concurs with the report given by Miller (2015:19-21). However, this high medical technology maybe contributing to the high cost of medical care services.

Findings of this study indicate that participants were satisfied with the thoroughness of care which is provided in emergency free of charge. This may be linked to the

availability of advanced medical technology. This description of health technology concurs with the findings of Boise et al (2012:12).

Apart from expert care provided during emergency, findings also indicate that immigrants are thoroughly screened for different kinds of medical conditions. If the immigrants are found to be suffering from any condition which may be a threat to immigrant's health or to the community, they are provided different with relevant medical treatment. Immigrants are also immunised against several infections, which improve their health. These practices are in line with the ICRMW international Bill of Rights mentioning that migrant workers and their members of their families have the right to the enjoyment of the highest attainable standard of physical and mental health (Pace 2009:9; Bingham 2010:11).

Though there are some positive aspects experienced by participants in utilisation of healthcare service, there seems to be also challenges regarding the utilisation of those services.

### **5.3.3 Challenges related to utilisation of healthcare services**

The study indicates that Eritrean immigrants are faced with several challenges in relation to utilisation of healthcare services. Some of the challenges they are experiencing are related to their personal situation while other are structural.

Personal factors are directly related with the immigrant's self-characteristics or behaviour. Some of the factors include immigrants cultural believes. Some of those beliefs of Eritrean is the reluctance to use medical services unless a person is very sick. The other aspect raised is issues of gender congruency where male patients want to be treated by male healthcare practitioner. These findings attest to Cooper (2010:7), who reports that gender concordance in relation to healthcare provider is considered very important to many Eritreans.

From the findings, generally, the healthcare seeking behaviour or culture of individuals in Eritrea, and in USA as immigrants is poor, compared to the native residents. Culture determines the health seeking behaviour of Eritrean immigrants (ANA 2010:5; ASPE 2012:6). This reluctance to utilise medical health may also be related to immigrants' priority as the results have indicated that their main purpose of immigrating to USA is betterment of economic status instead of healthcare services. This attests to Anderzejewski et al. (2011:3).

Another issue raised is inability to speak and understand English language used by the healthcare practitioner. This challenge makes some participants to stop using treatment prematurely or fail to make follow-up visit to the health facilities. Language as a barrier to utilisation of healthcare services is also documented by ANA (2010:5).

Another deterring factor to utilisation of healthcare services is the attitude of Eritrean immigrants towards payment of medical insurance. Eritrean immigrants view payments of health insurance system as waste of money. This makes them not to have healthcare coverage making them not to utilise healthcare services as they cannot pay cash. As most of Eritreans immigrants are employed in low-paying job, they end up uninsured. This attests to findings by Jewers and Ku (2013:8) mentioning that the rate of being uninsured for low income immigrants is two times higher than the low income Americans born citizens.

Findings also indicate that apart from personal factors affecting utilisation of healthcare services by Eritreans immigrants, results indicate that there are structural factors that also affect the healthcare service utilisation. Structural factors refer to those aspects or situations that are out of control of the immigrants. Participants' mentioned about the complexity and its action when you get service under health insurance coverage.

One of the structural factors hindering utilisation of healthcare is the limited eligibility of immigrants to federal and state tested public benefits, such as Medicaid. The effect of this is also seen and described by the study participants, especially for those who are of mixed status, and the immigrants of less than five years in USA. The findings are in line

with those of Chaudry and Fortuny (2011:10) who reports that there are several eligibility criteria which should be achieved one can get specific healthcare insurance. This situation excludes most of Eritreans immigrants from utilisation of healthcare services.

The other structural challenge mentioned is the specification regarding the services which are supposed to be use by migrants as some of medical insurances which Eritreans immigrants are eligible to just allow them to use specific public institution. Some of the institutions are far from the dwelling place of the immigrants. This creates challenges as they are expected to hire a transport which may be costly to most low income Eritreans. This make some of participants to just ignore the health condition till it complicates. The use of only public institution is in contrast with the recommendations by UNHCR (2014:2).

