

NAVIGATING COMPLEX REALITIES: BARRIERS TO HEALTHCARE, LAW
ENFORCEMENT AND MENTAL HEALTH CONCERNS OF UNDOCUMENTED AFRICAN
IMMIGRANT WOMEN IN THE UNITED STATES

by

Oluwatoyin Olukotun

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ABSTRACT

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It is well established that undocumented immigrants experience structural barriers to accessing resources and services including healthcare. Existing literature largely examines the experiences of undocumented Latino immigrants. To address this gap, the qualitative descriptive study was conducted to understand undocumented African immigrant women's barriers to healthcare access, their experiences seeking healthcare within a racialized context and how the complex stressors they face impact their health and well-being. This study was undergirded by a postcolonial feminist framework. Twenty-four undocumented African immigrant women and twenty nurses were interviewed about their perceptions of barriers to healthcare access for undocumented immigrants. Data were collected using in-depth, semi-structured interviews and analyzed using thematic analysis. The findings derived from interviews with the women centered around one major theme *navigating complex realities*. The three data-based manuscripts generated from this study further elaborate on the idea that undocumented African women were tasked with navigating barriers to accessing health care, navigating bias within various institutions and coping with the impact of their complex realities

on their emotional well-being. The findings of this study contribute important knowledge to our understanding of the barriers that undocumented African women experience when seeking healthcare and when in need of law enforcement services to ensure their safety. Findings also reveal the mental health concerns of undocumented African women. Deconstruction of the experiences of undocumented African women is an essential component in learning how to create safe spaces and in driving impactful social change.

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TABLE OF CONTENTS

ABSTRACT	ii
LIST OF FIGURES.....	viii
ACKNOWLEDGMENTS.....	ix
CHAPTER I: INTRODUCTION.....	1
Statement of Problem.....	1
Purpose of the Study and Research Questions	3
Significance of the Study	4
Definition of Terms.....	5
Assumptions.....	8
Aims and Organization of the Dissertation.....	8
Conclusion.....	10
CHAPTER II: REVIEW OF THE LITERATURE	11
Critical Review of Key Policies Affecting Undocumented Immigrant’s Access to Health Care and Social Resources.....	11
Critical Analysis of Immigration Policies and Embedded Structures.....	15
Barriers to Healthcare Access and Healthcare Experiences of Undocumented Immigrants	20
Summary	27
CHAPTER III: METHODS.....	32
Theoretical Perspectives.....	32

Methods	37
Purpose of the Study and Research Questions	37
Participation Selection Strategies	38
Recruitment	39
Protection of Human Subjects	40
Data Collection	41
Data Analysis	43
Scientific Rigor	45
CHAPTER IV: RESULTS.....	49
Manuscript 1: Navigating complex realities: Barriers to healthcare access for undocumented African immigrant women in the United States.....	49
Manuscript 2: The changing identity of undocumented African women becoming Black in the United States: Navigating bias at the intersection of the healthcare system and the criminal justice system	82
Manuscript 3: The mental health implications of living in the shadows: the lived experience and coping strategies of undocumented African women	116
Summary of Findings from Interview with Nurses.....	147
CHAPTER V: DISCUSSION AND SYNTHESIS.....	150
Synthesis of Findings	150
Policy and Practice Recommendations	154
Conclusion.....	156

REFERENCES	158
APPENDIX A: Institutional Review Board Approval Letters	166
APPENDIX B: Screening Script for Women	169
APPENDIX C: Recruitment Letter for Women	170
APPENDIX D: Interview Guide for Women	171
APPENDIX E: Interview Questions for Nurses	172
APPENDIX F: Demographic Questionnaire for Women	173
APPENDIX G: Study Informational Sheet for Women	174
APPENDIX I: Recruitment Flyer for Women	182
APPENDIX J: Recruitment Email for Nurses	183
CURRICULUM VITAE	185

LIST OF FIGURES

Figure 1. Thematic diagram summarizing undocumented African immigrant women’s experiences navigating complex realities.....	44
Figure 2. Thematic diagram summarizing nurses’ perceptions of barriers to care for undocumented immigrants.....	45

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This dissertation is dedicated to all immigrants who leave familiar territories for foreign terrain in search of better opportunities for themselves and their families. May you find peace and happiness.

CHAPTER I: INTRODUCTION

Statement of Problem

As of 2014, there were an estimated 11.1 million undocumented immigrants living in the United States (Krogstad & Passel, 2014). Though more than half of the population originates from Mexico, the undocumented population is also comprised of individuals from other Latin American countries, Asia, Europe and Africa- with African immigrants making up three percent of the population. Estimates also show that women constitute forty-seven percent of the undocumented population (Passel & Cohn, 2011). As a result of restrictive policies and the current socio-political climate, undocumented immigrant women in the United States experience several vulnerabilities.

In terms of socioeconomic status and employment status, a significant percentage of undocumented workers belong to the labor force as low wage workers. Estimates show that about 6 million undocumented workers are employed and are usually earning less than half the minimum wage. In an examination of employment rates of undocumented immigrants, there exist notable gender differences. Ninety-six percent of undocumented men belong to the work force, compared to only sixty-two percent of undocumented women. The lower rates of employment for women have been attributed to women having to stay at home to care for children (Passel, Caps & Fix, 2004). This means that undocumented immigrant women typically work low wage jobs and are also more likely to be unemployed compared to their male counterparts.

Even with low-income status, due to federal law and public policy guidelines, undocumented immigrants in the United States have limited access to government assistive resources. They are not eligible for public funded healthcare or social welfare benefits such as

Medicaid, the Children's Health Insurance Program, Medicare, Foster Care, Adoption Assistance and Low-Income Home Energy Assistance Program (Broder, Moussavian & Blazer, 2015).

Additionally, a clause of a law named the Personal Responsibility and Work Opportunity Act mandates the reporting of undocumented immigrants who present to apply for social services by specific federal agencies (U.S. Department of Health and Human Services, 2009). The consequence of current immigration and public policy is the stigmatization of undocumented immigrants and the fear of being reported to immigration enforcement agencies by public organizations and health officials (Derose, Escarce & Lurie, 2007).

The combination of stigmatization, low-wage jobs and restriction to resources, has lasting implications for the social and health outcomes of undocumented women. While it is widely acknowledged that immigrant status alone increases one's vulnerability in a foreign country, the restrictive policies and fear puts undocumented women at increased risk of adverse outcomes (Okie, 2007). For undocumented women, their immigration status poses a barrier to accessing healthcare as well as other relevant resources (Adams & Campbell, 2012). In addition, African immigrant women face additional challenges such as

The experiences of undocumented immigrant women are undoubtedly unique compared to documented immigrants and American-born citizens; however, the plight of this population of women has largely been under-examined. African immigrant women's intersecting identities including their nationality, race, ethnicity, gender and immigration status can have implications on their lived experiences within the U.S. context. Additionally, studying and identifying trends in this population of women is challenging due to the limited available research. This study aims to contribute to the existing knowledge base by enhancing our understanding of the experiences

of undocumented African women, their health needs, and barriers to healthcare and other resources and services.

Purpose of the Study and Research Questions

The purpose of this qualitative study was to gain an in-depth understanding of how historical, social and political processes impact access to health care, health needs, and the health care experiences of undocumented African immigrant women in the United States. To accomplish this aim, the following research questions were examined-

1. How do undocumented African immigrant women navigate barriers to accessing healthcare when facing a health need?
2. What are the experiences of undocumented African immigrant women when accessing the health care system?
 - a. How are these experiences shaped by social, political and economic factors?
3. How do social, political, and economic factors affect the experiences of undocumented immigrant women?
4. What are the health concerns of undocumented African immigrant women?

Nurses were also recruited as part of the study to provide a second source of data. Research questions guiding interviews with nurses were as follows-

1. What are nurses' experiences with undocumented immigrants?
2. What are nurses' perceptions of barriers to care for undocumented immigrants in their setting?
3. What are nurses' perception of the impact of the current sociopolitical climate on access to care for undocumented immigrants?

4. What are nurses' knowledge of the experiences of undocumented women and the resources available to them?

Significance of the Study

Access to health care is essential for health maintenance in any given population. However, the literature indicates that undocumented immigrants have limited healthcare access, and few have access to health insurance (Goldman, Smith & Sood, 2005). Limited healthcare access is of concern due to the relationship between not having insurance or access to healthcare, and the development of poor health outcomes (Institute of Medicine, 2009). While some might argue that providing services to undocumented immigrants would drain the nation's resources, others contend that denying basic services to individuals based on immigration status violates basic human rights and the ideals of social justice (Berk, Schur, Chavez & Frankel, 2000).

Furthermore, access to healthcare is essential for undocumented women as they might experience heightened vulnerability to poor health outcomes. In the United States, immigration policies have historically aimed to facilitate the entrance of male-dominated skilled labor into the country (Pannel & Altman, 2009; Johnson, 2009). Such policies that offer migrants permanent residency and naturalization based on skilled labor disadvantage women who are less likely to be employed in such areas (Ruhs, 2013). Consequently, a woman's immigration status is often dependent on a male member of their family system (Harzig, 2003; Orloff & Garcia, 2013). This implies that women might also be financially dependent on their partner or might be forced to seek informal employment opportunities that increase their risk of labor exploitation. A combination of the aforementioned factors heightens immigrant women's vulnerability to exploitation and violence, particularly when they are undocumented. Therefore, it is important

that we understand how women cope with and navigate barriers to accessing resources such as healthcare.

Lastly, as a practice profession, nurses should be concerned with the health care experiences of patients who access the healthcare system. As healthcare providers attempt to find meaningful ways to decrease health disparities, there is a need to be attentive to how healthcare experiences influence a patient's desire to access the health care system. This is an important consideration as studies indicate that mistrust of the health care system and perceived discrimination are also significant factors to consider when examining the drivers of health inequities for ethnic minority populations (Hunt, Gaba & Lavizzo-Mourey, 2005; Trivedi & Ayanian, 2006; Rickles, Dominguez & Amaro, 2012). In order to create a safe space for patients, the experiences of marginalized populations when they seek care need to be examined. This is particularly important for undocumented immigrants who already harbor a fear and mistrust of institutions.

This study is timely considering the current sociopolitical climate where undocumented immigrants face uncertainty in terms of how changing policies and practices aimed increasing the deportation of undocumented immigrants will impact them. Findings from this study have potential implication for driving social and political advocacy centered on immigrants' rights and immigration reform. Additionally, studies that examine the experiences of undocumented immigrants with the healthcare system are essential to uncovering how healthcare organizations and providers can create spaces where undocumented immigrants feel safe and respected within the healthcare setting.

Definition of Terms

Some key terms that will be utilized in the study require definition to enhance clarity within the paper.

Undocumented immigrant: For the purpose of this study, undocumented immigrant is defined as “individuals who entered as temporary residents and overstayed their visas, or are engaged in activities forbidden by their visa, or who entered without a visa” (U.S. Department of Health and Human Services, 2009). In public discourse and even in some research literature, the term “illegal immigrant” or “illegal alien” is often used to describe immigrants who are undocumented. While I recognize the use of the term especially by immigration officials and in official documents, it is important to acknowledge that these terms are pejorative and have roots in anti-immigrant and xenophobic movements.

Permanent resident: Immigration status granted to an immigrant that authorizes them to permanently reside and work in the United States. Immigrants who receive permanent resident status are given a registration card, informally known as a green card, that serves as proof of their status. A permanent resident is eligible to apply for United States citizen after five years of residency (3 years for individuals married to an American citizen) (USCIS, N.D.).

Sanctuary city: Broadly refers to cities in the United States that implement policies and procedures meant to protect undocumented immigrants from prosecution or detention by prohibiting use of municipal funds in the assistance of federal immigration enforcement officials. Typically, sanctuary cities also prohibit the police or city official from inquiring from city residents about their immigration status. It is also important to note that sanctuary policies and procedure differ across municipalities (Villazor, 2009). In some jurisdictions, sanctuary policies are ordinances while other jurisdictions might utilize symbolic statements to demonstrate support for undocumented immigrants (Aboii, 2014).

Victims of Criminal Activity: U Nonimmigrant Status: Similar to DACA, the U visa grants temporary presence to a specific category of undocumented immigrant or resident of another country. Enacted as a part of the Victims of Trafficking and Violence Protection Act and the Battered Immigrant Women's Protection Act of 2000, it specifically applies to individuals who are victims of specific crimes or who have suffered mental or physical abuse and who provide assistance to law enforcement officials in the investigation and prosecution of criminal activity. In addition to being a victim of qualifying criminal activity and cooperating with law enforcement, applicants have to meet some other requirements. Broadly, the applicant must have suffered "substantial" physical or mental abuse, must possess information regarding the criminal activity, and be deemed "helpful" or likely to be helpful to law enforcement. Additionally, this status only applies to individuals who were victims of crimes that occurred in the United States or violated United States laws. The list of "qualifying" criminal activities are numerous and include crimes such as extortion, abduction, torture, among several others (USCIS, 2016).

Considering the strict requirement and potential arbitrary interpretation of these requirements by immigration officials, there is a chance that individuals who are victims of crime are denied or elect to not pursue this visa status. Additionally, there is cap on how many visas can be granted per year under this provision. When annual caps are reached, individuals are not eligible for these visas until the following year. However, following U visa approval, recipients can apply for employment authorization documents. After at least three years of being physically present in the United States, U visa holders can apply for an adjustment of status in order to be granted permanent residence (USCIS, 2016).

Victims of Human Trafficking: T Nonimmigrant Status: T nonimmigrant status or a T visa, created in 2000, grants temporary protected status to victims of sex or labor trafficking

allowing them to remain in the United States for up to 4 years. In order to be eligible for this status, victims are required to collaborate with law enforcements' investigation and prosecution of human traffickers. Individuals who are granted a T visa are eligible to apply for work authorization and can access federal and state benefits (USCIS, 2018).

Assumptions

- Undocumented African immigrant women inhabit marginalized spaces in the United States.
- Undocumented African immigrant women are in the best position to contribute valuable knowledge that accurately describes their experiences.
- Access to health care is a human right and therefore, undocumented immigrants deserve to have access to health care.

Aims and Organization of the Dissertation

This introductory chapter describes the characteristics of the undocumented immigrant population in the United States and the challenges they experience. In addition, this chapter also outlines statement of problem, purpose of the study, research questions, assumptions and definition of important terms that will be used in this paper. The second chapter will provide a literature review on access to health care, health needs, health outcomes and health care seeking experiences of undocumented immigrants. Due to the impact of immigration and public policy on the experiences of undocumented immigrants, key policies will also be discussed and analyzed. The third chapter highlights the study methodology including a discussion on theoretical framework, participants, recruitment, data collection and data analysis. Chapter four outlines findings from the study which will be disseminated through three manuscripts. The first manuscript reports on findings on the barriers to care for undocumented African women and how

they navigate these barriers. The second manuscript describes undocumented African women’s experiences of navigating bias at the intersection of the healthcare and the criminal justice system. The third manuscript describes the mental health concerns and coping strategies for undocumented African women. The content of the three manuscripts are detailed in Table 1. Lastly, chapter five will synthesize the three manuscripts and highlight the implications of the research findings for policy, practice and research.

Table 1. Manuscripts and Target Journals

Manuscript	Title	Aim	Target Journal
1	Navigating complex realities: Barriers to accessing healthcare for undocumented African Immigrant Women	Reports findings on the barriers to accessing healthcare and how women navigate the barriers	Social science and medicine
2	Navigating bias at the intersection of the healthcare system and the criminal justice system	Reports findings on the experiences of undocumented African immigrant women navigate bias at the intersection of the healthcare and criminal justice system	Advances in Nursing Science

3	The mental health implications of living in the shadows: the lived experience and coping strategies of undocumented African women	Reports findings on the implications of women’s complex realities on their mental health and the coping strategies they employ	Behavioral Sciences
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Conclusion

This dissertation aimed to understand the barriers that impede access to healthcare for undocumented African women and how women navigate these barriers. Consistent with the postcolonial feminist perspective, this study foregrounds how undocumented women’s sociopolitical context impact their experiences, their health and access to resources. In addition, it also explores the impact of women’s complex realities on their emotional well-being. The manuscripts generated from this dissertation study will be submitted for publication to the target journals listed in Table 1. Findings from this study will contribute to the developing literature on the healthcare seeking experiences and the health concerns of undocumented women in the United States and inform organizational change within healthcare settings to create safe spaces where undocumented immigrants can seek care.

CHAPTER II: REVIEW OF THE LITERATURE

In order to understand the complex challenges that undocumented immigrants face in the United States, a few topics have to be examined. The following chapter outlines existing literature on access to health care, health concerns and outcomes for undocumented immigrants. The chapter will conclude by speaking to the current socio-political climate in relation to immigrants and key immigration policies that directly or indirectly impact access to health care for undocumented immigrants.

Critical Review of Key Policies Affecting Undocumented Immigrant's Access to Health Care and Social Resources

Policies that affect undocumented women's access to health care and social services are numerous. In the following section, I will highlight key policies including the Personal Responsibility and Work Opportunity Reconciliation Act, Deferred Action for Childhood Arrival, U non-immigrant status visa provision, the Patient Protection and Affordable Care Act, and the Emergency Medical Treatment and Labor Act. In this section, I will outline the provisions within the policies and subsequently, offer a critical analysis of the aforementioned policies and in so doing, will deconstruct the structures that undergird the policies.

The Personal Responsibility and Work Opportunity Reconciliation Act

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) enacted in 1996 outlined strict eligibility criteria for receiving federal public benefits and assistance. Within the PRWORA document, undocumented immigrants classified as "aliens" are excluded from receiving federal benefits. The term "undocumented immigrant" is then defined as "individuals who entered as temporary residents and overstayed their visas, or

are engaged in activities forbidden by their visa, or who entered without a visa” (U.S. Department of Health and Human Services, 2009).

Passed as a response to the perceived increased burden that undocumented immigrants posed on the public benefits system and to deter migration to the United States, the PRWORA excluded undocumented immigrants from receiving any sort of retirement, welfare, health or disability benefits from the federal, state or local governments (Kullgren, 2003). However, exceptions are made for the treatment of emergency medical conditions, for the purposes of maintaining public health such as immunizations and the treatment of communicable disease, and other programs approved by the attorney general as being necessary for the protection life and safety. Outside these exceptions, states or local jurisdictions who attempt to use public funds for assistive services for undocumented immigrants are at risk of facing penalties and sanctions (Kullgren, 2003).

Under the PRWORA, some undocumented immigrants who meet the state’s Medicaid eligibility might qualify for Medicaid to cover the costs of emergency care. For the purpose of the law, an emergency medical condition is defined as:

“a medical condition (including emergency labor or delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in 1) placing the patient’s health in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part” (Momentum & Lewis, 2007).

The clarity of this definition is contestable. Several litigations have passed through the judicial system that required a determination of whether the individual’s condition was emergent. In some cases, decisions about Medicaid coverage for health services provided after the

individual's condition stabilizes are also made within the confinement of a courthouse (Momentum & Lewis, 2007).

Beyond the criteria of proving that there is an emergent medical condition, undocumented individuals are also required to meet residency requirements outlined by the state. Once again, decisions as to who qualifies for emergency Medicaid are not straightforward as they appear to be arbitrarily made by public officials or presiding judges. While the criteria discussed above are general and basic eligibility requirements for emergency Medicaid coverage, it is important to note that these criteria are operationalized in different ways across different states (Momentum & Lewis, 2007).

A second portion of PRWORA that might impede undocumented immigrant's access to care is the mandated reporting of undocumented immigrants to the Immigration and Customs Enforcement (previously INS) by specific public officials in certain agencies. This mandate is often misinterpreted by the lay public as there are many misconceptions as to what type of officials are required to report to INS and which officials are not. The law states-

“States in administering their TANF block grants, the Social Security Administration in administering the SSI programs, the Department of Housing and Urban Development, and public housing agencies must report to INS four times a year aliens they know are unlawfully in the U.S.” (U.S. Department of Health & Human Services, 2009)

As evidenced by the instruction in the law, only certain officials and agencies have a duty to report undocumented immigrants. This mandate only applies to situations where undocumented immigrants present to seek public benefits for themselves and have been determined to be undocumented by the federal agency to which they present (U.S Department of

Health & Human Services, 2009). While other officials might take it upon themselves to report undocumented immigrants they might encounter, they are not obligated to do so by law. This means that hospital staff, school and law enforcement officials have no legal duty to report individuals who are undocumented.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) was a comprehensive healthcare reform law that was signed into law in 2010. The law sought to expand healthcare coverage to Americans by requiring US citizens and permanent residents to have health insurance coverage or be forced to pay a tax penalty. To increase accessibility to health insurance, state-based health exchanges were created and states were offered the option of expanding their Medicaid program. Despite the significant expansion of health care coverage to the uninsured in the country, the law explicitly excludes coverage for undocumented immigrants within the market place exchange and through public insurance (Wallace et al, 2012). Within the law, it is written that the provisions of the law only apply to immigrants who are “lawfully present” in the United States. Those who are deemed “lawfully present”, according to the definition used in United States policies and regulation include permanent residents, asylees, refugees, foreign nationals with active visas and other classification as outlined by the Immigration and Nationality Act (Siskin & Lunder, 2014). Using this criteria, the law does not extend to undocumented immigrants who have been granted temporary status (not “legal” status) under the Deferred Action for Childhood Arrival executive action or the U-Visa granted to victims of violence and criminal activity.

Emergency Medical Treatment and Active Labor Act

The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted in 1986. The intent of this law was to ensure that patients are able to access emergency, stabilizing medical care regardless of their ability to pay for the care. For the purpose of the law, the criteria for what constitutes emergency medical conditions are identical to those outlined in the PRWORA. When patients present to the emergency room, hospitals are required to provide “an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (EMC) exists” (Gusmano, 2012).