The other challenge to utilisation of healthcare service is the approach to healthcare services which participants mentioned that it is not focusing in curing the disease but as a way of creating dependency of users to the healthcare system. This make participants to be reluctant to continuously use the healthcare service or to adhere to prescribed treatment. This finding is consistent to the study finding done Jewers and Ku (2013:17).

Another structural factor identified as a challenge for utilisation of healthcare service by Eritreans immigrants is related to their interaction with healthcare professionals. Issues raised include compulsory use of interpreters and accompanied by misunderstandings. The compulsory use of interpreters violates the rights of privacy and confidentiality as documented by Bingham (2010:7). Realising the existence of stigma and discrimination among Eritreans towards HIV/AIDS and mental illness mentioned by Cooper (2010:8), the use of interpreter may have negative impact on the utilisation of healthcare services by Eritrean immigrants.

Though some participants mentioned that they have very good experience when interacting with healthcare professional, Results indicate that some participants have experienced negative attitudes from healthcare professionals. This situation makes



other participants to avoid utilising the healthcare services. The other aspect raised was the use of multidisciplinary team which made other participants assume that it waste their time and also their finance as everyone involved in provision of healthcare services will need to be paid..

These findings indicate that personal issues of Eritrean emigrants, policy issues, socio-economic status, immigration status of Eritrean and financing systems of healthcare services have a huge impact in determining utilisation of healthcare services to Eritrean immigrants in Indianapolis

## **5.4 RECOMMENDATIONS**

Based on the findings, the researcher recommends the following:

- Proper orientation of Eritrean immigrants regarding healthcare system in Indianapolis
- Healthcare policy reviews in order to accommodate Eritreans who cannot financially afford healthcare services
- Provision of the right of choice to Eritrean immigrants who do not want the presents of an interpreter when utilising the healthcare services
- Emphasising rendering of cultural congruent healthcare services by healthcare providers.
- Further research using quantitative research approach in order to get the perceptions of Eritreans immigrants towards healthcare services in Indianapolis

## **5.5 LIMITATION OF THE STUDY**

The study has the following limitations:

- Only Eritreans immigrants who have attended the gathering have been recruited to participate in the studies. This might have left out other participants who may have different experiences.
- The researcher is an Eritrean immigrants working in one of the healthcare facilities in Indiana. This might have an impact on how participants responded

during interview. However, the researcher have used interview guide to ensure that participants are asked more or less similar questions. Participants were also ensured about their rights as participants and that whatever they say will not be used against them. Aspects of confidentiality were also emphasised.

## **5.5 CONTRIBUTIONS OF THE STUDY**

This study is the first of its kind and among the rare studies so far done, regarding Eritrean immigrants in USA, and the researcher hopes this would be a building block and starting point for further studies.

The study also identified the major barriers to healthcare utilisations by Eritrean immigrants in Indianapolis. This will contribute to the body of knowledge regarding the experiences of immigrants. The recommendations made will assist in policy change to address the structural challenges which affect utilisation of healthcare services by immigrants, not only Eritrean, but also other immigrants found in Indianapolis. If the recommendations are implemented, they will assist in provision of healthcare services to the Eritreans. The findings will also assist in providing relevant information regarding the importance of utilising the healthcare services by Eritrean immigrants.

## **5.7 CONCLUSION**

This study explored and described the experiences of Eritrean immigrants regarding utilisation of utilisation of healthcare services in Indianapolis. Qualitative descriptive phenomenological design was applied. Data were collected using a semi-structured interview format, on eight conveniently selected Eritrean immigrants, living in Indianapolis. Data were analysed using Interpretive Phenomenological Analysis Framework. Three superordinate themes emerged from the data analysis: Healthcare financing system, Positive side of healthcare services and Challenges related to utilisation of healthcare service. All these factors have impact on the utilisation of Healthcare services by Eritrean immigrants. Recommendations have been put forth to

improve access and utilisation of healthcare services by Eritrean immigrants. It is envisaged that the findings of this studies will have significant impact in the improvement of utilisation of Healthcare services by Eritrean immigrants based on the implementations of the recommendations of this studies.

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# ANNEXURE- A



**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

**REC-012714-039**

**MSHDC/411/2015**

Date: 18 March 2015 Student No: 4493-339-8  
Project Title: The experiences of Eritrean immigrants regarding utilization of healthcare services in Indianapolis.  
Researcher: Mesghane Ghirmai Asgedom  
Degree: Masters In Public Health Code: D1S4986  
Supervisor: Prof AH Mayhandu-Mudzusi  
Qualification: D Litt et Phil  
Joint Supervisor: -

**DECISION OF COMMITTEE**

Approved

Conditionally Approved

for Prof L Roets  
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE  
*L. Roets*

*MM Moleki*  
Prof MM Moleki  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES

# **ANNEXURE- B**

## **CONSENT FORMS**

### **Section 1: Information**

**Dear Participant,**

My name is Mesghane Ghirmai Asgedom. I am a student for Master's Degree in Public Health at the University of South Africa. I am conducting a study entitled": The experiences of Eritrean immigrants regarding utilisation of healthcare services in Indiana, USA". The purpose of the study is to gain understanding the experiences of Eritrean immigrants regarding utilisation healthcare services in Indiana, USA in order to develop and recommend guidelines for supporting them.

I am requesting you to participate in this study to share your experience with me. The study involves an individual face to face interview which will last between 45 minutes to an hour. Your participation in this study will be highly appreciated. Data collected from the interview will enable me to gain a broader understanding of your experience regarding utilisation of health care services as an Eritrean immigrant in Indiana, USA. Your participation in this study is voluntary. All the information discussed will remain confidential. You have the right to withdraw from the study any time without even mentioning the reason. Your right to anonymity and confidentiality will be maintained at all times. No payment will be offered. In case you become distressed due to participation in the interview, debriefing will be offered by me or be referred to psychologist.

Thank you for your consenting to participate in this study  
MESGHANE GHIRMAI ASGEDOM (Researcher)

## Section 2: Participant consent declaration

I .....the undersigned person is willing to participate in the research conducted by Mr Mesghane Ghirmai Asgedom from UNISA:

I understand that the research is aimed at gathering information about experiences regarding utilisation of health care services by Eritrean immigrants in Indiana. I am aware that I will be one of the participants to be interviewed and discuss my experience for this research project with Mr Asgedom.

I understand that my participation in this research is voluntary. I will not be paid for my participation. If, I feel uncomfortable in any way during the time of the interview, I have the right to decline and end the interview. I may withdraw and discontinue participation at any time without any precondition if I feel to do so.

My Participation in the research involves being interviewed by Mr. Asgedom that may last at least 45 to an hour and may extend further with telephone interview and other means of communication. I realize that during interview notes will be taken the interview will be audio-recorded.

I understand that my participation in this research will be confidential and that the researcher will use my name in any report..

I understand that this research study has been approved by the University of South Africa ethical clearance committee.

I have read and understand the information pamphlet and explanation provided to me. All my questions were answered to my satisfaction, and I voluntarily agree to participate in this study.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Mesghane G Asgedom

Principal researcher \_\_\_\_\_

For further questions Contact @ 317-603-6381

## **ANNEXURE- C**

### **INTERVIEW SCHEDULE**

- 1 Kindly tell me about your experience regarding utilization of healthcare services in Indiana.
- 2 Which health care services have you used?
- 3 What type of care did you receive from the health care services?
- 4 What do you think should have been done differently?
- 5 What did you like /hate most about the health care services you received from Indiana?

Probes and prompts will be used depending on participant's responses.