As a provision of this law, undocumented immigrants who present to hospital emergency rooms with emergent care needs are eligible to receive stabilizing medical care and at the minimum appropriate medical screening provided by a qualified profession, despite their undocumented status and their ability to pay for services. Care for non-emergent acute or chronic illness are not addressed by this law thus, undocumented immigrant who are considered to be stable might have to obtain care through other sources.

Critical Analysis of Immigration Policies and Embedded Structures

Migration to the United States is a complex process. Historically, in addition to national origin, immigration exclusion criteria have targeted groups based on literacy level, economic status, criminal history, race and sexuality. Though the use of explicit racial and nationality exclusion has been abolished from immigration policy, current immigration policies still have racially disparate impacts (Johnson, 2009).

Due to the existence of geo-political, and aggressively enforced borders, there are only a few avenues for “authorized” migration into the United States. These avenues embedded in immigration policy are strictly regulated through the use of economic litmus tests and limits on

the number of immigrants allowed from specific countries per annum. Under the current policies, people from low-income countries (largely the global south) have a difficult time entering the country compared to individuals from developed and predominantly white nations (Johnson, 2009). This is because highly skilled workers and individuals with family members in the country receive priority for admission while individuals with limited education and less financial means are excluded.

The nature of these policies that facilitate migration for some while obstructing it for others are not a coincidence. Exclusionary immigration policies function to sustain what has been termed as “global apartheid” (Loyd, 2011) using laws and practices that are undergirded by racist, xenophobic and other discriminatory ideologies and that work to further a neo-liberal capitalist agenda. Loyd critically examines how anti-Black immigration policies have been operationalized in the United States using incidents such as detention and interdiction of Black Caribbean immigrants in the 1980’s arguing that current detention policies and aggressive tactics bear root in U.S government treatment of Haitian immigrants. In an effort to deter and control migration, nations continue “...to exercise the sovereign right to determine who may enter and stay within their territories and under what conditions” (Loyd, 2011). However, the selection and admission process is not made in a political or social vacuum as these decisions are largely influenced by specific assumptions and attitudes about race.

The conceptualization of American citizenship is also gendered. Historically, citizenship was granted to white men who owned properties. This was because the usefulness of women to the advancement and sustenance of the republic was contested by both men and women who believed that women were more suitable for the private and domestic sphere. The legacy of such conceptions of citizenship is the enactment of immigration policies that aim to facilitate the

entrance of male-dominated skilled labor into the country (Pannel & Altman, 2009; Johnson, 2009). These policies, used to control in-migration, disproportionately benefit men as women are less likely to be employed in such areas. The professions where women work are often not prioritized by a work visa system that prioritizes professionals in the sciences, technology, engineering and mathematics. The implication of such practices is that women's immigration status is dependent on a male member of their family unit. Additionally, of recent, women's migration has also been characterized by women leaving their communities for paid domestic work and elder care in foreign countries- a situation which heightens their vulnerability to exploitation (Hondagneu-Sotelo, 2013; Andrevski & Lyneham, 2014).

There is an intrinsic relationship between racialized, gendered citizenship and labor. Historically, immigration policies have been a reflection of economic agendas that thrive on the use of cheap labor (Mohanty, 1991). The exploitation of immigrants for economic advancement represents a form of racialized and gendered neo-colonialism with historical roots. The historical practice of using Black people for forced labor and other non-White populations for cheap labor bears semblance to the implications of immigration policies today. Migrant workers and undocumented immigrants, often non-white people, are forced to take low-wage jobs that contribute to the advancement of the economy (Johnson, 2009). In return, they are at risk of being exploited as their employer-employee relationship is often not protected by labor laws due to their undocumented status that does not grant them formal work authorization.

The existence and institutionalization of oppressive structures in the realm of migration is also evident from the deconstruction of language in immigration policy discourse. Embedded in the text of these policies is a pattern of language with racialized tropes. Terms used to refer to undocumented immigrants both in immigration policy and political discourse range from

“illegals”, “illegal aliens” and “aliens”, among other derogatory terms. The derogatory nature of these terms reflects the political and social response to what is perceived as the influx of non-White immigrants. Such language is used to rationalize and support the legality of aggressive treatment and practices involving the use of force, fences and detention centers (Ngai, 2014).

Another loaded term embedded in the PRWORA is “personal responsibility”. Discourse surrounding personal responsibility emphasizes the role of individualism as opposed to collective responsibility. Iris Marion Young saliently describes this perspective as a requirement that “each must self-sufficiently bear the costs of its choices and has no moral right to expect help from others, even if the individual or family should suffer harm or disadvantage” (2011). The emphasis on individual responsibility and the disregard for the welfare of marginalized people is evident in the law’s intentional exclusion of undocumented immigrants from receiving federal aid.

Discourse surrounding “personal responsibility” has roots in neoliberal ideology. Neoliberalism is characterized by an emphasis on economic practices that promote participation in free markets and free trade (Young, 2011). Paramount to the sustenance of a neoliberal capitalist agenda is the state’s ability to preserve a context where such economic practices can exist and thrive. Preservation of the proper functioning and material wealth and power of the state is accomplished using aggressive methods such as the military and other forms of law enforcement officials and strategies (Harvey, 2005).

Neo-liberalism, racialized, gendered and classist ideologies and immigration policies are intrinsically interrelated and have very complex implications for marginalized people. Within the same state, policies are created to criminalize certain types of migration while skilled workers from other countries are rewarded with an “authorized” mode of migrating. Yet, undocumented

migrants are used in exploitative ways as members of the labor workforce while being denied citizenship (Johnson, 2009). These policies result in inequalities in access to power and resources, continuous exploitation and devaluing of marginalized populations and the labor workforce, and violence. Neoliberalist functions of the state are also evident in the use of U.S. Immigration and Border Enforcement officials who enforce immigration policies by policing borders using weapons, and the use of aggressive strategies such as raids, incarceration and detention (Loyd, 2011).

Beyond the use of troubling terminologies and the link between US policy and neoliberalism, the use of humanitarian principles is also problematic. Literature on humanitarianism offers a framework for critique of current exclusionary immigration policies that make exceptions for a select group. In U.S. immigration policies, conditional benefits are granted to immigrants who are ill or victims of criminal activity (USCIS, 2016). Policy exceptions to stricter immigration law also operate on the principle of selective exclusion and serve as a mode of control that reproduces social hierarchy. Ticktin (2011) categorizes interventions that individualize global problems of “inequality, exploitation and discrimination” as promoting “regimes of care”. She defines this category of intervention as being inclusive of “a set of regulated discourses and practices grounded on this moral imperative to relieve suffering”. Ticktin asserts that these regimes have been implemented by a variety of actors and shift the focus from pursuing collective, systemic change to acting compassionately to an emergent threat or crisis. Enactment of the suffering “Other” narrative that needs to be rescued through exception clauses is troubling and has similarities to colonial tropes that informed colonial interventions (Ticktin, 2011).

Furthermore, these few exceptions to the rule in U.S immigration policy should be problematized for several reasons. First, they reinforce the good immigrant/ bad immigrant dualism where some immigrants are deemed to be deserving of citizenship and its associated benefits while others are categorized as underserving criminals (Loyd, Mitchelson & Burrige, 2013). Also, they function to change the narrative from the examination of aggressively enforced borders and the conceptualization of citizenship to a seemingly humanitarian and noble approach of rescuing “helpless” immigrants during emergent times of need. This motive is exposed by Mohanty’s (2013) critique of the desire of neoliberal states to depoliticize issues that are deeply rooted in race, class and gender oppression, thereby domesticating them and making them issues that are suggestive of a humanitarian response of care. Evidently, access to care for undocumented immigrants is restricted by immigration and health policy undergirded by the oppressive structures of race, class, gender and nationality.

Barriers to Healthcare Access and Healthcare Experiences of Undocumented Immigrants

The following sections outline themes from an in-depth literature review on undocumented immigrants, their access to the healthcare system and their health outcomes. Empirical literature offers ample evidence to support the notion that undocumented immigrants experience complex barriers to care, health disparities and have unique health needs and concerns.

Healthcare Utilization Patterns and Barriers to Accessing Healthcare

The literature review offers strong evidence of a relationship between immigration status and health insurance coverage. Marshall et al examined access to health care of documented and undocumented foreign-born Latino women using a questionnaire (2005). Results from this study indicated that there was a significant difference between insurance rates among documented

immigrants compared to undocumented participants. Ninety-one percent of undocumented women reported not having any form of health insurance compared to fifty-eight percent of documented women. The authors attributed their findings to low-average income reported by women who participated in the study.

These findings were echoed in a second study that examined insurance status among immigrants and uncovered the transient nature of insurance coverage in the undocumented population. At the time of study, 95% of undocumented participants reported being uninsured for two years prior to the study, with none reporting consistent health insurance coverage. Additionally, undocumented participants were 33% less likely to maintain health insurance compared to US-born citizens (Goldman, Smith & Sood, 2005). These findings were reiterated in a 2009 study, which revealed that almost double the number of undocumented participants were uninsured (69%) compared to documented residents (37%) (Prentice, Pebley & Sastry, 2005).

There also appeared to be a relationship between immigration status and having a usual source of care. Several studies show that undocumented immigrants often do not have a usual source of health care. Compared to documented immigrants, a significantly lower percentage of undocumented immigrants reported having a usual source of primary care and undergoing routine health screenings (Rodriguez, Bustamante & Ang, 2009). Marshall et al also documented a significant difference between documented and undocumented women self-reporting about having a regular source of care. Fifty-six percent of documented participants reported having a usual source of care compared to only twenty-six percent of undocumented participants (2005). The findings from these studies suggest that undocumented immigrants are not only uninsured, but they also might not be able to identify where to go for their health needs.

Some of the studies reviewed indicated that negative experiences such as discrimination, cultural insensitivity, and poor perception of the healthcare system influenced immigrants' decision to seek health care. A 2009 study revealed that undocumented immigrants were less likely to report having received excellent/good quality of care after accessing the healthcare system and being treated differently than other patients (Rodriguez, Bustamante & Ang). They reported receiving poor care due to their inability to pay for care, their ethnic background and their accent. Also, in a qualitative study conducted in Arizona in the wake of the Arizona Senate Bill 1070 law, undocumented Latino immigrants reported being treated with insensitivity and hostility by health care personnel within the health care setting (Cleaveland & Ihara, 2012). A similar study revealed a common misconception among immigrants that hospital staff would report undocumented immigrants to immigration authorities (Maldonado, Rodriguez, Torres, Flores & Lovato, 2013). Based on these findings, it is evident that the health care environment may not constitute a safe space and undocumented immigrants could be further marginalized by actions of health care personnel in this space. Undocumented immigrants may also harbor a fear associated with the legal implications of their immigration status and being reported by health care workers.

The impact of the fear of deportation on immigrant health is a pervasive theme even in the literature. In a 2011 study aimed at examining the impact of aggressive immigration enforcement tactics on immigrant health in Massachusetts using community-based participatory research, participants reported that their health and access to health services was influenced by fear of deportation and concerns about not being able to provide required documentation needed to apply for health insurance and to access health care services (Hacker et al). Compared to the aforementioned studies, this study is unique in that the study participants included immigrants

from Haiti, Central America, Brazil and North Africa. In another study, fear of deportation and immigration status was cited as a major barrier to HIV management care for African immigrant living with HIV in the Twin Cities, MN (Othieno, 2007). This means that patients living with HIV did not seek care due to the belief that the health care system is in some way linked to the Immigration and Naturalization Services, now existing as three entities- U.S. Citizenship and Immigration Services, U.S. Immigration and Customs Enforcement and U.S. Customs and Border Protection. Delayed HIV diagnosis and poor management of HIV has significant implications for the health of the individual as well as public health efforts to prevent HIV transmission.

Health Concerns and Health Outcomes

A few studies highlighted the relationship between undocumented status and health management and maintenance. Marshall et al's, study reported on earlier also examined the health status of participants. Findings showed that documented women were three times more likely to report having excellent health as compared to undocumented women (Marshall, Urrutia-Rojas, Mas & Coggin, 2005). Another key finding that raises concern is that more undocumented women reported not taking any medications for their diagnosed health conditions compared to other participants. While the author does not provide an explanation for these findings, one can assume that the ability to obtain medications to manage chronic disease is influenced by lack of health insurance and lack of financial means to afford prescribed medication.

While the poor perception of health status documented by Marshall et al is concerning, the documented disparities in access to preventive screening care, and the physical and mental health outcomes are more alarming. A study by Castro-Echeverry et al (2013) examined the relationship between immigration status and survival for Hispanic breast cancer patients.

Through analysis of patient medical records, the study revealed that undocumented patients presented with more advanced stages of breast cancer ($p < 0.001$). After diagnosis, the 5-year survival rate was higher for documented immigrants compared to their undocumented counterparts (75%, 63% respectively). Additionally, the mean diagnosis to treatment interval was higher in undocumented patients at 142.7 days compared to 102.1 days for documented patients. Despite these findings, there was no significant difference in mortality rate from breast cancer between the two groups after adjusting for all covariates. In another study examining screening adherence by immigration status, non-citizens were less likely to report ever receiving a Pap smear or a mammogram (De Alba, Hubbell, McMullin, Sweningson & Saitz, 2005). Based on these studies, it appears that undocumented immigrant women have lower rates of accessing and utilizing primary and preventive care needed for early detection of disease.

There also exists disparities in chronic disease management outcomes. The implications of poor health care access are even more pronounced for undocumented persons with chronic illness who are in need of continuous disease management and follow-up. Existing data indicate that undocumented immigrants with end-stage renal disease presented at advanced stage of the disease (Chernin et al., 2012). During symptoms and chronic illness management, they reported physical and psychological distress due to unpredictable access to emergent-only dialysis which gives them access to dialysis when the patient's condition is considered emergent (Cervantes, Fischer & Berlinger, 2017). Similar findings were noted for undocumented Hispanic immigrants with HIV infections who were shown to enter HIV management care with more advanced disease than documented persons (Poon, Dang, Davila, Hartman & Giordano, 2013).

Two studies were identified that investigated health outcomes in regard to maternal child health. The results for undocumented women were troubling (Reed, Westfall, Bublitz, Battaglia

& Fickenscher; Korinek & Smith, 2011). A 2005 study examining the health needs of pregnant women revealed that undocumented women were less likely to meet the weight gain recommendations and less likely to receive prenatal care (Reed, Westfall, Bublitz, Battaglia & Fickenscher). The potential consequences of inadequate prenatal care were reported and indicated that undocumented women were at increased risk of complications during labor and actually experienced significantly higher rates of complications during labor including fetal distress (Reed, Westfall, Bublitz, Battaglia & Fickenscher, 2005).

Findings on access to prenatal care were reiterated in a second study that revealed that undocumented pregnant Hispanic women in Utah with no form of government issued documentation had significantly lower rates of prenatal care utilization compared to permanent residents and citizens (Korinek & Smith, 2011). Korinek and Smith's study indicated that immigration status influences access to prenatal care. However, for undocumented immigrants with a driver license (which they are eligible for in Utah) prenatal care utilization rates were similar to those of their documented counterparts. The findings thus supported the conclusion that undocumented immigrants with government issued forms of identification are more inclined to using the health care system.

There were also documented mental health disparities for undocumented immigrants. Hacker et al (2011) examined the impact of immigration enforcement on immigrant health by conducting focus group interviews with male and female participants from various countries including Guatemala, Haiti, China, Morocco, among a few others. Their study revealed that both documented and undocumented immigrants reported high levels of stress, anxiety and hopelessness which had a negative impact on their emotional well-being. For undocumented immigrants, their feelings of stress, anxiety and hopelessness were related to the constant fear of

deportation while documented participants were more concerned about the welfare of their family. Among most participants, there was a common perception that local law enforcement collaborated with immigration enforcement officials to deport immigrants.

Mental health outcomes for undocumented immigrants were also examined in other studies. by Joseph (2011), undocumented Brazilians reported that discrimination and undocumented status affected their mental well-being resulting in weight gain/loss, insomnia, anxiety, depression and fear. Additionally, respondents who reported having a poor quality of life cited physically strenuous jobs and exploitation perpetrated by documented Brazilian immigrants as major stressors. Likewise, in a second study, undocumented Latinos were identified to be more likely to have a diagnosis of anxiety or alcohol abuse disorders (Perez & Fortuna, 2009).

Intimate partner violence was another major health concern for women without documented status in the United States. Undocumented status increased vulnerability for abuse, created a barrier to victims seeking help, and is used as a tool for batterers to control victims (Moynihan, Gaboury & Onken, 2008). The literature suggests that for immigrant women experiencing domestic violence, immigration status influences their decision to utilize available resources. For Latino women, immigration status was identified as one of the factors preventing victims from seeking help (Ammar, Orloff, Dutton & Aguilar-Hass, 2005). For undocumented women who are victims of intimate partner violence, the literature indicates that they may be less likely to seek help due to fear of deportation and the legal implications of their status (Heyman, Nunez & Talavera, 2009; Maldonado et al, 2013).

Contrary to the negative health outcomes suggested in other studies, a study by Iten et al (2014) suggests that undocumented immigrants are able to access care in certain geographical

locations. This study, conducted in the San Francisco Bay and Chicago areas (deemed sanctuary cities) examined the relationship between immigration status and health care experience and diabetes outcomes in undocumented Mexican immigrants. Though undocumented immigrants were more likely to report barriers to following their diabetes management regimen, there were no significant differences in the clinical measurements of diabetes control amongst undocumented immigrants compared to their documented participants. Also, there were no significant differences in patient perception of culturally competent care among undocumented and documented participants (Iten, Jacobs, Lahiff & Fernandez, 2014). The authors attribute these unusual findings to the characteristics of sanctuary cities where immigration status is not ascertained during an individual's encounter with the health care system.

Summary

The literature review indicates that the disparities affecting undocumented immigrant women are complex and numerous. Significant factors that may restrict access to healthcare include language and cultural barriers, lack of financial resources, lack of formal employment, health insurance coverage status, poor knowledge of the healthcare system, fear of discovery and deportation and restrictions to access due to policy (Marshall, Urrutia-Rojas, Mas & Coggin, 2005). Though some of these barriers are shared concerns for all immigrants in the United States, a few are uniquely specific to and descriptive of the experience of undocumented immigrants.

Evidently, immigrant women already experience multiple vulnerabilities associated with being an immigrant and a woman. Thus, the gender implications of this discussion are particularly important for multiple reasons. Firstly, immigrant women, regardless of immigration status, are disproportionately affected by intimate partner violence (Adams & Campbell, 2008; Erez, Adelman & Gregory, 2009; Raj & Silverman, 2002). The literature reveals that

immigration status adds another layer of vulnerability to gender-based violence (Adams & Campbell, 2008). Undocumented status poses a barrier to help-seeking and the use of available resources. In cases where undocumented mothers are the primary caregivers of children, being with a violent partner puts both the woman and her child at risk for significant harm and potentially death.

Although policy restricts access to most care for undocumented immigrant women, stigma, fear and limited experience within the healthcare system are also barriers that further deter healthcare utilization. The intentional exclusion and stigmatization of undocumented status can have major implications on the relationships between communities with a large undocumented population and their healthcare providers. The effect of exclusion and stigmatization is a distrust of healthcare professionals and hypervigilance when accessing the healthcare system. When feelings of fear and stigmatization transcend into a woman's perception of healthcare providers, the healthcare environment is no longer regarded as a safe space. This has potential implications on women's health care utilization and potentially health outcomes.

Undocumented immigrants' decision to access care is also heavily influenced by their perception of the health care system and past experiences when they do access care. Poor satisfaction with healthcare services and the fear of being deported for using health services are barriers that should be taken seriously. The continuous stigmatization of undocumented immigrants and the fear of deportation could ultimately result in the avoidance of the healthcare system, even when medical care is necessary. This could have serious implications for the health of undocumented immigrants.

The current political atmosphere and discourse have revealed hostile attitudes that some citizens have towards undocumented immigrants. This stigma and strong political sentiments have major implications for the attitudes of healthcare providers in interacting with undocumented patients as well as the comfort level of undocumented immigrants in accessing healthcare. This should be of major concern for healthcare workers as data from the literature review reveals that undocumented immigrants are more likely to report receiving lower quality care compared to their documented counterparts (Rodriguez, Bustamante & Ang, 2009).

As recently as 2015, the nursing profession called attention to the plight of undocumented immigrants through a special edition published in *Nursing Outlook*, that discussed access to health care for this population and the role of the nursing profession (Messias, McEwen & Clark, 2015). As the nursing profession responds to the call to address the health needs of undocumented people, it is essential that we understand what their experiences are in order to inform political and social action. My study aims to gain this knowledge specific to the unique needs and experiences of undocumented African women.

Though the existing literature is informative and beneficial in understanding the experiences of women in this population, there are large gaps. Firstly, the existing literature is mostly descriptive of the experiences of Latino/a and Hispanic undocumented immigrants. Undoubtedly, the experiences of undocumented immigrants of various ethnic backgrounds are similar in some regards. However, a thorough analysis of the historical experiences of Black immigrants such as the detention and incarceration of black Caribbean immigrants sanctioned by the US government reveals unique elements of racism and anti-Black and anti-Brown policies and practices within US borders (Loyd, 2011; Morgan-Trostle & Zheng, 2016). It would

therefore be incorrect to assume that Black African, and Latino/a and Hispanic undocumented immigrants share identical struggles.

Of the studies reviewed, the majority had mixed samples of men and women. Very few studies have examined the experiences of undocumented women alone. The studies with solely female participants examined health outcomes unique to women focusing for instance, on breast cancer, birth outcomes and intimate partner violence. While these studies provide valuable epidemiological evidence on the health disparities that exist, it is equally important that researchers attempt to understand the experience of undocumented women in relation to their socio-political context.

It is also important to note that research on the undocumented population tends to focus on regions with a high density of undocumented individuals including states like Texas, New York, California, and New Mexico. These are typically places where advocates have worked to implement sanctuary provisions or policies at the municipality level that aim to protect undocumented immigrants from prosecution or detention by prohibiting the reporting of undocumented immigrants by city officials to immigration enforcement agencies (Villazor, 2008). Additionally, the political ideology in the local jurisdiction can determine what resources a woman is able to access. For instance, in some states, undocumented immigrants may be eligible to obtain a driver's license based on some criteria while they might be ineligible in another state. Because the experiences of undocumented immigrants differ across states, it is essential that researchers examine how immigrants navigate and resist the overt hostile environments that may exist in non-sanctuary jurisdictions as well the challenges they might encounter in sanctuary jurisdictions that lack supportive ordinances.

Another analytical dimension lacking in the existing literature on undocumented immigrants and their access to health care is a critical examination of how undocumented immigrant women are influenced by larger structures. Existing studies often treat immigration status, nationality and ethnicity as demographic variables which downplays how these “variables” are socially-constructed categories that serve to further marginalize women. To address this gap, my dissertation study adds a postcolonial feminist analysis of how undocumented immigrant women’s access to healthcare is influenced by larger, contextual structures. Considering the complexities associated with being undocumented in the United States, a postcolonial feminist frame of analysis that considers the impact of sociopolitical and historical context is suitable for deconstructing the experiences of undocumented African immigrant women.

CHAPTER III: METHODS

Theoretical Perspectives

Undocumented immigrant women in the United States face several challenges after their arrival to the country. Specifically, there are disparities noted in the literature on several health and social indicators (Marshall, Urrutia-Rojas, Mas & Coggin, 2005). Analyzing and understanding the drivers of these complex inequities requires a critical approach that deconstructs the structures that impact the experiences of immigrant women. This means that it is imperative that research begin to move beyond explicating immigrant women's health disparities through the analytical lens of the cognitive aspects of "culture", level of acculturation and the simplification of social categories into demographic variables (Viruell-Fuentes, Miranda & Abdulrahim, 2012). Studies that employ such frame of analysis oversimplify the complex contextual factors such as racism, xenophobia, and immigration policy, that influence the experiences of immigrant women in the United States. This study employed a postcolonial feminist approach to inform data collection and analysis.

A study of access to health care and the health care experiences of undocumented African immigrant women using a feminist approach is well-suited for elucidating how sociopolitical process influence access to health care and how immigrant women resist and navigate these structures. Rather than focusing on transitions or cultural differences to explicate phenomena related to immigrant health and healthcare utilization, critical perspectives such as post-colonial feminism (PCF) account for the chaotic and complex reality that often typifies the daily experiences of individual women. This is accomplished by considering the effects of gender, race and other sociocultural and political factors that impact women's social location and thereafter, their daily experiences (Viruell-Fuentes, Miranda & Abdulrahim, 2012). In the

following section, I will provide a brief overview of the feminist perspective utilized as well as a discussion of its utility and applicability to my study of undocumented African immigrant women.

Postcolonial Feminism

A postcolonial feminist approach promotes the destabilization of dominant discourses of Western feminism and knowledge particularly in relation to the experiences of “third world women” (in postcolonial feminist discourse, the term “third world women” is used interchangeably as “women of color” in reference to women in middle and low-income countries and women of color in Western nations). Chandra Mohanty, a feminist scholar who speaks on both feminisms, refers to this Western hegemony as “discursive colonialism” and describes it as “a certain mode of appropriation and codification of ‘scholarship’ and ‘knowledge’ about women of color by particular analytic categories employed in specific writing on the subject which take as their referent feminist interests as they have been articulated in the U.S. and Western Europe” (Mohanty, 1988). This mode of knowledge production is deeply problematic due to its inattention to contextual factors. An analysis of culture, ideology or economic conditions that is not situated within the context of global power hierarchies is incomplete and ignores the complex ways in which first and third world are interconnected (Mohanty, 1988).

Using Western feminist issues as the frame of analysis for “third world women’s” experiences yield knowledge that is ethnocentric and not truly descriptive of the experiences of non-Western women. This is most evident in the distinction between Western feminist self-representation versus Western feminist representation of third world women (Mohanty, 1988). Mohanty likens the distinction in representation of “Self” versus “Other” to the Marxist delineation between “the real ‘productive’ role of wage labor” versus “the ‘maintenance’

function of the housewife” (Mohanty, 1988). In an examination of how both categories are framed, it is evident that one position is intended to be perceived as inferior to the other. The consequence of the ethnocentric and Eurocentric perspectives through which third world women’s issues have been represented is the normalization of the Western experience while Othering the experiences of non-Western women.

An ethnocentric approach is evidenced by the foregrounding of patriarchy and gender as the main oppressive structures for women globally. This assumption of universality in experiences for Western and “non-Western women” has frequently been critiqued for its overemphasis of gender in analyzing women’s experiences while minimizing or ignoring the effects of race, class, colonialism and other complex structures that shape the experiences of women of color (Mohanty, 1988). Inherent within the PCF is a critical perspective that acknowledges how third world women’s experiences are a product of complex socially constructed systems.

Central to this conversation, is the legacy of colonialism in creating racialized power hierarchies, the implications of which persist today (Mohanty, 1988). As Uma Narayan states, “colonialism as an historical phenomenon...connect [s] and divide [s] Westerners from subjects in various Third-World nations in a series of complicated and unequal relationships. Colonial history is not only history of Western domination of ‘non-Western’ populations but is also a history of the creation of racially distinct and oppressed populations (Narayan, 1997). By rejecting the naturalization of race as a biological feature, PCF emphasizes how race is a social product of slavery and colonialism that has been historically used to rationalize domination and is currently being used to maintain existing social hierarchies. For women of color, the social and

political legacies of colonialism are inescapable and therefore, an understanding of the impact of colonial history is critical.

Postcolonial feminism is not a mere extension of Western feminism. It emanates from specific postcolonial contexts and the issues explored are affected by how women of color are situated in their respective societies (Narayan, 1997). Critical to the understanding of the experiences of third world women is the idea that these socially constructed structures carry different meanings across various spatial, geographical, and historical contexts. However, regardless of context, these systems have serious implications for women such as differential access to resources and health inequities (Khan et al, 2007).

PCF also acknowledges that the “personal” hardships that women experience are in fact political. The politicization of seemingly personal issues brings them into the public domain and highlights their systemic and systematic nature. In so doing, knowledge produced using a critical lens like PCF “enables the political contestation in which the status quo is criticized, and alternatives envisioned” (Narayan, 1997). What Narayan speaks of is the crux of social justice praxis. PCF fosters the development of knowledge that challenges the status quo and creates political and social change. Yet, it also acknowledges that women of color themselves have always been the main drivers of political and social movements in their various social and political locations (Narayan, 1997).

PCF affirms that the knowledge embedded in the experiences of women of color is authentic, legitimate and can be reported by women themselves. However, researchers have to be attentive and intentional as PCF studies have the potential to still bury the voices of the subaltern. Spivak states that “the assumption and construction of a consciousness or subject sustains such work and will, in the long run, cohere with the work of imperialist-subject

constitution, mingling epistemic violence with the advancement of learning and civilization” (1988). In other words, Spivak worries that the scholarship of scholars will reaffirm colonizing tropes and narratives. It is thus critical that scholars understand the risks of reproducing essentialist and oppressive narratives in the very same way that traditional Western knowledge production has done. Spivak cautions the “elite-subaltern” who aim to give the subaltern a collective voice on their complicity in potentially inadvertently engaging in marginalization.

To support the process of impactful decolonization, a PCF lens promotes engagement with women. By engagement, Spivak refers to the practice of speaking to, “rather than listen to or speak for” historically silenced third world women (Spivak, 1988). While the subaltern can speak, scholars need to engage with them. According to Mohanty, “it is time to move beyond the Marx who found it possible to say: They cannot represent themselves; they must be represented” (Mohanty, 1988). This required paradigm shift is critical to changing the narrative of cultural hybridity and binary oppositions that is a result of discursive colonialism.

Rationale for Qualitative Research

The purpose of this study was to understand how historical, social and political processes impact access to health care as well as the health care experiences of undocumented immigrant women in the United States. A qualitative study can best accomplish this aim as qualitative research seeks to understand the “what”, “how” and “why” of a specific phenomenon. This is accomplished by seeking an in-depth understanding of the realities of the participants using detailed and rich data (Ormston, Spencer, Barnard, & Snape, 2013). The goal of qualitative research is in close alignment with my research objective of “understanding” a phenomenon.

My study was guided by a postcolonial feminist qualitative inquiry framework which adds an analysis of the structures of race, gender, immigration status and other socio-political

factors that might affect an undocumented woman's experience and her reality (Khan et al, 2007). The assumptions and objectives of post-colonial feminism aligned well with my research objectives and my beliefs that knowledge is socially constructed and is strongly dependent on context. Thus, true knowledge lies with the members of the community experiencing the phenomena that is the subject of inquiry. The researcher is merely a tool for organizing and disseminating the community members' knowledge (Anderson, 2014). Additionally, I believe that history, social and geographic context is essential in the creation of knowledge within communities that have endured oppression through colonialism and racism. In my focus on the experiences of undocumented African women, the use of a postcolonial feminist perspective supported a critical analysis of their experiences within a given socio-political context.

Methods

Purpose of the Study and Research Questions

The purpose of this cross-sectional qualitative study was to gain an understanding of how historical, social and political processes impact access to health care as well as the health care experiences of undocumented African immigrant women in the United States. To accomplish this aim, the following research questions were examined-

1. How do undocumented immigrant women navigate barriers to accessing healthcare when facing a health need?
2. What are the experiences of undocumented immigrant women when accessing the health care system?
 - a. How are these experiences shaped by social, political and economic factors?
3. How do social, political, and economic factors affect the experiences of undocumented immigrant women?

4. How does a woman's undocumented status influence her daily experiences in the United States?

a. How does the availability/unavailability of social networks affect her experience?

To contextualize women's narratives, nurses were also recruited as a part of the study. Research questions guiding interviews with healthcare providers were as follows-

1. What are nurses' experiences with undocumented immigrants?
2. What are nurses' perception of barriers to care for undocumented immigrants in their setting?
3. What are nurses' perceptions of the impact of the current socio-political climate on access to care for undocumented immigrants?
4. What are nurses' knowledge of the experiences of undocumented women and the resources available to them?

Participation Selection Strategies

This section will include a discussion on the sample selection, sample size, recruitment strategies and human subjects' protection.

Sample Selection

The sample consisted of 24 undocumented African immigrant women who share a common experience of being undocumented African immigrants in the United States. The inclusion criteria for this study were as follows;

1. Self-identifies as an African immigrant woman and as being undocumented at the time of the interview.
2. Participant is older than 18 years of age
3. Participant currently lives in the United States

Twenty nurses were also recruited. The inclusion criteria for nurses were as follows;

1. Work as a healthcare provider
2. Be 18 years of age or older

Recruitment

Purposive, criterion-based sampling was utilized in the initial phase of the recruitment process. This sampling method assures that the participants are able to provide insight that enhances the understanding of their experience as undocumented African immigrant women, which is the main objective of the study (Ritchie, Lewis & Elam, 2003). With the assistance and permission of the staff, women were recruited from two local immigrant churches, a local community clinic and community leaders. Women were also recruited from a national organization that serves as a network system for Black, undocumented immigrants in the United States.

Snowball sampling was also utilized as a strategy for recruitment. Snowball sampling begins with a few “information-rich interviewees” who can recruit more subjects from their social networks (Patton, 2015, pp. 270). It is a useful approach for studies where the sample inclusion criteria include characteristics that are sensitive, and which might be easily disclosed by individuals (Ritchie, Lewis & Elam, 2003). This sampling method was therefore ideal for a study on undocumented immigrants who were otherwise hard to reach and recruit. Despite the use of snowball sampling, recruitment was challenging. Recruitment efforts began in January of 2017 and ended in September of 2018.

Flyers were utilized during the recruitment process and were distributed to various recruitment sites and organizations. The content of the flyers provided a brief overview of the study objectives. However, considering the current political climate, the researcher believed it

was appropriate to exclude the term “undocumented” from the flyer. Consequently, the flyer stated that the researcher was recruiting “African immigrant women”. Women who called the researcher to express interest in participating in the study were then given more specific information regarding the study eligibility criteria. The flyers used for the study were approved by the University of Wisconsin-Milwaukee (UWM) IRB and had the researcher’s name and contact number on them.

Recruitment of healthcare providers was less challenging. Nurses were primarily recruited from Midwestern healthcare organizations and through networking at the UWM College of nursing. Some nurses were also recruited through snowball sampling.

Protection of Human Subjects

The study proposal was submitted to the University of Wisconsin- Milwaukee’s Institutional Review Board for review prior to commencing the recruitment of study participants. Women who met the criteria and who consented to participation in the study were interviewed by the researcher at a place and time that was convenient for them. Prior to commencing the interview process, participants were informed of their right to terminate the interview or to drop out of the study at any time. Upon completion of the study, participants received a gift of \$30 gift card to Walmart for participating in the study. I believed that offering a gift to women who participated is an important consideration in research with marginalized populations whose knowledge has historically been seen as invaluable and illegitimate in dominant Western discourse. The gift was given to each participant to communicate to them that the researcher appreciated and valued their contribution and their time.

There was a risk to participants associated with the potential criminalization or stigmatization of undocumented status in the United States. To minimize this risk, ensuring the

participants' privacy and confidentiality was paramount. Privacy concerns had implications for how informed consent was obtained and how compensation was handled. Due to the sensitivity of immigration status and the importance of anonymity and privacy for the participants, the researcher had to take extra measures to ensure that the participants' identities were protected. To ensure utmost confidentiality, special requests were made to UW-Milwaukee's IRB to authorize the use of verbal informed consent and the use of identification numbers matched with a pseudonym to document receipt of the gift by the participant. Verbal consent was audio-recorded prior to beginning the interview. Additionally, all participants were assigned pseudonyms and an identification number that was recorded. These records were only accessible to the researcher and members of the research committee and have been stored in a locked cabinet in the researcher's home.

There was also a risk of emotional distress as the interviewer posed questions regarding women's safety. When women became emotionally distressed, the interviewer promptly stopped the interview and comforted the participant. The researcher attended each interview session with useful resources for women who might be experiencing violence.

Data Collection

Demographic information was collected to enhance the depth of the study by contextualizing the lives of the women (Appendix F). While the demographic information collected was valuable, obtaining perceptual information was critical to deconstructing the phenomenon under inquiry and responding to the research question. Perceptual information refers to the participant's perception of the topic of inquiry (Bloomberg & Volpe, 2008). The use of participant's perception is central to both qualitative and postcolonial feminist research

because it acknowledges that the participants' knowledge and experiences is their truth and is truly descriptive of their reality.

Perceptual information was obtained using semi-structured in-depth interviews, with open-ended questions that are outlined in Appendix B. Semi-structured interviews ensured that the interview process was flexible. By ensuring this flexibility, the interviewer gained rich data with immense depth resulting in the identification of new concepts (Corbin & Morse, 2003). While focus groups could also have generated rich information, individual interviews were conducted for this study due to concerns about the participants' privacy.

The interview interaction with women was informed by the principles of responsive interviewing. Responsive interviewing emphasizes the building of an interviewer-interviewee relationship based on trust that results in more of a mutual sharing of experiences (Rubin & Rubin, 2011). While face-to-face interviews is ideal, some interviews had to be conducted over the phone due to issues of geographical distance and limited funding. For face-to-face interviews, interviews were conducted at a location that had been mutually agreed upon by both the interviewer and the interviewee. To maintain confidentiality and to protect the participant's privacy, interviews were held in a private space such as the participant's home. All interviews were audio-recorded and conducted by the principal investigator. Subsequently, interviews were transcribed for data analysis.

In addition to the audio-recorded interviews, the researcher wrote memos throughout the research process. Memos included field notes collected before, during and after the interview and at all phases of the research process. This helped the researcher track what was seen, heard and experienced while collecting data and during the process of reflection (Miles & Huberman, 1984).

Data Analysis

Transcribed interviews were analyzed using principles of thematic analysis. Thematic analysis is characterized by systematic analysis of data through which themes or patterns of meaning are identified. Core steps central to this method of analysis include coding and classification of data, and interpretation of the themes by finding commonalities within the different sets of data. (Lapadat, 2010). Data were reviewed iteratively with the aim of identifying previously missed themes and concepts. The six-step process that was employed during the analysis include (Braun & Clarke, 2006)-

1. Familiarizing oneself with the data
 - a. Transcription of audio-recorded interview
2. Generating initial codes
3. Identifying themes
4. Reviewing the identified themes
5. Defining and naming themes (See figure 1 and 2)
6. Final analysis and write-up of report

During thematic analysis, data analysis can be informed by themes obtained from the theory or existing evidence (Boyatzis, 1998). This is an appropriate method considering that a postcolonial framework makes specific assertions about how the research participants' realities are shaped by external forces. Using a postcolonial feminist lens, data were closely examined to elucidate the impacts of social and historical processes in the experiences of undocumented African women; however, to avoid the problem of forced theoretical imposition, I needed to be attentive to the dialectical relationship between the data, *a priori* knowledge and postcolonial feminist assumptions about the influence of socio-political processes (Lather & Lather, 1991).

The thematic diagrams below illustrate the themes identified from the interviews conducted with both the women and the nurses.

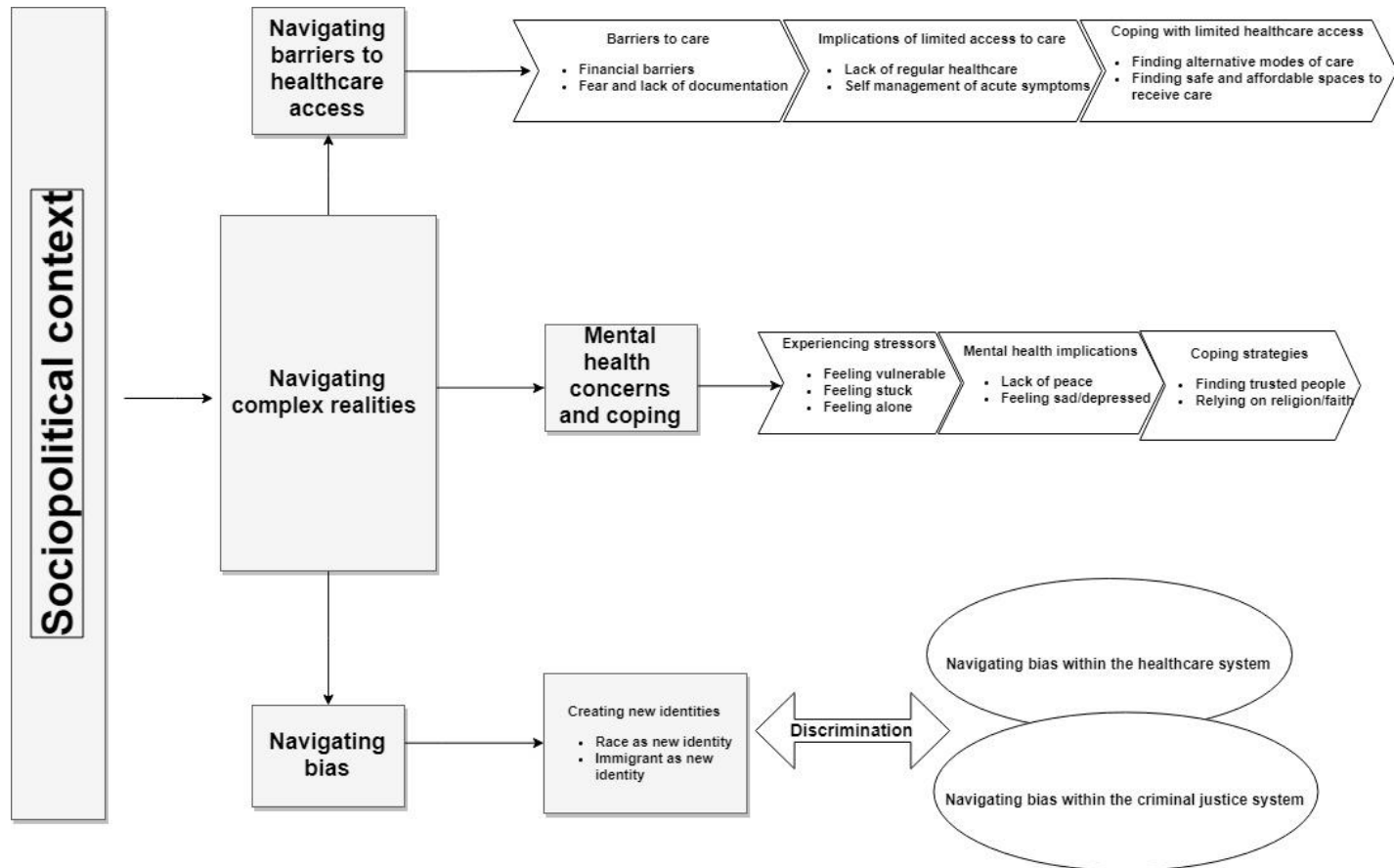


Figure 1. Thematic diagram summarizing undocumented African immigrant women’s experiences navigating complex realities