## **ANNEXURE- D**

### **REQUEST FOR PERMISSION: CATHOLIC CHARITIES OF INDIANAPOLIS**

**To: The manager**  
**Catholic charities of Indianapolis**  
**From: Mesghane Ghirmai Asgedom**  
**MPH Candidate: University of South Africa**

**Re: Request to conduct a study in your facility and inquiring information**

My name is Mesghane Ghirmai Asgedom. I am a student for Master's Degree in Public Health at the University of South Africa. I am conducting a study entitled": The experiences of Eritrean immigrants regarding their health and healthcare services in Indiana, USA". The purpose of the study is to explore the experiences of Eritrean immigrants regarding their health and healthcare services in Indiana, In order to develop and recommend guidelines for supporting them in the way that would be effective. I have attained ethical clearance from the University of South Africa (See attached copy of ethical clearance). The study will be supervised by Professor AH Mavhandu-Mudzusi who is working at University of South Africa: Republic of South Africa. All relevant ethical aspects such as confidentiality, voluntary participation and protection of both the institution and the individuals including health care providers and institutions involved will be adhered to (See attached copy of proposal). For more information contact me on this number: 317-603-6381 or my supervisor at this number: +27 82 4062494

Thank you for your support.

Mesghane Ghirmai Asgedom

*GA Mesghane*

01/01/2015

## **ANNEXURE- E**

### **PERMISSION OR ASKING INFORMATION: EXODUS REFUGEE IMMIGRATION SERVICES**

**To: The manager  
Exodus Refugee Immigration Services  
From: Mesghane Ghirmai Asgedom  
MPH Candidate: University of South Africa**

**Re: Request to conduct a study in your facility and inquiring information**

My name is Mesghane Ghirmai Asgedom. I am a student for Master's Degree in Public Health at the University of South Africa. I am conducting a study entitled": The experiences of Eritrean immigrants regarding their health and healthcare services in Indiana, USA". The purpose of the study is to explore the experiences of Eritrean immigrants regarding their health and healthcare services in Indiana, In order to develop and recommend guidelines for supporting them in the way that would be effective. I have attained ethical clearance from the University of South Africa (See attached copy of ethical clearance). The study will be supervised by Professor AH Mavhandu-Mudzusi who is working at University of South Africa: Republic of South Africa. All relevant ethical aspects such as confidentiality, voluntary participation and protection of both the institution and the individuals including health care providers and institutions involved will be adhered to (See attached copy of proposal). For more information contact me on this number: 317-603-6381 or my supervisor at this number: +27 82 4062494

Thank you for your support.

Mesghane Ghirmai Asgedom

*GA Mesghane*

02/06/2015



## **ANNEXURE- F**

### **PERMISSION SEEKING LETTER: HEALTHCARE CENTRE/HOSPITAL**

**To: The manager  
Healthcare centre/Hospital**  
**From: Mesghane Ghirmai Asgedom**  
**MPH Candidate: University of South Africa**

#### **Re: Request to conduct a study in your healthcare facility**

My name is Mesghane Ghirmai Asgedom. I am a student for Master's Degree in Public Health at the University of South Africa. I am conducting a study entitled": The experiences of Eritrean immigrants regarding and healthcare services in Indiana, USA". The purpose of the study is to explore the experiences of Eritrean immigrants regarding utilisation of healthcare services in Indiana, USA in order to develop guidelines for supporting them. I have attained ethical clearance from the University of South Africa (See attached copy of ethical clearance). The study will be supervised by Professor AH Mavhandu-Mudzusi who is working at University of South Africa: Republic of South Africa. All relevant ethical aspects such as confidentiality, voluntary participation and protection of both the institution and the individuals including health care providers involved will be adhered to (See attached copy of proposal). For more information contact me on this number: 317-603-6381 or my supervisor at this number: +27 82 4062494

Thank you for your support.

Mesghane Ghirmai Asgedom

*GA Mesghane*

01/01/2015