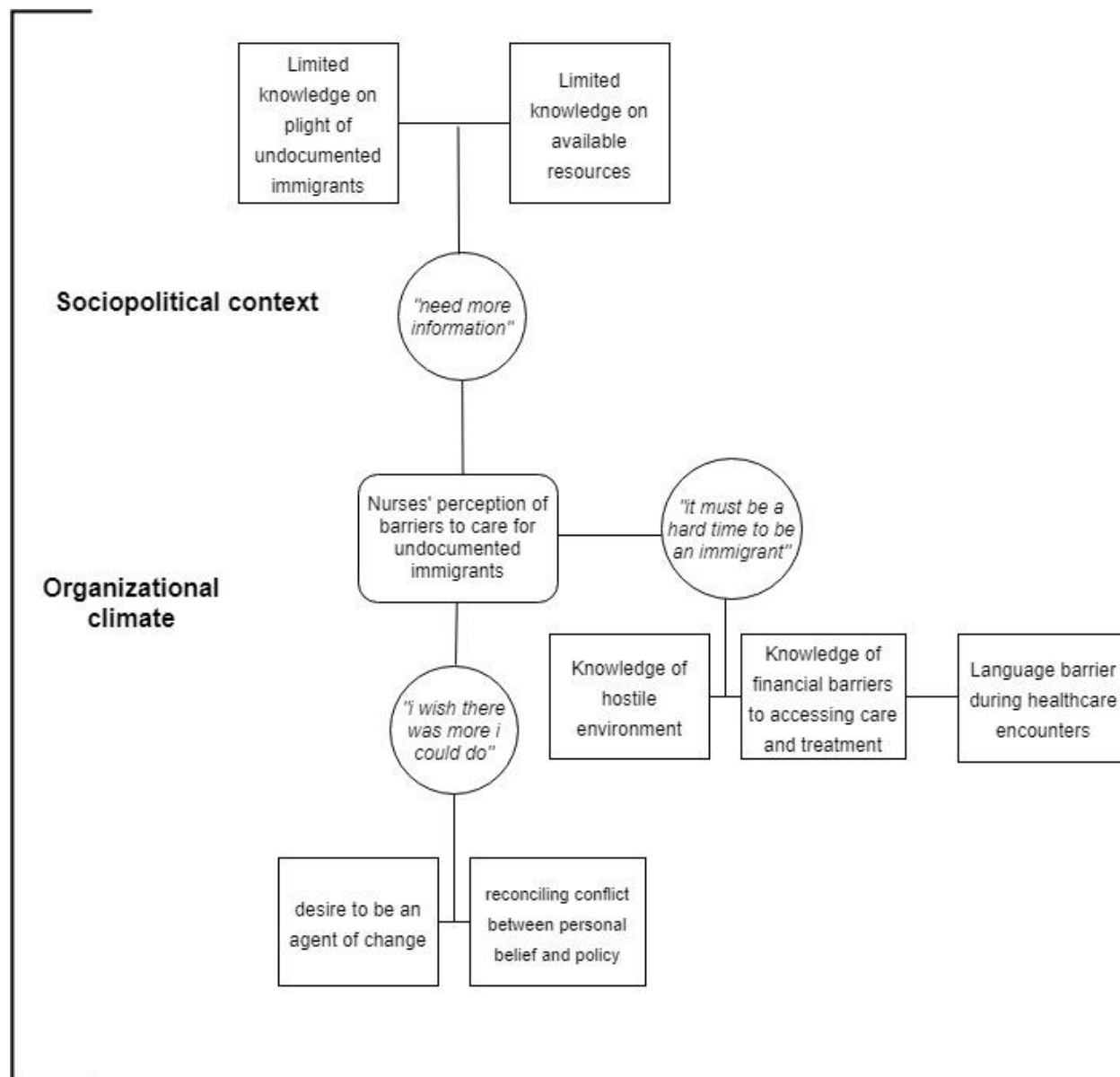


Figure 2. Thematic diagram explaining nurses' perceptions of barriers to care for undocumented immigrants

Scientific Rigor

Ensuring rigor in qualitative research is an important consideration in the study design to ensure the utility of the research findings. Rigor in qualitative research requires the use of strategies that ensure trustworthiness which consists of credibility, transferability, dependability and confirmability (Guba and Lincoln, 1989). Trustworthiness can be achieved by intentional utilization of strategies such as conducting negative case analysis, triangulation, reflective

journals, respondent validation, prolonged engagement and an audit trail (Guba and Lincoln, 1989; Morse, 2015). The following section will outline specific methods that were utilized to enhance the trustworthiness of the study results.

Credibility

Credibility refers to the extent to which the research findings are believable or credible based on the participant's perspective (Morrow, 2005). This is an important consideration in qualitative research because the purpose of the study is to identify and synthesize themes based on information provided by the participant. This ensures that the reported findings are truly descriptive of the participants' experiences.

Credibility in qualitative research can be established in various ways. In this study, respondent validation (member-checking) was employed to ensure that the themes being identified were "true" and credible. This method has been described as "the single most important way of ruling out the possibility of misinterpreting the meaning of what participants say and do and the perspective they have on what is going on, as well as being an important way of identifying your biases and misunderstandings of what you observed" (Maxwell, 2012, p. 126). In the context of this study, respondent validation occurred at different phases of the research process. Within the context of the interview, the participant's responses were paraphrased and repeated to the interviewee to confirm accurate understanding and interpretation by the interviewer. Additionally, respondent validation was achieved by summarizing the main points from the interview and sharing these with three interviewees immediately after the interview, in another effort to confirm accuracy.

Credibility was also established using triangulation which involved the use of multiple sources of data to confirm findings (Morrow, 2005). For the purpose of this study, triangulation

was established through the use of field notes and memos to confirm the authenticity of findings. Analyst triangulation was also employed by soliciting the expertise of my dissertation chair and other committee members to check the credibility of the themes identified.

Transferability

Transferability refers to the extent to which readers are able to apply the study findings to different contexts. This can be achieved through the use of in-depth descriptions of the phenomenon, using extensive details that allow the conclusions reported to be transferable to other situations (Lincoln and Guba, 1985; Houghton, Casey, Shaw & Murphy; 2013).

Transferability was enhanced in this study through the use of detailed and thorough description of the research context, process, my role as a researcher, the participants and lastly, the assumptions undergirding my study (Morrow, 2005).

Dependability

Dependability is concerned with the consistency and repeatability of the data. The central focus when evaluating a study's repeatability is that the research process is consistent across different phases of the research process (Morrow, 2005). Repeatability of a study can be enhanced when the researcher carefully tracks and records decisions that affect the research design and process through use of an audit trail. An audit trail includes information regarding "research activities, processes; influences on the data collection and analysis; emerging themes; categories or models; and analytic memos" (Morrow, 2005). Dependability of findings was enhanced by documenting the research process in an audit trails and having frequent discussions about research activities with the dissertation chair.

Confirmability

Lastly, confirmability refers to the extent to which the result can be confirmed by others. The underlying assumption is that every researcher approaches the study with a unique perspective informed by *a priori*, experiential knowledge and worldview (Morrow, 2005). Reflexivity is, therefore, a critical component of maintaining confirmability in qualitative research as reflective research practice can decrease threat to trustworthiness posed by researcher bias (Maxwell, 2012). The effect of bias is visible when the researcher selects data that align with their existing theories or preconceptions and when the researcher selects only the data that “stands out” (Miles & Huberman, 1994, p. 263). Since it is impossible to eliminate experiential knowledge or knowledge of preconceived theories, the researcher should understand and acknowledge how their experiences may impact the data collection and data analysis process. Confirmability was established through the use of reflective journaling. During the process of critical self-reflexivity, as the researcher, I responded to questions such as “What do I know?” and “How do I know what I know?” and engaged in reflection of how personal experience, motives and bias could affect the study.

Reflexive iteration is an inherent part of qualitative analysis. As a researcher conducting a qualitative study, I had to continuously evaluate and reconstruct my research design to ensure that the study objectives, research questions, methods and strategies to ensure rigor inform each other (Maxwell, 2012). Iteration was practiced by constantly reviewing my research process and design to make sure that it was serving its intended purpose.

CHAPTER IV: RESULTS

Chapter 4 is a compilation of the findings from the study in the form of three manuscripts. Manuscripts 1, 2 and 3 primarily focus on the findings from interviews with women. The last section of this chapter provides a brief summary of themes identified from interviews that have not previously been discussed in the prepared manuscripts. Consistent with a postcolonial feminist perspective, my intention is to focus on the women's narrative.

Manuscript 1: Navigating complex realities: Barriers to healthcare access for undocumented African immigrant women in the United States

The first manuscript reports on the barriers to accessing healthcare and how women navigate these barriers. It is formatted based on the author's guidelines for *Social, Science and Medicine*, the target journal for publications. The paper provides a summary of pertinent literature on access to healthcare for undocumented immigrants, postcolonial feminist methodology, the data collection and data analysis process followed by a description of the findings using women's narratives. The results are then analyzed, and policy and practice implications are discussed.

Navigating complex realities: Barriers to healthcare access for undocumented African immigrant women in the United States

Abstract

Access to health care is an important factor that impacts the health outcomes of any given population. In the United States, undocumented immigrants encounter a myriad of complex barriers that impede their access to health care, negatively impacting their health outcomes. Existing literature largely focuses on undocumented Latina/os. Considering the multiple vulnerabilities that undocumented African women experience, it is important that we deepen our understanding of their experiences when seeking health care. Therefore, this qualitative study was conducted between 2017 and 2018 to understand the barriers to healthcare for undocumented African immigrant women in the United States as well as how women navigate these barriers. Semi-structured interviews were conducted with 24 undocumented African immigrant women and 20 nurses. Findings indicate that undocumented African women experience complex barriers that impede their access to care. However, women demonstrated agency by managing their health in unconventional ways and attempting to navigate these barriers to find safe spaces to access care. Women's experiences were supported by accounts from the nurses interviewed. Our findings highlight the importance of safety-net healthcare settings and the need for healthcare providers to create safe spaces for undocumented women to access care.

Keywords

United States; Women; Undocumented immigrants, African immigrants, healthcare access

Highlights

- Examines the barriers to healthcare for undocumented African immigrant women
- Existing literature focuses on plight of undocumented Latina/o
- Financial constraints, fear and lack of documentation are significant barriers
- Women attempt to navigate barriers to access care

1. Introduction

As of 2014, there were estimated to be about 11.1 million undocumented immigrants living in the United States (Krogstad & Passel, 2014). Though more than half originates from Mexico, the undocumented population is also comprised of individuals from other Latin American countries, Asia, Europe and Africa- with African immigrants making up three percent of this population (Passel & Cohn, 2011).

Recent global events have highlighted the contentious nature of immigration and immigrant rights. Current issues that have been particularly polarizing, centered include Britain's exit from the European Union, the ongoing global migrant crisis driven by economic, social and political instability in migrants' home countries, and the growing popularity of anti-immigrant, nationalist rhetoric and policies in the Global North. While migrants appear to be experiencing an increasing amount of hostility globally, recent policy changes and the socio-political climate in the United States have further complicated the experiences of undocumented immigrants specifically living in the US. Thus, it is important that researchers seek to understand how the socio-political climate might impact undocumented immigrants' access to healthcare. In this paper, we report our findings on the barriers to healthcare access for a sample of twenty-two undocumented African women in the United States.

1.1. Barriers to accessing healthcare and implications for undocumented immigrants in the United States

Several studies have highlighted the challenges associated with accessing the health care system for undocumented immigrants (Montealegre & Selwyn, 2012; Dang et al., 2012; Martinez et al., 2013). Common barriers to accessing health care include financial status, lack of health insurance coverage, limited English proficiency, lack of transportation, not knowing

where to go for care, concerns about not being able to provide required documentation needed to apply for health insurance and to access health care services, distrust of health care staff and the fear of deportation (Dang et al., 2012; Montealegre & Selwyn, 2012; Maldonado et al., 2013; Hacker et al., 2015). While these are barriers that generally affect immigrant communities, the experiences of undocumented immigrants are undoubtedly unique due to their immigration status and policies that restrict access to resources.

Lower health care utilization rates are also an important finding for undocumented immigrants (Nandi et al., 2008; Chavez, 2012). Compared to documented immigrants, a significantly lower percentage of undocumented immigrant's participants reported having a usual source of primary care and undergoing routine health screenings (Rodriguez et al., 2009). Though in some states, undocumented pregnant women are eligible for state insurance that covers pregnancy related care, they might still delay initiation of prenatal care and are more likely to have inadequate prenatal care (Reed et al., 2005; Munro et al., 2013). The literature suggests that for undocumented immigrant women, utilization of prenatal care is impacted by fear, their undocumented status and lack of government issued documentation (Korinek & Smith, 2011; Rhodes, 2015). Delay in prenatal care has implications for maternal-child health outcomes. A study conducted by Reed et al., (2005) revealed that undocumented women experienced significantly higher rates of labor complications and fetal distress.

Difficulty accessing health care has been noted to also have significant implications for early diagnosis of illness and chronic disease management for undocumented women. A study by Castro-Echeverry et al (2013) examining the relationship between immigration status and survival for Latina breast cancer patients revealed that undocumented women presented with more advanced stages of breast cancer. After diagnosis, the 5-year survival rate was higher for

documented immigrants compared to their undocumented counterparts. Additionally, the mean diagnosis to treatment interval was higher in undocumented patients compared to documented patients. In a study examining the experiences of immigrants with HIV, undocumented immigrants with HIV infection were shown to enter HIV management care with more advanced disease than documented immigrants (Poon et al., 2013). Additionally, 2014 study on the relationship between immigration status and health care experience and diabetes outcomes in undocumented Mexican immigrants indicated that undocumented immigrants were more likely to report barriers to following their diabetes management regimen (Iten et al.).

The literature review clearly shows that undocumented women experience barriers to accessing care that impact maternal-child health outcomes, chronic disease management and overall wellness. It also uncovers a gap in knowledge on the experiences of non-Latino/a undocumented immigrants. While the experiences of all undocumented women are undoubtedly similar, it is important to examine how women from varying ethnic and racial backgrounds might face unique challenges (Gee & Ford, 2011). Additionally, with the constant shifts in the socio-political climate and immigration policies in the United States, it is imperative that researchers pursue the development of new knowledge aimed at deconstructing the impact of the socio-political context on access to healthcare for undocumented women. To achieve this aim, this descriptive qualitative study was conducted to understand undocumented African women's healthcare seeking experiences.

2. Methods

In order to account for the complex realities of undocumented African women, the study was undergirded by the tenets of postcolonial feminism. A postcolonial feminist approach challenges the assumption of universality in experiences by foregrounding how socio-political

and historical context impacts women's experiences (Mohanty, 1988). Critical to a postcolonial feminist approach is the idea that women's lives and their experiences vary across spatial, geographical, and historical contexts. Understanding these contexts, enables us to deepen our grasp of existing health inequities and differential access to resources (Khan et al., 2007).

Postcolonial feminism fosters the development of knowledge that challenges the status quo and creates political and social change. It acknowledges that women themselves have always been the main drivers of political and social movements in their various social and political locations (Narayan, 1997). Thus, while the researcher plays an important role, a postcolonial feminist stance cautions against the replication of power hierarchies existent in the broader society that often spills over into the research-participant relationship. A postcolonial feminist approach allows us to deconstruct these power hierarchies in order to lessen their manifestation through self-reflection on the part of the researcher (Racine, 2003).

A study of the health care seeking experiences of undocumented African immigrant women using a feminist approach is well-suited for elucidating how intersecting structures of oppression influence access to health care and how immigrant women resist and navigate these structures. Rather than focusing on demographic transitions or cultural differences to explicate phenomena related to immigrant health and healthcare utilization, critical perspectives such as post-colonial feminism allow for the analysis of complex realities that often typify the daily experiences of women of color.

2.1. Recruitment

In this study, a total of twenty-four undocumented African immigrant women were recruited along with 20 nurses. Interviews with nurses served as a second source of data. To be eligible for the study, immigrant women had to self-identify as being an African immigrant and

being undocumented. They also had to be 18 years of age or older, speak and understand English or French and currently live in the United States.

Purposive, criterion-based sampling was utilized to recruit initial participants. Initial participants were recruited through collaboration with local churches, a local community clinic and a national immigrants' rights organizations. Subsequently, snowball sampling was utilized as a strategy to improve recruitment rates. Snowball sampling is a useful approach for studies where the sample inclusion criteria include characteristics which are sensitive (Ritchie et al., 2003). In this case, women's undocumented status was extremely sensitive, particularly given the current political environment. For instance, five women who initially said they would participate, later decided not to. The current sociopolitical climate thus had important implications for recruitment of participants. The snowball sampling method was therefore ideal for this study with undocumented immigrant women who were hard to reach and recruit.

2.2. Sample

The sample comprised of twenty-four undocumented African immigrant women, whose ages ranged from 23 to 55 (Mean= 35.69). Nine women had full time employment, one had part time employment, seven were employed casually (irregular employment where the availability of work varies) and seven were unemployed. Most of the women (n=13) reported an annual household income of less than \$19, 999; four women reported annual incomes of less than \$10,000 per year. Twenty-one women lived in the Midwest of the United States, two in the South and one on the East coast. Women also reported on their highest level of education completed. Four reported their highest level of education completed as high school, seven reported having an associate degree, eight reported having a bachelor's degree and three reported having a graduate degree. Of the women interviewed, fourteen reported having at least one child.

The number of children reported ranged from 1 to 3 with women having an average of 1 child. In terms of women's health insurance coverage status, eighteen of the women interviewed reported being uninsured at the time of the interview.

2.3. Data collection and analysis

Data was collected using audio-recorded, individual interviews with eligible participants. Nineteen interviews were conducted face-to-face and five were conducted over the phone. Telephone interviews were conducted for participants whose state of residence was geographically distant from the researcher's location. Demographic information was also collected to help contextualize the lives of the women (Table 1). Transcribed interviews were analyzed using principles of thematic analysis. Thematic analysis is characterized by systematic analysis of data through which themes or patterns of meaning are identified. Core steps central to this method of analysis included coding and classification of data and interpretation of the themes by finding commonalities within the different sets of data. (Lapadat, 2010). Data analysis was an iterative process. The researcher transcribed the interviews and read through the transcripts to check for accuracy and to get familiarized with the data. To classify the data, the researcher created initial codes based on identified topics and themes. The transcripts were reviewed, and initial codes were assigned to data that were pertinent to the research aims and objectives. The coded data were then organized, and the codes were grouped into themes. The data were reviewed iteratively with the aim of identifying previously missed themes and concepts.

Trustworthiness is an important consideration in qualitative inquiry. It requires the use of strategies that enhance credibility, dependability, confirmability and transferability of the research data (Guba and Lincoln, 1989). Credibility was enhanced using member-checking and

triangulation. Following the interview with three participants, the researcher summarized the main points from the interview to the participant in another effort to verify accuracy of the findings. Credibility was also established through triangulation. Triangulation was accomplished through the use of interviews with healthcare providers as a second source of data and through the recruitment of women from different regions of the United States. Themes identified from interviews with women from residing in various regions of the country and the healthcare providers were consistent. Dependability was enhanced by keeping an audit trail and discussing research activities and decision with a research mentor. To enhance confirmability, the researcher engaged in continuous reflective journaling. Transferability was enhanced by the researcher providing in-depth descriptions of the research context surrounding data collection (Guba and Lincoln, 1989; Morse, 2015).

2.4. Ethical consideration

This study was reviewed and approved by the University of Wisconsin- Milwaukee's Institutional Review Board. Women who met the criteria and consented to participating in the study were interviewed by the researcher. Prior to commencing the interview process, participants were informed of their right to terminate the interview at any time or drop out of the study. The researcher also reviewed the study informational sheet with the participant prior to beginning the interview. In an effort to minimize the risk of the breach in participants' anonymity, verbal consent was obtained, and audio recorded. This was essential, considering the sensitive nature of one's immigration status and the potential implications of the participants immigration status being disclosed. Participants received a \$30 gift card to thank them for their time in participating in the study.

3. Results

Initial codes were identified during the coding process. Women's perception of the barriers they experienced to healthcare access was captured under the major theme *navigating barriers to healthcare access*. This major theme captured the idea that women face complex, structural barriers that they were required to navigate in order to receive healthcare. Under this theme, initial codes were collated, resulting in the three minor themes pertinent to women's perception of barriers to the healthcare system- *difficulty accessing healthcare*, *implications of limited healthcare access*, and *coping with limited healthcare access*. Women reported difficulty accessing care due to financial factors, and fear of detection and lack of documentation. Consequently, women had difficulty getting regular care and had to self-manage their acute symptoms. Coping with limited healthcare access required women to find alternative modes of care and find safe spaces to receive care.

3.1. Difficulty accessing healthcare

Women reported difficulty accessing healthcare when they had a health concern. Even when there was a dire need for health care, women's decisions on whether to seek care was influenced by a combination of factors. Also, the degree to which the barriers reported affected women's ability to access care varied depending on the woman's circumstances and contextual factors at the time that care was needed. Two subthemes were identified in relation to the difficulty women faced in accessing care- 1) barriers to financing healthcare costs and 2) fear and lack of documentation.

3.1.1 Barriers to financing healthcare costs

Women's ability to pay for care impacted how, where, when and if they sought care. This was a concern reported by most women but particularly women who held low wage jobs or were unemployed. Due to their immigration status and not having authorization to work in the

country, it was common for women to work "under the table" jobs where they were paid relatively low wages. Women reported being underemployed, underpaid and sometimes having difficulty making ends meet. One participant discussed her wages working in a daycare and a local grocery store-

The work is ok. It's hard because I have to work a lot. The pay is so low at the day care that I have to work 12 or 16 hours shift sometimes just to make enough money. / Sure, I am paid like \$5 an hour. I know it's because I don't have my papers. Because that's not even minimum wage (Participant 18).

This participant's experience was typical for women with informal jobs. Some women also reported having difficulty finding work and they therefore had no income. They thus relied on an intimate partner, friends, relatives and/or other members of their social network for financial support. For women who worked low wage jobs with unstable employment, affording basic necessities, including health care was a challenge. In cases where women were able to access acute or primary care, their financial status also posed as a barrier to them getting follow-up, specialty care and diagnostics testing. One participant who was uninsured shared her experience being referred to get an ultrasound at a time when she was also unemployed:

I recently had to undergo surgery and interestingly enough I went to a clinic 2 years ago to get a pap smear and she saw something in my left pelvic area. I knew it was written in the notes that I was supposed to go get an ultrasound done. But I don't have money for an ultrasound so I couldn't go get an ultrasound done (Participant 12).

This participant's situation exemplifies how women had to forego pursuing initial care and/or further follow-up due to financial constraints. Other women shared similar stories of not being able to follow through on referrals for specialty care.

Insurance status also impacted women's ability to pay for care and consequently affected their health care. Generally, women interviewed were uninsured and were required to pay out of pocket for whatever health costs they incurred. This was a source of frustration for them-

especially for women who had incurred bills for seeking health care. Women reported having to pay full, out of pocket costs for all expenses related to their health care including doctors' visits, prescription medication, diagnostic testing with costs ranging from \$20 billed at community clinics serving low-income patients to \$7000 billed at an emergency department. A participant who had been coping with chronic gastrointestinal symptoms for about two years said:

For me to see a doctor, I have to pay out of pocket and it makes it very difficult because I have health challenges that I am dealing with it. And just to get a doctor to see me or evaluate me requires at least a thousand dollars or something more. And I don't want to do that because I don't have that money (Participant 19).

It is important to note that some participants did have a history of being insured. Five women reported having insurance while pregnant that enabled them to access healthcare for pregnancy-related care. However, women lost that insurance coverage once they were two months post-partum. Only four participants had active health insurance obtained either through their employer, the health insurance marketplace or through the state insurance for low-income residents. Participants with health insurance generally reported being able to access the health care system with relative ease compared to those who did not have insurance. Yet, even participants with insurance would sometimes forego seeking care due to high co-pays and co-insurance costs which they could not afford.

Women's reports of experiencing financial barriers to accessing appropriate care was confirmed by nurses who reported being frustrated by the dearth of available resources to help underserved patients such as those who are undocumented. They reported that while safety-net clinics might offer sliding-scale fees based on a patient's income, patients often must present paper work such of proof of income or proof of residence to qualify for the discounted rates. Nurses who work in settings other than the safety-net clinic reported that for undocumented patients who are uninsured patients, the full burden of the cost of care would typically be placed

on the patient. The nurses interviewed reported that while there are available programs for patients who are underinsured or uninsured, many of those programs require eligible patients to have social security numbers.

3.1.2. Fear and lack of documentation

In addition to the challenges associated with paying for care, fear also prevented some women from accessing the healthcare system unless seeking care was absolutely necessary. This was the case for thirteen women who considered their invisibility and staying "under the radar" as being paramount to their ability to stay in the country. Maintaining that invisibility required them to avoid institutions, including health care organizations, where their status might be revealed. Some women expressed that this fear was exacerbated by aggressive policies aimed at increasing deportation of undocumented immigrants as well as the increasing visibility and overtness of xenophobic rhetoric that create a hostile environment for immigrants. The fear of accessing various institutions such as healthcare was exemplified by one participant who stated:

Even if you want to go to the doctor, you would be scared that they will find out that you don't have your papers. Who knows what could happen. That's why I don't even go (Participant 20).

The idea that discovery of their status even within the health care setting might have negative repercussions was pervasive among women. Another participant said

I have no desire to see a doctor even if I was not feeling well unless it's serious. Because right now, you don't know what type of questions they would ask about your status since the new president wants to deport everyone. You just have to be careful (Participant 4).

Accounts from nurses who practice in safety-net clinics were consistent with this finding. Nurses reported having to reassure immigrant patients that they do not collaborate with immigration agents and that their clinic was a safe space to seek care. These nurses reported that patient verbalized feeling increased fear of being detained by immigration agents. Nurses who

practiced in other settings acknowledged that considering the hostile socio-political climate, undocumented immigrants might feel heightened levels of fear resulting in decreased utilization of the healthcare.

Lack of documentation such as an identification card or other identifying information posed as a barrier to healthcare for some women. Some women were under the impression that if they presented to a health care setting seeking care, they would be asked for some form of identification. One participant discussed her concerns:

But what if they ask you for some information and you don't have it? Like a social security number. I don't have one right now. You don't know the type of people that you will encounter there. If they are anti-immigrant, if they like Donald Trump. You can't know what people's intentions are if they happen to find out what your status is (Participant 1).

Depending on the participant's state of residence, they could obtain some form of identification issued by the state, but this was only the case for eight women. While some women had documentation for identification and/or a social security number, there were a few women who had neither. Women with no form of identification at all expressed the greatest degree of fear and vulnerability associated with not having documents. Women believed that even without disclosing their status, their inability to produce such documents and information would expose them as being undocumented and increase their risk of deportation.

3.2. Implications of difficulty accessing care

The complex barriers that impeded women's access to care had implications for their ability to manage their health. This theme consisted of two subthemes- 1) lack of regular care and 2) self-management of acute symptoms.

3.2.1. Lack of regular care

It was not unusual for the participants interviewed to not have seen a health care professional in the past year. This was the case for seventeen of women interviewed. Most often this was because women were not insured and could not afford the out of pocket costs of seeing a health care provider. As a result, they were forced to forego preventive care and in some cases, would delay getting medical attention for acute symptoms until their condition became more critical. Twelve women in the study also reported having chronic medical conditions such as hypertension, pre-diabetes, endometriosis, fibroids and chronic pain. While they realized that routine care was a critical component of chronic disease management, obtaining routine follow-up care was challenging. One participant with a history of chronic heart palpitations who was uninsured shared that she had not seen a doctor for four years.

Well, I used to have health insurance under my dad, so I had a regular doctor. I would go whenever I wasn't well or for annual check-up. But my dad lost that job a few years ago when employers started using the Everify [web-based system used by employers to confirm employment eligibility of employees] thing. They found out that he couldn't legally work and he was terminated him so we lost our health insurance coverage. So I haven't had health insurance in a while. I haven't seen a doctor in 4 years. Thank God I haven't gotten really sick (Participant 3).

Another participant recognized the importance of preventive care. She shared that while in her home country, she would see her doctor often, yearly at the minimum, with relative ease.

However, because of her immigration status in the United States, she had not seen a health care professional in years.

I used to go for yearly checkup. I'm educated and I might not have a lot of knowledge about healthcare, but I know the importance of preventive care. You know, I have not had a pap smear or even a physical in a few years. Last time I saw a doctor, they said that they were going to monitor me for being pre-diabetes. I haven't been able to follow-up on that. I don't think I'm diabetic right now because I feel fine but who knows? (Participant 5).

This participant's situation was particularly concerning because like many other women in the study, she had a health condition that required regular follow-up with a health care professional.

However, the complex barriers she faced impeded her ability to do so. Furthermore, it was not unusual for women to receive a significant diagnosis following an evaluation with a health care provider after years of not seeing a health care provider. This means that women potentially had undiagnosed and untreated conditions such as hypertension or diabetes for a significant duration of time.

In addition to the lack of routine primary and preventive, the difficulty women had in accessing specialty care was also problematic. Women reported immense difficulty accessing gynecological health services, mental health support and specialized diagnostics and testing recommended by a general practitioner. This finding was supported by nurses who reported frustration with the dearth of available resources to assist vulnerable patients with accessing specialty care, medications and medical supplies. This was a concern for nurses as some patients could not afford to pay for essential medications such as blood thinners and medications for heart disease, diabetes and hypertension.

3.2.2. Self-management of acute symptoms

Given the limitations in healthcare access, self-diagnosis was relatively common among participants. Women reported entering their symptoms into a "Google" web search and diagnosing themselves based on their review of the search results. A 25-years-old participant who described experiencing chronic, intermittent chest pain and also had concerns about her dental health said:

There are so many different health challenges that I have that I would like taken care of but I cant do anything about it because I don't have insurance. Like I would like to see a therapist or even see a doctor so I can get bloodwork done to see what's wrong with me. So basically I have had to do my own research and use google as a resource just to help me figure out what's wrong with me. Diagnose myself basically. It sucks and it would be nice to have to have a clinical professional actually assess me and give me an accurate diagnosis and their recommendations (Participant 13).

Subsequently, women would self-medicate to treat their symptoms. The women reported treating symptoms with over the counter medications as well as other home remedies. One participant with some training and experience as a nurse shared that she was able to treat acute symptoms by having friends or relatives bring her antibiotics and other medications from her home country. This prevented her from having to see a health care provider to receive a prescription.

3.3. Coping with limited access to care and resources

Women had to cope with the barriers that prevented easy access to care. However, many women found unconventional ways to manage their health care without having to access the health care system.

3.3.1 Finding alternative modes of care

Women often managed their health and sought care through avenues that did not involve accessing the mainstream health care system. Several women reported soliciting health information from a variety of sources including trusted health care professionals within their social networks, pharmacist recommendations and the internet. A participant reported seeking health care advice from a medical doctor she knew.

There's a doctor at my church that I ask questions about my health. I am able to get recommendations from him on what he thinks I should do when something is wrong. He also helps by telling us where we should go to go find things that we might need (Participant 4).

Seeking input from community members was very common among women in the study. Aside from medical professionals (nurses, physicians, pharmacist), participants also sought input on health-related matters from other individuals such as religious leaders, friends and relatives who sometimes had no medical training or background. One participant reported consulting with a faith leader in her home country regarding abnormal swelling that a general practitioner noted

in her neck. Though the physician recommended that she undergoes further diagnostics testing, she was certain the testing would cost more than she could afford. Therefore, her plan was to try an herbal drink prepared specially from her home country.

Due to immigration and insurance status, women also had to find other unconventional ways of obtaining healthcare. One participant reported going to health fairs where screenings were being conducted:

I don't see a doctor regularly. I try to look for community health fairs. I just recently went to a health fair or an expo kind of thing where they check your blood pressure, cholesterol level and those basic stuff (Participant 17).

By attending free health fairs, this participant was able to get basic screening conducted by the sponsoring organization. However, such events did not sufficiently address other acute health concerns that she reported such as gastrointestinal symptoms and dental concerns.

3.3.2 Finding safe and affordable spaces to receive care

For this sample of undocumented African women, it was essential that they found safe spaces within the health care system to receive care. Social networks and women's local immigrant communities were instrumental in connecting women to health resources that they could access. Yet, the process of finding safe and affordable spaces to receive care was sometimes a challenging task as some women reported not having any knowledge of where they could access care if they needed it. Depending on the city and neighborhood that women resided, clinics for low-income persons were either not easily accessible or women had no knowledge of them.

Some women did report being aware of free clinics and community clinics for low-income persons they could use if they had a health concern. Women also sought care at a variety of other settings including the emergency room, quick care walk-in clinics, Planned Parenthood,

walk-in clinics and ambulatory clinics. One participant who needed the services of a physician for an acute condition detailed how she decided on the provider who she saw for her care.

I just felt a conviction to go see another doctor. I went to go see this other doctor, I talked to her about my status, I talked to her about not having insurance. That I didn't have money for this./ She was African...she was like me, I wanted to see her specifically because I felt that she would understand where I was coming from. /Some people cannot understand. You don't understand if you've never been there. You don't get it if you have not dealt with the immigration process or know people who have had issues with immigration. That's nothing I can say that's going to make you understand. You can have compassion, but that's it (Participant 12).

This participant selected this provider because she was an African immigrant who she believed would understand her reality. Safe spaces were characterized by interactions where women felt like they would not be judged, stigmatized or degraded as a result of their immigration status. In contrast, women did not feel safe in spaces where they were unsure of individual or organizational attitudes toward immigrants or undocumented immigrants and where they might encounter individuals who "did not understand" their plight and the challenges they faced. The importance of encountering people who would empathize with their situation was mentioned in the context of interactions with not only health care providers, but also law enforcement officers, employers and people they encountered in their daily lives.

Women's experience seeking safe spaces to receive care was supported by the account of nurses. Nurses who work in safety net clinics reported having built trusting relationships with immigrant communities that they serve. These nurses were aware that immigrants sought care from their organizations because organizational leaders and staff are intentional about finding resources for patients and about ensuring that patients feel safe and respected. Some strategies nurses discussed included the use of interpreters, hiring bilingual staff, and having community forums to reassure patients that the clinic is still a safe space despite the hostile, anti-immigrant sociopolitical climate. Generally, nurses who work in acute care setting within large healthcare

organizations discussed their individual efforts in ensuring patients felt safe such as treating patients with respect and integrity and being empathetic. However, they were unsure of any organizational initiative directed specifically at reassuring immigrant patients.

DISCUSSION

Our findings corroborate results from similar studies that have examined health care access for undocumented persons. However, in addition, our postcolonial feminist analysis offers new insights into the nuanced experiences of undocumented African women and how women resist and navigate the barriers they experience.

Consistent with existing knowledge, our study reveals that undocumented African women face a lot of the same challenges as their Latina counterparts including financial barriers, documentation and insurance status. We found that undocumented African women inhabit multiple complex, marginalized identities that impact their access to health care and their health care seeking experiences. While seeking health care, women's choices were made under the constraints of a hostile socio-political context and a challenging socioeconomic environment. When women work long hours and multiple jobs, finding time to access the healthcare system can also be challenging. Additionally, women with no documentation might not be able to obtain a driver's license and thus, may not have transportation access to the healthcare system.

In recent times, various policies have been implemented aimed at increasing deportation and detention rates for undocumented immigrants. Notable policies include the use of executive action to support mass deportation of undocumented immigrants and to penalize sanctuary cities, and a "zero tolerance" approach that authorizes the immediate detention and prosecution of migrants who cross the United States/Mexico border seeking asylum (Pierce & Selee, 2017; U.S. Department of Homeland Security, 2018). Immigration policies and practices that target

undocumented immigrants have been shown to increase fear, decrease mobility of immigrants and decrease trust in officials (Hardy et al., 2012). As a result of policies aimed at deporting immigrants and restricting their access to resources, undocumented immigrants in the United States experience several vulnerabilities, particularly in accessing health services. This has obvious implications for the health and well-being of undocumented women as our study has demonstrated.

There were several dynamics to women's perception of healthcare access. The average length of stay in the United States for women was about twelve years. Consequently, most women had experienced several shifts in perception and attitudes towards immigrants and resultant policy changes in the United States. In the past, women could obtain a social security number, driver's license and employment with relative ease. Pertinent policy changes include the 2005 REAL ID Act that requires states to verify an applicant's immigration status before issuing licenses and the 1996 release of E-Verify used to verify prospective employee's employment eligibility (Ewing, 2010; USCIS, 2011). These two policies impact undocumented immigrant's access to formal employment and a driver's license.

In our study, it was evident that women demonstrated agency in managing their health. When care was needed, some women were successful in finding safe spaces and trusted providers. Women's ability to access affordable care underscores the importance of safety net clinics that are essential to the provision of care for low-income patients such as Planned Parenthood, federally-qualified health centers and free-clinics (Nguyen et al., 2016). Even when women were not able to access care through safety net clinics, they engaged in health management activities and tapped knowledge from individuals within their social networks. Despite discovering unconventional ways of managing their health, it is important to note that

most women reported having health needs that were not attended to for a duration of time due to difficulty accessing care through the formal health care system. In addition, some women still had health needs that were unmet at the time of the interview.

Another critical finding is the difficulty women reported in accessing regular, primary care. It is well documented that primary care settings play an integral role in ensuring that patients have access to prevention interventions, disease screening and early management of disease (Starfield et al., 2005). Access to preventive care has implications for improving women's health as well as for decreasing the nation's healthcare costs. It is estimated that increased access to and utilization of clinical preventive services in the United States could reduce healthcare expenditure by \$3.7 billion dollar per year (Maciosek et al., 2010). Thus, our findings, in addition to the data on the benefits of preventive care support the need to counter proposed policies aimed at defunding health centers such as Planned Parenthood that offer health services, including disease screenings, to low-income women regardless of documentation status.

Women's experiences navigating barriers to access healthcare could have been influenced by a variety of factors. It is important to note that there was sociodemographic heterogeneity amongst the women. The sample consisted of women who had differences in employment status, insurance status, length of stay in the United States, and were at different phases of the immigration process. Additionally, there were variations in the geographic location of the women interviewed. Some cities in the country are known to be "sanctuary cities". This refers to cities in the United States that implement policies and procedures meant to protect undocumented immigrants from prosecution or detention by prohibiting use of municipal funds in the assistance of immigration enforcement officials. Typically, sanctuary cities also prohibit the police or city officials inquiring about immigration status from city residents. Sanctuary

policies and procedure differ across municipalities where law enforcement officers are discouraged from cooperating with immigration officials (Villazor, 2009). Such factors undoubtedly have a differing impact on women's experiences and access to healthcare and other community resources.

LIMITATIONS

There are some limitations to this study. Two women opted to have some of their responses to some interview questions be off-the-record. Resultantly, this write-up is exclusive of important information that could have been provided by women who could not participate and information that could not be included as a result of fear. However, the information obtained from women and the number of participants interviewed was adequate for the researcher to reach data saturation with the actual data obtained and the data that were usable.

The use of phone interviews was another limitation. We would have preferred that all the interviews be conducted in person; however, this was not possible for at least five of the women due to geographic distance between the researcher and the participants. Nevertheless, a few scholars have made the point that telephone interviews are equally as useful and are especially advantageous for ensuring participant anonymity when discussing sensitive topics and doing research with hard to reach populations (Novick, 2008; Trier-Bieniek, 2012). Additionally, the telephone interviews did not appear to compromise the data obtained as the themes identified from the findings from interviews conducted over the phone were consistent with those from women interviewed face-to-face.

CONCLUSION AND IMPLICATIONS

This study focused on the barriers to accessing health care for undocumented African women in the United States. The findings presented offer an analytical dimension lacking in the

existing literature on how access to healthcare specifically for undocumented African women is influenced by contextual structures. Existing studies often treat immigration status, nationality and ethnicity as demographic variables, which downplays how these “variables” are socially-constructed categories that marginalize women.

Beyond our commitment to a social justice agenda, ignoring the needs of undocumented immigrants could have negative public health implications. Indeed, the challenges with health care access experienced by undocumented immigrant women experience poses a significant threat to public health. The containment of infectious disease is largely dependent on the infected individual’s ability to seek health care when symptoms are first noted (Fraser et al., 2004; Quinn & Kumar, 2014). However, when health care access is limited, there is an increased risk of spreading communicable disease due to a delay in seeking care. Additionally, when individuals experience barriers to care, they are more likely to present for care when their condition is more complicated (Carrillo et al., 2011). This results in preventable adverse health outcomes for the individual but may also have implications for the health of the broader public.

Finally, this study uncovers the need for comprehensive immigration reform. Undocumented women appear to be in a challenging situation that leaves them vulnerable to many forms of disparities and resultant poor health outcomes. This requires that the conversation around healthcare for undocumented immigrants be reframed. Expanding healthcare and preventive care to this population is a matter that should be assessed and examined from a public health and social welfare perspective, rather than a political one. Politicizing such an issue that is a critical determinant of individual health status, quality of life, existence and the nation's population health is potentially dangerous to the health and safety of not only undocumented women but the US population more broadly.

Table 1. Demographic data for women interviewed (n=24)

Variable	Mean
Age (23-55 y)	35.69
Length of Stay in U.S (2-22 y)	11.52
	n (%)
Marital Status	
Married	7 (29%)
Widowed	1 (4%)
Divorced	1 (4%)
Separated	3 (13%)
Never married	12 (50%)
Children	
Yes	14 (58%)
No	10 (42%)
Region of Residence in U.S	
Midwest	21 (88%)
South	2 (8%)
East	1 (4%)
Employment Status	
Full time (40 hours a week)	9 (38%)
Part time (< 40 hours a week)	1 (4%)
Casual worker (work when work is available)	7 (29%)
Unemployed	7 (29%)
Highest Level of Education	
High school	4 (17%)
Some college credits	2 (8%)
Associates degree	7 (29%)
Bachelor's degree	8 (33%)
Graduate degree	3 (13%)
Annual Household Income	
Less than \$10,000	4 (17%)
\$10,000 to \$19,999	9 (38%)
\$20,000 to \$29,999	5 (21%)
\$30,000 to \$39,999	4 (17%)
\$40,000 to \$49,999	1 (4%)
\$50,000 or more	1 (4%)

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Manuscript 2: The changing identity of undocumented African women becoming Black in the United States: Navigating bias at the intersection of the healthcare system and the criminal justice system

The second manuscript reports the findings on undocumented African immigrant women adopting new identities and navigating bias within the healthcare and criminal justice system. It is formatted based on the author's guidelines for *Advances in Nursing Science* and it responds to the following call for papers:

Culture, Race and Discrimination in Healthcare

Manuscript due date: October 15, 2018

In the past decade, issues of discrimination based on culture and race have risen to the surface in many countries worldwide, along with a growing nationalist movement that rejects "the other." In this issue of ANS we seek manuscripts that address these factors as they influence health and well-being of individuals, groups and communities, and the delivery of nursing and healthcare in culturally diverse communities. Articles must address the development of nursing knowledge that informs nursing practice, education and research.

In addition to being submitted for publication, these findings were also presented at the Transcultural Nursing Society 2018 conference in the form of a poster titled *Exploring the healthcare seeking experiences of undocumented African women in the United States.*

The changing identity of undocumented African women becoming Black in the United States: Navigating bias at the intersection of the healthcare system and the criminal justice system

Abstract

Access to institutions such as healthcare and law enforcement is critical to maintaining safety and wellness. However, experiences of racism adversely impact how undocumented immigrants engage with various institutions. This qualitative study aimed to understand undocumented African women's experiences accessing healthcare. Additionally, women spoke of their perceptions of law enforcement. Twenty-Four African women were interviewed. Our findings indicate that women had to navigate bias in different facets of their lives. Findings uncover the need for healthcare providers to provide culturally safe care and to creatively identify ways through which undocumented women can seek help to ensure their health and safety.

Key words: African immigrants, undocumented immigrants, women's health, immigrant's health, postcolonial feminism

Statements of Significance

What is known or assumed to be true about this topic:

Access to the healthcare system and law enforcement are integral components of coordinated efforts to attend to the needs of women who are victims of violence. Yet, undocumented immigrants experience several complex and structural barriers to accessing healthcare and law enforcement. Their experiences navigating these barriers are complicated by a racialized society plagued by discriminatory treatment perpetrated by healthcare professionals and law enforcement personnel. Consequently, undocumented immigrants have lower healthcare utilization rates and are less likely to seek help from law enforcement in the face of danger. Healthcare professionals are well-positioned to address the health-related needs of undocumented immigrant women. Within their healthcare organization, healthcare providers can create safe spaces where undocumented women can seek care and create avenues where women can seek help when in danger, without fear.

What this article adds:

This article enhances our understanding of the nuanced experiences of undocumented African women navigating bias within the healthcare and criminal justice systems. This study contributes significant knowledge on how undocumented women's experiences within their racialized context could impact access to healthcare institutions and potentially their health outcomes. Based on the voices of women already existing on the margins of society, our findings provide information on how healthcare providers can engage with undocumented women to avoid further marginalization.

BACKGROUND

The dynamics of racism within the healthcare environment and its impact on health outcomes is well-documented in research literature. Studies have repeatedly shown that marginalized populations experience discriminatory practices within the healthcare setting.^{1,2} This is concerning as there is increasing evidence that healthcare professionals' explicit as well as implicit racial biases impact patient-provider interactions, treatment decisions, treatment adherence and health outcomes.³

The relationship between racism and health outcomes is also evident in the persistence of health disparities for ethnic minorities. In the U.S., ethnic minorities bear a disproportionate burden of disease, disability and mortality across several health indicators.⁴ Of note, is the long-standing relationship between racial discrimination and adverse birth outcomes for African American women.⁵ Additionally, Black women in the United States also bear a disproportionate burden of breast cancer mortality.⁶ This indicates that racism has serious implications for racialized women, even within the context of their healthcare-seeking encounters.

Due to historical and current racial discriminatory practices in the healthcare system, undocumented African immigrants may experience a more complex relationship with such institutions. Findings from prior work indicate that immigrants' experiences with the healthcare system impacts their perception of the healthcare system and their decision on whether to seek healthcare.^{7,8} Evidence on healthcare experiences and perceptions of the healthcare system for undocumented immigrants also reveal that they might harbor a mistrust of the healthcare system. Mistrust of the healthcare system is an expected finding as undocumented immigrants are more likely to report negative experiences such as discrimination, poor quality care, being treated with hostility, cultural insensitivity, and an overall poor perception of the healthcare system.^{9,10}

In light of the evidence of the experiences of racial minorities within the healthcare system, it appears that race could also impact undocumented Africans' healthcare experiences. Fear of discrimination has been identified as a barrier to seeking care among African immigrants generally.⁸ African immigrants' fear of discrimination and mistrust of the healthcare system is a legitimate consideration given the continuous marginalization of Black patients within the healthcare system. Research data consistently show that Black patients in the United States are more likely to receive substandard care when accessing the healthcare system.^{11,12}

Racism perpetrated by law enforcement institutions also complicates Black immigrants' perception of institutions and consequently their health outcomes. The recent Black Lives Matter movement has highlighted how institutional racism is operationalized in the criminal justice system through aggressive policing of Black residents.¹³ The racial inequity perpetrated by the criminal justice establishment is also evidenced by the disproportionately higher rates of detention and deportation of Black and Brown immigrants.¹⁴ These ongoing discriminatory practices perpetrated have implications for the health of African immigrant women. The racialized policing and detention of immigrants directly impacts immigrant health by reducing mobility and consequently, access to healthcare due to fear of deportation.¹⁵ More importantly, fear of deportation is a significant indicator of immigrant women's reluctance to contact law enforcement when they are victimized, potentially jeopardizing their safety.¹⁶

Beyond race, ethnic minorities might also experience marginalization based on other social categories such as socioeconomic status and nationality. These overlapping social categories cannot be analyzed in isolation from one another. For racialized groups, racism indeed intersects with other forms of domination based on class, religion, ethnicity or nationality.¹⁷ The intersection of these forms of domination implies that an African immigrant in the United States

might be forced to navigate racism, xenophobia, religious discrimination, among others forms of discrimination. The experiences of African immigrants are further complicated by the increased visibility of white nationalist movements and anti-immigrant rhetoric, practices and policies undergirded by racism and xenophobia. The intersection of these forms of marginalization has implications for access to institutions such as those that provide healthcare and public safety services for African immigrants in the U.S.

For the healthcare system, this indicates the need for culturally safe health care that fosters provider reflexivity to avoid further marginalization of undocumented women, and low-income women generally.¹⁸ Reports of both poor healthcare experiences and the negative perception of law enforcement is particularly concerning considering that undocumented immigrant women are vulnerable to abuse and violence.

This qualitative study was undertaken to examine the healthcare seeking experiences of undocumented African immigrant women. Our analysis of findings, forming the basis of this paper, showed how women's experiences of healthcare access within a given racialized context, intersected with their perceptions of law enforcement, to impact their health, safety and well-being.

THEORETICAL FRAMEWORK

This study was informed by a postcolonial feminist framework which situates women's experiences within the context of historical and sociopolitical processes that have marginalized women of color. Postcolonial feminism contests the purposeful homogenization of women of color that has historically characterized hegemonic feminist scholarship.¹⁹ It asserts that the intentional obscurity of the heterogeneity of women is informed by false assumptions of universality in the experiences of women that overemphasizes the role of gender while

minimizing or ignoring the effects of race, class, colonialism and other structures that shape the experiences of women of color.¹⁹ Postcolonial feminist research centers knowledge that is truly descriptive of women's experiences and fosters the production of transformative and emancipatory knowledge that leads to social change.^{20,21}

Considering the complex realities of undocumented African immigrant women, a framework that considers the interacting effects of multiple social categories and systems that shape women's realities is most appropriate. Postcolonial feminism enables us to situate women's perceptions of and experiences with the healthcare system and law enforcement within the context of a racist and xenophobic sociopolitical environment.

METHODS

This descriptive, qualitative, study employed purposive sampling to recruit participants through collaboration with local churches, national immigrants' rights organizations and community leaders. Recruitment occurred between March 2017 and October 2018. Snowball technique was also utilized to recruit women within participants' social network. Recruitment continued until saturation was achieved. A total of forty-four women participated in this study, which included 24 undocumented African immigrant women (See Table 1) and 20 nurses who were recruited from midwestern healthcare organizations that serve immigrants and refugees. Consistent with a postcolonial feminist approach, we focus on the voices of the women participants. Our primary intent here, is to create a space where the voices of women who have been rendered invisible and have been silenced can help to inform health and social policy. Findings from the interviews with nurses will be reported in a separate manuscript.

Participants self-identified as an African immigrant living in the U.S. who was not documented. Semi-structured, individual interviews were conducted with participants by the

Principal Investigator (PI) who is also the first author. Guided by a postcolonial feminist framework, interview questions were designed to elicit women's stories about the impact of their current sociopolitical context on their experiences within different spaces and institutions. For example, women were asked, "What is it like being an African immigrant in the United States? How does being a Black woman impact your experiences in this country? How does being undocumented affect your ability to get health care?". Probes were used to clarify participants' responses or to elicit more information as needed. Nineteen interviews were conducted face-to-face and five were conducted over the phone. Interviews were digitally recorded and lasted an average of one hour. Demographic data were also collected and all participants received a \$30 gift card upon completion of the interview.

This study has some limitations. Women's responses to the interview questions might have been impacted by fear of institutional agents. The level of fear among undocumented women was evidenced by the decision of five prospective participants to drop out of the study after expressing their interest and commitment, citing concerns about the potential ramifications of their participation. Additionally, two women requested to have some of their responses to interview questions be off-the-record. Consequently, the reported findings potentially exclude important information that could have been obtained from women who could not participate due to fear. Some of the interviews were conducted over the phone due to geographic distance between the PI and the women. Nevertheless, theoretical saturation was reached. Additionally, data from the interviews conducted over the phone corroborated data from face-to-face interviews.

Ethical Considerations

The XXXX- Institutional Review Board approved the study. Women gave verbal consent to maintain anonymity and privacy. To further ensure anonymity, when women mentioned their country of origin, the country has been replaced with “Africa.”

Data analysis

Data were transcribed verbatim from the audio-recordings of the interviews, which were all conducted in English. Transcripts were analyzed using the tenets of thematic analysis (See figure 1). Data analysis was an iterative process that consisted of the researcher reading each transcript several times to identify patterns, codes, and themes.

RESULTS

The findings reported in this manuscript were classified under one major theme “navigating bias.” Women were confronted with bias within the broader society, within their healthcare encounters and they feared the impact of bias in interactions with law enforcement. Their perception of institutions such as law enforcement and the healthcare system were not created in a vacuum. Rather, they were impacted by contextual factors, mainly the sociopolitical environment and women’s resultant experiences with discrimination. Three identified themes, under the broader theme of navigating bias, offer insight into women’s perception of their positioning within their sociopolitical context, and their perceptions of healthcare encounters and law enforcement: 1) creating new identities, 2) avoidance of law enforcement, and 3) navigating bias within the healthcare system.

Creating new identities

The women interviewed came from African countries that are largely racially homogenous and predominantly Black. Upon arrival to the U.S., women reported creating new identities of being “Black” as well as being “immigrant.” This was a challenge for some women

as they soon realized that these categories have specific ramifications on how they are perceived and treated within certain spaces.

Race as a new identity

Women reported becoming aware of the implications of race in the U.S. by experiencing racism in different forms, including interpersonal and institutional racism. Women described situations where they felt they were being profiled and treated disrespectfully because they were perceived as “different.” The most commonly reported experiences of racism included being followed and closely monitored by store clerks while shopping, being called racially-charged and derogatory terms, being viewed as a threat, and people making racist assumptions about their intelligence or their financial status. Due to their background of coming from non-racialized countries, being hyperaware of their race was relatively new for women. One woman’s description of this realization embodied women’s perception of how race is central to the fabric of U.S. society: “Yes, it was definitely new. Coming from a country where we all Black. We’re Africans and there’s no difference. Even when you say Caucasians, everyone had the understanding that we are all just people. But here it’s clear that there’s a difference. People emphasize the distinction.”

Most women were shocked by how race impacted their lives in the U.S. They responded to discriminatory encounters in a variety of ways. Nine women responded by being angry and heartbroken. But twelve women said that such encounters did not impact them in any way. One participant who had been in the United States for over 20 years described how experiencing the challenges of being an African immigrant had affected her:

The only thing I have regretted is...about coming here is...they change you, they can easily change you. Americans can change you, they can make you an angry person

because, back home.... like I said, I didn't have to fight with anybody about anything. Here, I have become a very angry person, very..., yea, I realize I have anger, and I thank God since last year, since I took out this job, I realize, No, this is not you, there is a gentleness about you, so you need to let that gentleness stay because, this is not you from the start so why are you like this now? It's the fact that here, there is so much discrimination. I am a person who likes fairness.

Women who reported not being affected by these encounters brushed them off as acts of ignorance or as one participant reported, "not giving someone else the power to control how they feel." While some women reported not being emotionally impacted by acts of racism or microaggressions, they all acknowledged how structural racism affected them. A thirty-three-year-old participant who once sought employment as a waitress reported on her experience and perception of what it means to be Black in America:

I have walked into interview before and I could tell based on the interaction and the interviewer's reaction that they thought I was going to be a white person not a Black person. So they're like oh snap, she's Black./ I mean it's just like stereotyping, especially when you're in a predominantly white space. You don't want speak too loud or be too aggressive. Not that there's anything wrong with being loud or aggressive but it's just in some spaces, we are not allowed to be human. We're not allowed to be our full selves.

All the women expressed that being Black in the U.S. complicated their experiences and resulted in them facing significant challenges. An integral part of adapting to this reality was knowing how to modify their actions and alter how they presented themselves so they were not perceived as being threatening, suspicious or aggressive.

Immigrant as a new identity

In addition to being Black in a racialized society, women also adopted the role of being an immigrant in a new country. Women associated their immigrant identity with several challenges. This included learning to navigate a new system, being targeted because they were an immigrant, as well as feeling isolated. To navigate this new system, women relied heavily on their social network. Upon arrival to the U.S., women's social networks comprised of relatives and/or close friends who were familiar with the U.S. system. As women socialized and became better acquainted with their environments, they were able to develop social relationships and build new networks. New networks typically consisted of individuals within their faith communities and with other African immigrants. This network of family and friends was instrumental in getting women connected to employment opportunities and healthcare. However, navigating the system and accessing resources remained a challenge for women due to the sociopolitical context that placed restrictions on access to certain resources for undocumented immigrants.

Additionally, increase in anti-immigrant sentiments also impacted women's daily lives. Women sometimes felt targeted because they were immigrants. They were concerned and affected by the rise in hostile rhetoric and policies against immigrants. Women noted that such xenophobia was not new, but acknowledged that the nature of the current sociopolitical climate made racism more overt and visible. One participant, who had immigrated ten years ago, reported having to deal with both racism and xenophobia stated: "People see that you're Black so they already treat you differently...and then when you speak, they now can hear that you're a different type of Black. You're an immigrant Black. Then even the Black people here will treat you differently because of that."

Women's immigration status appeared to be a vital part of their immigrant identity. They described how being an undocumented African immigrant in the U.S. could be an isolating experience. The increase in hostility towards undocumented immigrants and exclusionary policies limiting their access to resources resulted in women feeling marginalized. Women felt that while other immigrants and African Americans with similar challenges received support in the form of political and social advocacy, the spaces they themselves occupied as Black immigrants who were undocumented was isolating. One participant stated: "Everyone thinks that only Mexicans are in this country without their papers. It's because they watch too much TV. There is a lot awareness and support for Hispanic undocumented population. But for Black people, we don't really have anything. I mean there are organization for African Americans...but they don't really see us as part of them. So where do we fit in?"

Women navigated these kinds of challenges on a daily basis. They understood that they had to navigate an unfair system that marginalized them based on their intersecting identities of being "Black in America" while also being undocumented women. However, navigating these systems in the different facets of their lives was a critical part of their daily experiences. There were two systems in particular that they had to navigate – the healthcare system and the criminal justice system. At the intersection of these two critical systems, our analysis shows that women's health and well-being was jeopardized.

Navigating bias within the criminal justice system

Women's new identity of being Black in America, their identity as undocumented immigrants, and the resultant marginalization they experienced, impacted their interactions and perceptions of the criminal justice system, especially with law enforcement. In response to questions about experiencing victimization, women's perception of the criminal justice system

can be divided into two subthemes: law enforcement agents' bias, and mistrust and avoidance. Our findings on women navigating bias within the criminal justice system illustrate how their perception of law enforcement heightens their vulnerability to victimization and limits their ability to seek help when they are victimized. This, in turn, has serious implications for their safety and health outcomes.

Law enforcement agents' bias

Generally, women did not feel like they had easy access to law enforcement services due to fear of the outcome of the interaction. While most women had not had encounters with the criminal justice system, their fear of law enforcement resulted from vicarious experiences of discrimination. Six women had experienced encounters with law enforcement which further exacerbated their concerns. These encounters varied in intensity from traffic stops resulting in a ticket, to traffic stops that led to them being detained. Women often opted not to discuss the circumstances surrounding their encounters with law enforcement. However, they did express that they felt as though they were treated unfairly by law enforcement personnel and the law enforcement system. This was particularly true for the three women who experienced detention.

One participant who felt comfortable telling her story described a seemingly routine traffic stop that resulted in her being detained at an immigration detention center for six months. Her experience embodied women's fears about encountering law enforcement officers. Though law enforcement officers are not obligated to check a person's immigration status, this participant believed that officers are encouraged to investigate a person's status because they receive monetary incentives for detaining an undocumented immigrant. While women recognized that local law enforcement and immigration enforcement agents were separate entities, the distinction

did not matter to them because they were aware that local police could also choose to act as immigration enforcement agents.

While immigration status appeared to be a major factor cited by women for not feeling comfortable contacting law enforcement, some women also shared concerns about how their race could impact how they were perceived by law enforcement personnel. These comments were made in relation to patterns of aggressive policing of African American citizens by law enforcement in the U.S. Some women reported being victims of racial profiling perpetrated by law enforcement officers. Women spoke of being followed or approached by law enforcement officers because they might have been perceived as a threat or as a wanderer whose presence in a particular neighborhood was deemed suspicious. Due to women's fear of law enforcement, fear of deportation and detention, and their experiences with law enforcement, many women expressed concerns about their safety in the U.S. It is important to note that for most women, the concept of "safety" extended far beyond being a victim of a crime. Women felt unsafe not only because they were vulnerable to being victimized, but also because they were vulnerable to being detained and targeted by law enforcement.

Mistrust and avoidance

Women's perception of the relationship between bias and their experiences with the criminal justice system shaped their level of trust and perceived access to law enforcement. Women's mistrust of the criminal justice system was revealed when they discussed how they would respond if they were victimized. About a third of the women sampled reported being victims of crime such as theft, property damage, physical abuse and sexual assault. One woman who was abused and stalked by a former intimate partner stated: "A while ago, I was dating this guy who promised to marry me and help me file my paper. He is also from Africa. But he had a

lot of issues. He was into drugs. I lived with him for a few months...but I moved back to my cousin's place the day he slapped me. He kept calling me and coming to her house. I was a little scared but thank God he stopped."

When asked if she reported the incident to the police she responded, "Oh no. Call the police? When I don't have my papers? No oooo. I didn't." Due to their immigration status, women who had been victims of crime did not feel comfortable contacting law enforcement. They expressed concerns about being asked for documentation that they could not produce or being detained and deported. When asked about contacting law enforcement if they were ever a victim of a crime in the future, most women said they would not.

Navigating bias within the healthcare system

Similar to women's fear of law enforcement, their experiences of seeking healthcare was also situated within a context of general mistrust and uneasiness. Of the women interviewed, nineteen had accessed the healthcare system at least once since their arrival to the U.S. Their experiences with the health care system was divided into three subthemes; mistrust, provider bias and self-advocacy.

Mistrust

Women generally did not disclose their immigration status to healthcare providers. Only one participant reported disclosing her status to her physician because the physician was also an immigrant from the same country of origin. This woman felt that self-disclosure was necessary for her to get the care that she urgently needed to prevent worsening of her increasingly frequent, severe headaches. Women cited provider bias and the perception of them as immigrants as reasons why they were uncomfortable disclosing their status to a healthcare professional. One woman stated:

No, I would not tell a health care provider about my status. And it's funny too because I used to think that only undocumented immigrants had no insurance. I did not realize that a lot of people were uninsured. So whenever I had to tell a doctor that I was uninsured, I thought that was me disclosing my immigration status so that was terrifying. But no, I wouldn't tell them because I don't know what type of biases you have. I'm just not going to take the risk.

The sentiment shared by this participant was common among women. Participants felt that considering the current hostile sociopolitical environment characterized by both overt and covert xenophobia and racial discrimination, they needed to be cautious about sharing their status. This cautiousness extended to healthcare providers and the healthcare setting as well. Women believed that non-disclosure of their status helped them avoid stigma, judgement or other negative repercussions such as being reported to immigration authorities.

Similar to how they perceived law enforcement, women also reported not trusting that the healthcare provider would give them high quality care due to their inability to pay for care. This perception stemmed from women's personal experiences of receiving poor care and for one participant, her experience with being turned away when she sought care. This participant reported going to a community clinic and requesting a medical evaluation for fatigue. After being turned away from the clinic, she resorted to seeking care at an emergency room. She was diagnosed with an acute illness, and was admitted to the hospital.

Provider bias

Women's perception of their experiences with healthcare providers varied depending on where they were accessing care. Most women in the study accessed care at safety-net clinics and reported having fragmented care. The six women who had regular physicians reported being

happy with the care provided by their current primary care physician. This was because they had developed a good relationship with the general practitioner who helped meet their healthcare needs. Women who sought care at low-income clinics that catered to large immigrant populations also appeared to have a good experience overall. Most women's negative experiences occurred while accessing care at a hospital or an ambulatory clinic affiliated with a large healthcare organization. A total of sixteen women reported having had a negative experience at some point while seeking healthcare.

A common source of frustration for women was dealing with healthcare professionals who they felt did not take the time to listen. This sentiment was expressed in relation to provider interactions that seemed rushed or that the provider did not seem to understand what the women were saying. One participant stated:

I went to a doctor once and I guess she was running behind, so when she came in, she was assessing me and I was bringing up my concerns and what I came there for then. She had a comment that this is why she is always behind because people keep bringing up new things that they didn't come here for or something like that, so it made me feel very.... Unwilling to share what I was feeling like.

In addition to issues with communication, women also reported having encounters with providers who minimized either their symptoms or those of a relative they accompanied to an appointment. For example, one woman shared:

I went to see the doctor because I had been bleeding for a month straight. He came inside the room and seemed to be rushing to do everything. He called me someone else's name when he first walked in. I told him that that's not my name. He didn't even apologize. Then he didn't even examine me or ask me the type of questions that I thought he should

ask. He just said I should go to the lab to give my blood. It's like he was in and out of the room before I knew it. I had been bleeding heavily for a month? What if I die? Maybe he thought I was joking but I didn't like the way he treated me.

Aside from patient-provider communication challenges, women shared experiences of being treated poorly by members of the healthcare team. A participant who was admitted to the hospital reported that a member of the healthcare team wrote the word "illegal" on her paperwork to denote that she was undocumented. Another participant who was eligible for prenatal care through Medicaid, expressed reservations about getting adequate care at her OB clinic. She believed that the providers caring for her were only concerned about her well-being because the child would be a U.S. citizen. This same participant reported encountering nurses who were not responsive to her needs during her hospital admission. She attributed the poor treatment to her being on Medicaid and nurses feeling like her health care was being funded by their "hard-earned money" through the taxes they paid.

Generally, women expressed uncertainty about having experienced racial discrimination during their encounter with healthcare personnel. Poor treatment was often attributed to their insurance status, ability to pay for care, accent differences and being an immigrant. When women were not sure if a negative experience was a result of their race, they would ultimately conclude that it was more likely a result of other factors such as their insurance status or being an immigrant.

Self-advocacy

Women's experiences seeking healthcare was also characterized by having to advocate for themselves to get their needs met. This was particularly important to them because they had made the decision to seek care, with knowledge of the financial implications, and therefore, they

wanted to ensure that their concerns were properly addressed before the end of their visit. Self-advocacy worked well for women at times. The most salient example of this was a participant who had planned with her physician to go to the Emergency Room to be admitted for surgery. She described her experience as follows: “They did another ultrasound and the ER doctor comes to me and was like we're going to have to send you home because this is not life threatening. You're going to have to just go and go see your OBGYN. I was like no, no, no, no, no. My OBGYN told me to come because this is life threatening. Like what are you telling me. So he had to call the OBGYN.”

Having to be a firm advocate for their health needs was a common experience shared by women in the study. Women cited multiple reasons why they felt that their requests were not taken seriously. Some women believed it was a result of the healthcare provider's perception of their ability to pay for the care. Other participants believed it was because they were immigrants.

In some instances, despite self-advocacy, women still felt like their visits with the healthcare system ended without their needs being appropriately addressed. This occurred when the provider was not receptive to their concerns, was not helpful or did not make any extra effort to connect them with helpful resources. One participant shared:

Yes, I sprained my ankle a couple of years ago so I had to go to the hospital and there was like....it was like \$3000 just for that visit. All they did was tell me that I had a sprained ankle which I knew. That's all they literally did. I mean it was fine but the nurse I'm guessing they probably didn't as much as they could do because they realized that I couldn't put pressure on my foot because it hurt so much. They thought it was mild. I told them that it hurt a lot and that I could bear weight on it. But they didn't really listen. She

just said that they would be giving me crutches and having me follow up with my doctor. I told her I didn't have a doctor and she didn't really seem bothered. She gave me some number to call in order to get a doctor.

Women recognized that decisions about the outcome of their care was largely under the control of their care provider. While they could advocate for themselves, the provider-patient power dynamic could prevail over their efforts to self-advocate and in turn, impact their health outcomes. This was the case for the participant quoted above who reported residual, intermittent pain and swelling from an ankle injury. This participant believed that the current complications she was experiencing were a result of not receiving proper care following the injury.

DISCUSSION

From a postcolonial feminist perspective, our findings indicate that undocumented African immigrant women experienced multiple sources of vulnerability that impacted their health. At the same time, women were challenged with identifying a safe space within the criminal justice and the healthcare systems, due to fear of deportation and discriminatory actions. This study confirms what is found in the literature about undocumented immigrants' perceptions of law enforcement and experiences when seeking care as well as findings from other studies that show how undocumented immigrants harbor a mistrust of the healthcare system.^{9,10} This study, however, offers new insights into how undocumented African women navigate bias and how women's perspectives and challenges in accessing resources are situated within a given sociopolitical context.

The women interviewed occupied multiple spaces of marginalization. Their narratives revealed an understanding of how their lives are impacted by the interlocking structures of racism and xenophobia. They reported experiences of discrimination in multiple facets of their

daily lives including in public spaces and within institutional spaces, which shaped their perceptions and caused them to hesitate in seeking healthcare services when they needed them. Additionally, structural racism and xenophobia inherent in policy and enforcement practices created an environment where women felt targeted and distrusted institutions. The impact of interpersonal racism was also evident in women's healthcare encounters that were indicative of healthcare provider bias and women's concerns about being targets of discriminatory law enforcement practices. In our study, it was revealed that in addition to fear of deportation which has been reported in the literature, undocumented African women also feared the implication of their race on their encounters with law enforcement. This concern arose based on their experiences of racial profiling perpetrated by law enforcement officers and concerns about aggressive policing targeting African Americans and their communities, which has also been documented in the literature.²²

To further illustrate women's concerns about law enforcement and their resolve to protect themselves by reducing contact with police, we can analyze the relationship between law enforcement and Black women in the U.S. using Richie's theoretical framework of "the male violence matrix".²³ Richie offers a three-pronged matrix positing that Black women experience interlocking systems of interpersonal, community-level and institutional violence. While some of the women interviewed were victims of interpersonal and community-level violence, drawing on Richie's conceptualization of institutional violence deepens our understanding of the participant's vulnerability within the current social environment. This framework characterizes institutional violence as the assault and aggression toward Black women by state agents and through public policy that ultimately create a hostile environment for them and heighten their vulnerability to harm. For the undocumented African women in this study, their experiences and

knowledge of the manifestation of institutional violence in their lives created a bind for them as the institution charged with preserving their safety was actually the one they perceived as a threat to their safety.

Women's fear of law enforcement has serious implications for their health. Existing data indicates that undocumented status increases vulnerability for abuse, creating a barrier to victims seeking help. It is also used as a tool by batterers to control victims.^{16,24} Help-seeking may thus be challenging for undocumented women experiencing domestic violence as immigration status influences their decision to utilize available resources and prevents victims from seeking help.¹⁶ For undocumented women who are victims of intimate partner violence or other violent crimes, help-seeking decisions are also influenced by fear of deportation and the legal implications of their status.²⁵

Given that the law enforcement system posed a threat to women, undocumented women are faced with an enormous challenge of finding other systems and institutions to access when concerns about safety arise. Thus, women's mistrust of both the healthcare system and law enforcement is a threat to women's safety, health and well-being. Women also expressed concerns about providers' perceptions of immigrants. Their concerns about provider bias in relation to undocumented immigrants' surfaces at a critical time of polarizing, hostile anti-immigrant rhetoric by appointed political representatives as well as people in the community. Mistrust of healthcare professionals is an important consideration as studies indicate that mistrust of the healthcare system and perceived discrimination are significant factors to consider when examining the drivers of health inequities for ethnic minority populations.^{26,27} Within the provider-patient interaction, making an accurate diagnosis and care plan is largely dependent on the provider's ability to obtain thorough and accurate information about the patient's health and

other sociodemographic factors that might impact their health; however, when women do not trust healthcare providers, they are more likely to withhold pertinent information that would enable healthcare providers to direct them to the appropriate resources or support for their situation.

As a result of their marginalized identities, women in this study also reported feeling isolated at times, which is an additional risk factor for victimization and a barrier to seeking help.²⁸ Though women reported a mistrust of healthcare professionals, they still sought care when there was a health need. However, based on their perception of law enforcement services, women felt that avoidance was necessary. While healthcare providers can care for women who are victimized, a coordinated, inter-agency response is more effective in keeping women safe.²⁹ Additionally, women who are victims of violence are eligible for temporary status under the U-visa; however, an eligibility criterion requires that the applicant assists law enforcement by providing helpful information to facilitate their investigation and prosecution of the perpetrator.³⁰ Women who are aware of such relief opportunities might not pursue them due to their fear of law enforcement. This uncovers the need for a safe pathway for women to seek care and involve law enforcement when they are victimized.

Ideally, the health care setting should be a safe space for women; however, based on reported negative experiences and concerns, this evidently is not the case. At the very least, healthcare providers should not be complicit in further marginalizing patients who seek healthcare by perpetuating discriminatory ideologies in their professional practice.³¹ Yet, women reported rushed, and experiencing degrading, and discriminatory encounters with health care providers.

Our findings reveal the need to ensure that undocumented women can find safe spaces where their concerns about their health and safety needs can be met. Initiatives to create safe spaces for undocumented immigrants have been successfully implemented by some organizations. Intentional strategies at creating a culturally safe health care environment is exemplified by a Canadian healthcare facility's initiative that resulted in the removal of security personnel from the waiting room area of a clinic with a large population of indigenous patients. This change in policy was intended to create a safe space for patients by countering power differentials.³² While directives such as eliminating security personnel from certain areas are helpful, a common measure of not inquiring about or recording immigration status on medical records could also be a useful strategy.

The need for culturally safe care that seeks to prevent the re-traumatization of marginalized patients by promoting care that acknowledges sources of social domination and power differences within healthcare interactions is key. The lack of critical awareness of the sociopolitical structures that impact patient health results in professional practice that is in opposition to the tenets of cultural safety. Culturally safe healthcare providers recognize that healthcare environments can reify institutional racism and acts of structural violence in the lives of marginalized people.³³ Thus, the provision of culturally safe care is a critical component of creating safe spaces for undocumented African immigrant women within the healthcare setting and could also be considered for the criminal justice system. Though healthcare providers have little influence on how the criminal justice system operates, due to the intersecting effect of these systems on the health of ethnic minorities, more collaborative efforts are necessary to address the needs of undocumented immigrant women.

CONCLUSION

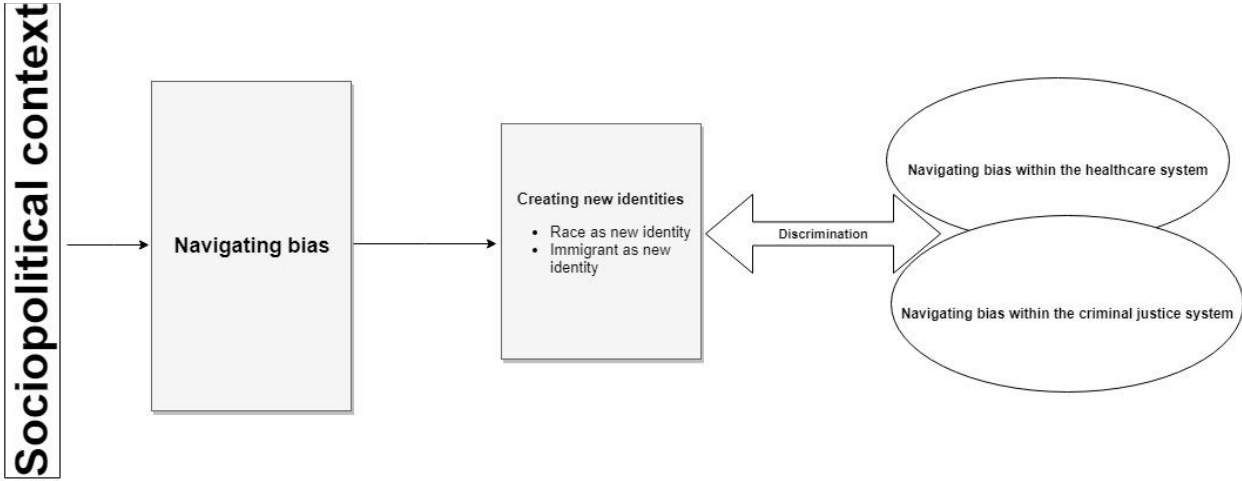
According to the American Nurses Association, advocacy is an important component of professional nursing practice and nurses often serve as advocates in their professional practice.³⁴ Addressing the needs of undocumented women requires structural change driven by political and social advocacy. Through increased awareness about the challenges facing this population of women and resultant advocacy, meaningful conversation could arise and lead to action. Nurses serving as advocates for the health and social needs of marginalized people is particularly important for subgroups who are disenfranchised, unable to participate in democratic governance, and with limited capacity to self-advocate.

Our use of a postcolonial feminist framework supported the harnessing of valuable knowledge from the women interviewed on how nurses and allies can direct their efforts. Evidently, an increase in advocacy is needed considering the current sociopolitical climate where undocumented immigrants face uncertainty on how current and future policies and practices will impact them. It is important that nurses engage with immigrant justice advocates to support immigrants' rights movement. Also, nurses should take leadership in creating culturally safe spaces within their healthcare organizations. This can be accomplished by enlightening ourselves as professional nurses about the issues facing undocumented immigrants and engaging in culturally safe professional practice. Furthermore, nurses should hold their colleagues accountable and intervene when they witness actions that marginalize patients within the healthcare setting. As a profession, we need to unequivocally establish our role as advocate and ally to enhance the health, safety and well-being of all women.

Table 1. Demographic data for women interviewed (n=24)

Variable	Mean
Age (23-55 y)	35.69
Length of Stay in U.S (2-22 y)	11.52
	n (%)
Marital Status	
Married	7 (29%)
Widowed	1 (4%)
Divorced	1 (4%)
Separated	3 (13%)
Never married	12 (50%)
Children	
Yes	14 (58%)
No	10 (42%)
Region of Residence in U.S	
Midwest	21 (88%)
South	2 (8%)
East	1 (4%)
Employment Status	
Full time (40 hours a week)	9 (38%)
Part time (< 40 hours a week)	1 (4%)
Casual worker (work when work is available)	7 (29%)
Unemployed	7 (29%)
Highest Level of Education	
High school	4 (17%)
Some college credits	2 (8%)
Associates degree	7 (29%)
Bachelor's degree	8 (33%)
Graduate degree	3 (13%)
Annual Household Income	
Less than \$10,000	4 (17%)
\$10,000 to \$19,999	9 (38%)
\$20,000 to \$29,999	5 (21%)
\$30,000 to \$39,999	4 (17%)
\$40,000 to \$49,999	1 (4%)
\$50,000 or more	1 (4%)

Figure 1. Thematic framework on Undocumented African women’s experiences navigating bias



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**Manuscript 3: The mental health implications of living in the shadows: the lived experience
and coping strategies of undocumented African women**

The third manuscript reports on the stressors women experience, their mental health concerns and coping strategies. The paper is formatted based on the author's guidelines for *Behavioral Sciences*. This paper also outlines a review of pertinent literature, study methodology, a description of findings, an analysis of findings and lastly, implications for policy and practice. These findings will be presented at the Midwest Nursing Research Society conference in Spring of 2019.

The mental health implications of living in the shadows: the lived experience and coping strategies of undocumented African women

Abstract

In the United States, undocumented immigrants often encounter complex challenges that impact their emotional well-being. Existing literature has primarily focused on Latino immigrants. Thus, little is known about the mental health needs of undocumented African immigrant women. To address this gap, we examined the stressors, mental health concerns and coping strategies of undocumented African immigrant women in the United States. This qualitative study used a postcolonial feminist framework approach. Twenty-Four undocumented African immigrant women were interviewed, and data were analyzed using thematic analysis. Findings showed that the women dealt with complex stressors created by the sociopolitical environment. These stressors contributed to feelings of depression and anxiety which they coped with using social support and religion. The results uncover the need for culturally relevant tools for screening and addressing the mental health needs of undocumented women and increased awareness amongst healthcare providers on how social context and policies adversely impact the mental health of marginalized groups. Lastly, at a structural level, the need for policy and social change that fosters an inclusive and safe environment for undocumented persons.

BACKGROUND

The African immigrant population in the United States is steadily increasing. Recent estimates show that there are currently over two million African immigrants in the United States, thirteen percent of whom are undocumented (Anderson, 2015; Anderson, 2017). Anti-immigration policies and practices in the past ten years have magnified the challenges associated with being undocumented in the United States making it challenging for undocumented immigrants to secure stable employment, and access health and social services. Additionally, there has been a steady rise in deportation rates since 2002 (Gonzalez-Barrera & Krogstad, 2014). While previous administrations had prioritized deportation of immigrants with felony convictions, currently all undocumented immigrants in the country are being targeted for removal. Consequently, undocumented immigrants live in the shadows and must cope with a variety of complex stressors resulting from restrictive and punitive policies as well as an increasingly hostile environment (Philbin, Flake, Hatzenbuehler & Hirsch, 2018). Yet, there is a paucity of evidence on how the current sociopolitical environment created by restrictive policies and hostile rhetoric might impact the psychological well-being of African undocumented immigrants. To address this gap, this paper reports findings on the stressors, mental health concerns, and coping strategies for undocumented African immigrant women.

Mental health status is a critical consideration for immigrant populations. Existing literature indicates that immigrants are exposed to specific risk factors that impacts their mental health at different phases of the migration process (Kirmayer et al, 2011). African migrants, for instance, often migrate to escape conflict, political instability, persecution and/or economic insecurity (Connor, 2018). The resultant pre-migration traumatization and violence has implications for their mental health (Venters & Gany, 2011). For undocumented immigrants, the

mental health effect of premigration stressors are further compounded by distinct post-migration stressors including economic difficulties, separation from family, fear of deportation and detection, exploitation, vulnerability, fewer familial networks, and language barriers (Cavazos-Rehg, Zayas & Spitznagel, 2007).

A few recent studies have examined mental health outcomes for undocumented immigrants. Hacker et al (2011) revealed that both documented and undocumented immigrants reported high levels of stress, anxiety, and hopelessness, which had a negative impact on their emotional well-being. For undocumented immigrants, their feelings of stress, anxiety and hopelessness were related to the constant fear of deportation while documented participants were more concerned about the welfare of their family living in the United States. The differences in the drivers of psychological distress for undocumented immigrants illustrate the unique challenges that undocumented immigrants face. Other studies have identified that undocumented immigrants were found to be at higher risk of depressive symptoms, PTSD and anxiety, and also reported that discrimination and undocumented status affected their mental well-being resulting in weight gain/loss, insomnia, anxiety, depression, substance abuse and fear (Joseph, 2011; Gonzalez et al, 2013; Martinez et al, 2015; Garcini et al, 2016). Additionally, anxiety and depressive symptoms have been found to be directly related to immigration status (Pannetier, Lert, Roustide & du Lou, 2017).

The role of discrimination on mental health is particularly important for African immigrants who often leave their racially homogenous birth countries to a racialized society. African immigrants are reported to experience discrimination and racism upon arrival to the United States (Showers, 2015). Though African immigrants arrive to their Western host countries being relatively healthy, a phenomenon termed “the healthy immigrant effect”, this

advantage erodes with time. This is notable in mental health outcomes of immigrants for whom rates of mental health issues increase over time to match the general population (Breslau, Aguilar-Gaxiola & Borges, 2007) as well as for undocumented immigrants who have higher rates of anxiety, panic disorder, and depression compared to the general population (Garcini et al, 2017). This change has been attributed to a combination of factors including experiences of discrimination, which have been identified as a significant risk factors and a driver of psychological distress in immigrants (Krieger, Kosheleva, Waterman, Chen & Koenen, 2011; Joseph, 2011; Leong, Park & Kalibatseva, 2013).

Despite the established need for mental health care services for immigrants, there are significant cognitive and structural barriers to seeking care. Generally, African immigrants are less likely to utilize mental health services when experiencing psychological distress. This is in part a result of the stigma associated with mental health symptoms (Venters & Gany, 2011). Other barriers to accessing mental health services for immigrants include beliefs about mental illness, distrust of providers, cost of care, language barrier and other health demands (Derr, 2015). In addition, undocumented immigrants care seeking might also be deterred by fear of deportation as well as difficulty navigating the system (Aggarwal, 2017). Consequently, undocumented African women might find it difficult to seek mental health care even when there is a known need.

Though undocumented African immigrants might not seek formal mental health care, prior work has found that immigrants develop adaptive coping strategies to deal with their stressors and psychological distress. Literature on immigrant coping strategies have identified social support, participating in meaningful activities, religious coping and belonging to a religious community as helpful strategies (Kim, Suh, Kim & Gopalan, 2012; Adedoyin et al,

2016). A study on undocumented Hispanic immigrants, however, revealed that problem-focused coping strategies such as prayer and meditation might exacerbate feelings of psychological distress because undocumented immigrants experience complex, structural issues that are often beyond their ability to solve (Cobb, Xie & Sander, 2016). It is, therefore, essential that we understand how these complex realities impact mental health and how undocumented women specifically, effectively cope. Existing literature on stressors and mental health symptoms largely focuses on Latino immigrants in the United States. Additionally, very few studies have simultaneously considered the stressors that undocumented women experience, the mental health implications and how they cope with them. To address this gap, this paper reports on the stressors, mental health concerns, and coping strategies for undocumented African women in the United States.

THEORETICAL FRAMEWORK

This study was undergirded by a postcolonial feminist framework. Postcolonial feminism represents a paradigm shift from the narrative of cultural hybridity that historically typified Western hegemonic discourse on women of color. Postcolonial feminism asserts that the experiences of women of color are influenced by larger sociopolitical processes acknowledging that women are situated in distinct spaces, and their realities shaped by these sociopolitical processes (Khan et al, 2007). Postcolonial feminism provides an analytic lens that allows for an examination of the experiences of undocumented African immigrant women in the United States that takes into account the impact of racism, xenophobia, and attitudes toward immigrants, policies and other sociopolitical factors in their lives.

In attempting to change the current hegemonic narrative of African women, postcolonial feminism is purposeful about critiquing of traditional methods of knowledge production by

challenging the positivist notion that knowledge can be objective and value-free. Rather postcolonial feminism emphasizes the idea that knowledge is socially-constructed, political and value laden. Mohanty asserts that knowledge production is “a mode of intervention into particular hegemonic discourses” with its practices embedded in existing power hierarchies therefore, the concept of “apolitical scholarship” is nonexistent (1988). Acknowledging the political implications of scholarship means naming the complex forces in action specifically in relation to third world women but also being deliberative in creating a space where women’s voices can be heard and can inform health and social policy.

METHODS

This descriptive, qualitative study involved data collection using semi-structured interviews with open-ended questions. Interviews commenced with participants being asked demographic information such as their age, country of birth, marital status, educational level, employment status and annual income. To elicit information regarding their mental health concerns and coping, women were asked to respond to the following questions: “Do you have any concerns about your emotional well-being? What do you do when you are feeling stressed?”.

A total of 24 women were recruited and interviewed for the study. 20 nurses were also interviewed to examine their perception of barriers to healthcare access for undocumented immigrants. Interviews with nurses were all conducted in person and findings from those interviews will be reported in a separate manuscript. For the immigrant women participants recruited, nineteen interviews were conducted in person while five were conducted over the phone. The women interviewed received a \$30 gift card upon completion of the interview. Each interview was audio-recorded and the average duration for the interview was one hour. The interviews were transcribed and analyzed using the tenets of thematic analysis.

Ethical Consideration

Ethical approval to conduct the study was obtained from the University of Wisconsin-Milwaukee's Institutional Review Board. Prior to conducting the interview, the researcher reviewed a study informational sheet with the women that outlined the study's procedures, risks and informed women of their ability to stop the interview at any time. After reviewing the informational sheet, women were given the opportunity to ask questions. Maintaining women's anonymity was critical during the study considering the sensitive nature of their undocumented status and the potential legal implications of discovery. Verbal consent was thus obtained from the women.

LIMITATIONS

There were a few limitations to the study. Many of the women interviewed were from the Midwestern part of the United States. Due to the potentially varying sociopolitical climate across regions of the United States, we may not have captured the more nuanced experiences that characterize the lives of undocumented African women living in other regions of the country. Nevertheless, we do believe that the patterns related to undocumented women's experiences that we have identified here would be basically similar across geographic regions of the United States. Additionally, five interviews were conducted via phone. As a result, the researcher was unable to note nonverbal cues and make perceptual observations. However, data from in-person interviews corroborated findings obtained from telephone interviews.

Sample

The average age of the participants was 36 years. The majority (n=21) of the participants lived in Midwestern United States. The other women interviewed lived in the Southern or Eastern region of the country. 13 women interviewed reported an annual household income of

\$19,999 or less. The average length of stay in the United States for women in the sample was 12 years. Nine women worked full time; one worked part time; seven reported having unstable jobs with irregular hours and seven were unemployed.

Data analysis

Interviews conducted were audio-recorded and analyzed using thematic analysis. First, the researcher reviewed the transcripts to check for accuracy. Then, each transcript was re-read with the intention of identifying themes and patterns across the participant's experiences. During the coding process, the researcher read each transcript and highlighted texts that were pertinent to the research questions and assigned codes to the text. The coding process was repeated for each transcript until they were reduced into themes and subthemes. The data reported in this manuscript was condensed into three themes which will be discussed.

Trustworthiness

Several strategies were employed to ensure trustworthiness of the data. To enhance confirmability, the researcher kept a reflexive journal throughout the research process. The journal included information such as the researcher's thoughts and personal reactions to women's narratives. This process was intended to help bracket researcher's bias. To enhance credibility, member checking was also employed by discussing the researcher's interpretations obtained after data analysis with three participants to verify accuracy. The researcher also verified accuracy of interpretations during each interview by summarizing and paraphrasing women's responses and clarifying these with the women. Transferability enhanced by the use of detailed demographic data of the participants has been provided alongside other data that help contextualize women's narratives. Dependability was established using audit trail.

RESULTS

This manuscript details our findings on the stressors undocumented African immigrant women experience, the implications of these stressors on their emotional well-being and their coping strategies. Three major themes were identified- experiencing stressors, mental health implications, and coping strategies. The stressors women reported included economic vulnerability, uncertainty and isolation. This resulted in women feeling sad and experiencing increased anxiety. Consequently, they turned to their social networks and religion to cope.

Experiencing stressors

Women reported experiencing multiple, complex stressors. The stressors women described can be classified under three subthemes- vulnerability, feeling stuck, feeling alone. Their experiences of discrimination are described in detail in a different manuscript but will be discussed briefly in this paper.

Vulnerability

Generally, the women interviewed indicated that they felt economically vulnerable. This was particularly true for women who were unemployed, employed casually or had low-income jobs. Many women were forced to work low-income jobs as a result of their immigration status and not having the proper documents that enabled them to work. Consequently, women were generally under-employed. For a few women interviewed, their current jobs were a drastic change from the professional jobs they worked in their home countries. A salient example of this was a participant with a Bachelor's degree who had years of experience working as a human resources manager in her home country. As an undocumented immigrant in the US she worked as a home care aide and a waitress for an annual income of less than \$10,000.

Women's feeling of economic vulnerability resulted in them being vulnerable to exploitation. Over half of the women interviewed believed that they were underpaid in their jobs

but could not leave because they had limited employment options. Women were thus often unhappy with their employment situation. For women who had no work authorization and were not employed, they often relied on a spouse, relative and/or friend for their financial needs. This enhanced their feelings of vulnerability as they were then dependent and concerned about having to be dependent for the rest of their lives. One participant expressed her concerns about her cousin who had been housing and supporting her financially since she arrived to the United States. She stated:

Sometimes I just feel down when I think about my life. I feel like my cousin is getting tired of hosting me. She acts irritated with some things I do. She wasn't like that before. I don't blame her...she has tried a lot. I'm hoping God will make a way for me to file my papers. I pray about it a lot. Right now, I am scared to go out sometimes. I have heard stories of immigration picking people up at the store and their jobs. It's very scary.

This participant expressed concerns about becoming a burden to her cousin. Her situation was relatively common as eight of the women interviewed reported a living situation where they were reliant on someone else for accommodation, which fits the definition of homelessness. Another participant had experienced being asked to find alternative living arrangements by a trusted friend who was housing her and had promised to host her upon her arrival to the United States.

Women who were employed but not authorized legally to work recognized the precarious nature of their employment. Their employment status was dependent on the “good-will” of the employer who knew that they were not authorized to work. This meant that women's employment arrangements were not permanent or binding and, in essence, they were at the mercy of their employer. Consequently, eleven women reported working at jobs where they felt exploited and treated unfairly. Labor exploitation occurred in the form of women being required to work long hours, not getting work breaks, being underpaid, being overworked, unsafe work

conditions or experiences of verbal abuse from employers. One participant who worked as a live-in caregiver expressed concern arose about being vulnerable to physical harm perpetrated by her employer. She was concerned that due to the nature of her job where she lived in people's home, she could be harmed and "disappear" and no one would know what happened to her. This concern as a result of stories she had heard about live-in caregivers being mistreated, abused and exploited by their employers.

Feeling stuck

In addition to economic vulnerability, women described uncertainty as causing them to also feel vulnerable. Though participants reported feeling a long-standing sense of uncertainty, their concerns were heightened by the current sociopolitical climate, which they perceived as being hostile. This was particularly true for women who were out of status and had no immigration proceeding pending. Women spoke of other undocumented persons in their communities being detained and deported and this worried them. One participant shared her perceptions of the shift in climate between the previous political administration and the current one stating:

I feel...I would say things are worse. Because we have a president who seems to be anti-immigrant and pro-deportation. Even though with President Obama everything wasn't perfect either but at least he did DACA [Deferred Action for Childhood Arrivals], but a lot of people were covered under that.

Women were uncertain about whether they would be detected by immigration officials, what their futures held, and how changing policies and practices would impact them. Consequently, it was challenging for women to plan their lives or make future plans. One participant likened her situation to "feeling stuck". Several women stated that whenever they could, they tried to continue on with their lives as though immigration status was not a factor. However, continuing on with their lives often meant that women had to re-conceptualize their aspirations. This meant

enrolling in a local community college to pursue a degree, instead of a university, which they would have preferred and working at a job for which they were overqualified. To the best of their ability, women still attempted to maintain some degree of normalcy by proceeding to have children and attain personal milestones. However, they acknowledged that ignoring the constraints that their immigration status placed on their choices was not an option as their status dictated the resources and services they could access. Even when they attempted to continue with their lives, their immigration status and its legal implications made it challenging for them to feel at peace, particularly considering the current sociopolitical climate.

Uncertainty was also related to the notion that most women interviewed were unsure when their situation would improve. Many women were hopeful that they would be able to change their immigration status at some point, but they were uncertain as to when that would happen. They were also uncertain of how they would be able to attain this status change. Consequently, they had to cope with their current situation indefinitely. This realization was concerning and saddening for women.

Feeling alone

Despite being connected to a social network in the form of friends and relatives within their communities and in their home countries, women reported feelings of isolation. Women's isolation was often centered on the fact that they felt alone in their experience as undocumented women. Feelings of isolation stemmed from the idea that most people "did not understand" the challenges they faced. One participant stated:

Like where do I belong? Here I am, in between...I am black, immigrant, I am undocumented. The black community does not really address immigration. They focus more on Black American issues. When you go to immigrant spaces, a lot of those organization are mostly geared toward Latino immigrants, not really black people. You don't really fit in there either. So it's like, you're a double minority on top

everything. So it's hard because I always feel othered. I think I have many different identities. In my day to day life I feel very othered.

This sentiment of not “fitting in” anywhere was worsened by women’s perception of not being able to rely on immigrants from their home country. Several participants felt that immigrants from their country intentionally withheld information from them about how to navigate the US system. Women believed that the lack of collegiality and community among immigrants from their home country was because settled immigrants preferred that newly arrived immigrants experience the same painful and challenging process of integration as they did. In order to gain information about how to survive as immigrants, women thus sometimes had to reach out to networks of immigrants from varying backgrounds or figure out how to find information independently.

Women also felt isolated because they could not travel back to their country of origin to visit their loved ones given their undocumented status and the fact that the likelihood of being able to return to the US should they exit the country was very slim. Consequently, several participants had not seen their family for years. For example, one of the women interviewed who was awaiting a decision on a petition for asylum had come to the United States without any relatives and had not seen her family for 10 years. Women’s status as undocumented immigrants was thus also isolating because they felt that they could not rely on just anyone for emotional support. They had to be cautious about who they disclosed their status to. Finding a trusted person or reliable outlet or support was not an easy feat. One participant shared her experience as follows:

It’s very easy to feel alone and lonely in this country. Sometimes it feels like you’re struggling all by yourself. Nobody cares, it’s every man for himself.

Several women reported having difficulty trusting people. They feared that they might unknowingly share their immigration status with someone with malicious intent who might

report them to immigration authorities. Thus, secrecy was of utmost importance. Being secretive about their status and their challenges, however, had negative implications for women as it often meant that they sometimes did not feel comfortable reaching out to members of their community for assistance and for helpful information that would connect them to resources.

Women's experiences of isolation were also a result of the discrimination they faced. Discrimination as a central part of women's experiences in the United States has been discussed at length in a different manuscript. However, it is important to note that women faced discrimination in different facets of their lives and as a result of their identity of being Black, an immigrant, and undocumented. This identity complicated women's realities in the United States and contributed to their experiences of isolation and marginalization.

Mental health concerns

The many stressors that women coped with had implications on their emotional well-being. Women in the study expressed concerns about their emotional well-being and their mental health. Emotional well-being was being impacted by socio-political context, immigration status, and life as an immigrant. This main theme is divided into two subthemes- feeling sad and lack of peace.

Feeling sad/depressed

Women reported feeling of sadness when confronted with their realities. One participant described how feelings of isolation caused her a lot of anxiety and worsened her depression. Over half of the participants reported recurrent feelings of sadness and depression over the course of their stay in the US. Sadness was attributed to economic challenges, isolation, and the uncertainty women faced. Because women awaiting an immigration proceeding decision could

not leave the country, several participants had not seen their family in years. Women described feeling sad due to missing their loved ones (son, parents, mother). One participant stated:

Everyone just seem to do their own thing. That sense of community is not really there. Things are hard for me now but the first few months were the hardest...you know adjusting to this new place. I was just sad and depressed all the time. I questioned my decision to come here every day. I don't know. It was hard. Just so many different challenges. It's like I left Ghana with a specific idea of what America would be like. But then when I got here I got the shock of my life.

Other participants' sadness and feelings of depression stemmed from "feeling stuck" and "lacking a sense of purpose". One participant expressed this sentiment saliently:

There is so much tension in the country right now...you don't know who's on your side and who's not. You're not sure who to confide in...and I don't know what the future holds. I feel like I am wasting my potential. It really gets me down a lot but I try my best to keep my spirits up.

This emotion of feeling unfulfilled was also described by a participant who had earned a Master's degree in her field. After graduation, she was confronted with the reality that without work authorization, she could not get a job that matched her new qualifications, nor could she pursue a doctoral degree like she had hoped to. As a result, she struggled with finding a sense of purpose, considering her circumstances, and experienced persistent feelings of depression. She stated:

It got to a point that they actually wanted to put on medications. Because of everything, I would be happy one moment and sad the next. It was so bad that they were going to put me on Prozac because of my mood and the things I was going through.

This participant's situation was quite common as women with post-secondary education were often underemployed and not working in their field using the degrees they had actually earned. Women reported that their situation and the challenges they faced often made them tearful. Even talking about their experiences invoked emotion as the interviewer had to pause in three interviews to provide emotional support to participants. Yet, due to issues of access and

lack of trust of healthcare providers (discussed at length in another manuscript), only one of the women interviewed had discussed her symptoms with a healthcare professional. Other women coped with their sadness alone and viewed it as a normal part of their experiences.

Lack of peace

Women also described feelings of anxiety and fear. These were largely attributed to the many uncertainties with which they had to cope. They worried about being detected by immigration authorities and/or deported and about the outcome of their pending immigration proceedings. The fear and anxiety that women experienced was a central part of their being undocumented and it had implications for women's ability to conduct their daily activities. Due to the fear of discovery, women had to be strategic about what type of spaces they accessed and when.

Generally, participants lived in a state of constant fear. They were scared to drive, and afraid to step out of their homes. Their fear even threatened their ability to seek healthcare. Women felt like they were a target and they might be approached by immigration authorities at any time. This fear was heightened by women's understanding of the current administration's efforts to increase the deportation of undocumented immigrants. One participant's description of her perception of the current sociopolitical environment embodied the women's emotional state:

When Obama was the president, I felt this sense of normalcy. The fear I feel now was not as pronounced. But then with this administration, you realize that your whole life could be changed with a flick of a pen, basically.

Women reported that the anxiety and fear they felt varied in intensity depending on their situation at the time and the sociopolitical climate. Participants who had been in the United States for longer periods often reported varying levels of anxiety that reflected the changing policies and practices. Additionally, women with a longer stay in the United States were more

likely to have attempted to regularize their status in the United States at some point. There were thus times when women did experience a stronger sense of security and less anxiety. For instance, one participant discussed being able to get work authorization after being sponsored by a spouse through which she could submit a petition to change her status. Obtaining work authorization enabled her to seek and gain formal, stable employment and feel more secure as she then believed she would soon be regularizing her status. However, her situation became complicated when her spouse decided against proceeding with the process. Consequently, the participant remained on the radar of immigration authorities and regained a heightened sense of vulnerability to deportation. This illustrates the dynamic nature of women's experiences with feelings of anxiety and fear.

Coping

Women found ways to cope with their complex realities. The coping strategies women described often fell into two categories- 1) finding trusted people and 2) Relying on religion/faith

Finding trusted people

Social support was an essential component of women's continued survival and coping. Over time, women were able to establish a strong social circle and a network in whom they could confide. One participant shared

So I've been trying to branch out like by doing this interview. Just trying to being more open with my friends with my family so that I can talk about my experiences and what I have been through because of my status. When I'm in immigrant spaces with other immigrants who would understand then I feel more comfortable. But that does not mean I walk around telling everyone about my status either. It means I'm more comfortable talking about my experiences with the people I trust in my circle. So for me, the people I tell are other black people who are also undocumented versus other immigrants who might hold certain opinions about you based on your status.

Women's social network served as an outlet for them to share their struggles with others with who they believed they could somehow identify and relate and who in turn could understand

their experiences. They discussed identifying other undocumented African immigrants who they trusted. Beyond that, social networks of friends, families, and faith communities also served the purpose of connecting them to resources and helping them navigate the many barriers they faced. One participant who had been detained by immigration officials, described how her faith community and local community rallied around her and helped her raise the money needed to hire a lawyer who would represent her. Women were also able to get connected with resources without necessarily sharing their immigration status. For instance, another participant discussed reaching out to her church for financial assistance when she could not afford to pay her rent. She informed them that she was having financial difficulty but did not want to disclose her immigration status.

Women's social support networks also comprised loved ones in their home country. Networks in their home country were particularly important as forming relationships with people in the United States was complicated by their fear of betrayal and not knowing who to trust. Participants reported calling friends and family in the home countries often to seek encouragement and to share their burdens. Beyond providing emotional support, social networks in women's home countries also provided them with instrumental support. Participants reported having their loved ones from their home countries send them food items and medications.

Relying on religion/faith

Religion was central to women's experiences of being resilient in the face of their challenges and complex realities. Religion gave women hope and enabled them to have faith that their situation would change. Religiosity was particularly important for one participant who was detained and separated from her family. While she was at the detention center, she reported praying and

fasting and relying on prayer to help her cope with being placed in detention. Another participant shared how her faith helped through a dark time:

I would say Jesus. I just had to pray. And even with prayer, it was still hard. Honestly, it was definitely hard. My reality was that everybody was out doing their own thing. And you start comparing yourself to other people. You see other people doing things and accomplishing things that you can't. And you realize that nothing makes sense. It just felt that I just kept going deeper and deeper into depression. I just thank God for my friends and my family. They understood and were able to support me when I was moody.

From their religion and faith, women found the strength to persevere. For one participant, her religious affiliation and faith community helped give her the sense of purpose that she desperately needed. She shared her experiences volunteering with a church group and how that experience gave her a different outlook at a time when she was battling depression:

Ummm I think it's a sense of purpose. It had to do with finding a sense of purpose. I got a volunteer position where I was able to like...it was a missionary type volunteer activity where I was able to take the youth at my church and mentor people. That was the purpose I needed. Just something to remind me that I am important. You know? It got to a point where it was hard for me...why am I here? What's the purpose? Like what sense does it make? Why am I wasting my time on this earth?

Religion also provided a framework through which women could make meaning of their often-confusing realities. Women developed positive appraisals of their situations and attempted to describe how their experiences contributed to their growth in some way in spite of the vulnerability, uncertainty and isolation. They often framed their current hardship as a phase they believed would eventually end at some point while comparing their current challenges to past challenges they had already overcome through their faith. Despite the challenges that women faced, at the time of the interview none of the participants expressed a persistent desire to return to their home country even though some women did express having intermittent episodes of feeling regret or wanting to return. They thus perceived their current phase as transitional. Their

belief that this phase of their lives was just another challenge that would pass, provided them with some degree of comfort.

DISCUSSION

This qualitative descriptive study examined the stressors, mental health concerns and coping strategies of undocumented African women in the US. Our findings reveal that undocumented African immigrant women experience significant stressors that have important implications on mental health. From a postcolonial feminist perspective, our analysis foregrounds how women's challenges and resultant mental health symptoms occur within a given sociopolitical context that impedes access to services and resources, resulting in increased vulnerability and marginalization. Women, nevertheless, resisted the impact of this hostile context and demonstrated resilience by relying on social support and their faith.

Similar to previous studies on the mental health needs of undocumented immigrants in the United States, the women interviewed reported anxiety and sadness (Garcini et al, 2016) with some women in the study describing symptoms of severe depression. Despite experiencing these symptoms, most women had not had the opportunity to discuss their symptoms with a healthcare provider. This is an expected finding as undocumented immigrants experience complex barriers to healthcare access (Hacker, Anies, Folb & Zallman, 2015). Difficulty accessing mental health services has serious implications for women's health and well-being. Chronic stress and resultant psychological distress impacts health outcomes as uncontrolled anxiety has been shown, for instance, to increase the risk for cardiovascular disease (Tully, Harrison, Cheung & Cosh, 2016).

Even when undocumented patients are able to access healthcare, getting specialty care, such as mental health services may be challenging. Considering that undocumented immigrants are likely to seek healthcare from primary care safety-net clinics, safety-net healthcare providers

should be equipped, and resources made available to attend to their mental health needs. Within the healthcare setting, assessing the mental health needs of undocumented immigrants requires culturally appropriate tools. There is a need for healthcare providers to have basic knowledge about the challenges that immigrants, and particularly undocumented immigrants, face in the current sociopolitical climate. Lack of awareness or understanding of the realities of undocumented people might pose a barrier to effective screening and interventions that would address their mental health needs. This is especially important for providers who cater to large immigrant communities. It is also vital that healthcare providers employ culturally appropriate screening tools that account for potential variations in the conceptualization of mental health symptoms among different immigrant groups. For instance, compared to the dominant Western notion of duality of physical and emotional parts of the body, some immigrants might somaticize emotional distress and report physical symptoms (Escovar et al, 2018).

The hostile sociopolitical context meant that women's daily lives were characterized by challenges which affected their sense of security and undermined economic and social capital. Women's reliance on faith and religion to cope offers an opportunity for faith communities to be intentional about helping immigrant women feel less isolated. This can be accomplished by developing programs and avenues through faith communities where women can build social networks and get connected to helpful resources. Low social support in immigrants has been associated with higher risk of reporting psychological distress (Puyat, 2012). Support groups of immigrants experiencing the same challenges could be therapeutic for women and could help them develop meaningful relationships with other immigrants and even non-immigrants.

Considering the strong ties to faith communities the women reported in the study, religious organizations can serve as a critical access point for safety-net providers to reach

undocumented women as interventions directed through their faith communities could increase the ease of access. Partnerships between faith-based organizations and healthcare professional to improve the health outcomes within underserved communities is not a novel idea. This approach has been applied to increasing cervical cancer screening and target obesity, in an Appalachian community and African American communities, respectively (Studts et al, 2012; Maynard, 2017). Other specific examples of such initiatives include a church-based health education and community-based outreach to vulnerable population using faith-based organizations (Levin, 2014).

A fundamental driver of women's hardships and the associated psychological distress is their immigration status. It has been established that the type of chronic stress that typifies women's daily lives leads to anxiety and depression (Khan and Khan, 2017). The findings of this current study are relevant given the inaction of the legislative branch to introduce legislation on immigration reform. Evidently, there is a need for immigration reform that grants immigrants with precarious status, protected and permanent status. Doing so will decrease fear in immigrant communities, grant them access to basic resources and formal employment, and enable them to come out of the shadows. Lastly, there is a need for further research on the mental health outcomes of undocumented immigrant. Current research is scant and is lacking in sample diversity. Future studies should examine how women's experiences differ by region of residence. Studies should also report on the longitudinal mental health outcomes of undocumented women.

CONCLUSION

The challenges that undocumented African women face increase their risk of psychological distress. Through the women's narratives reported in this paper, healthcare providers, faith communities, and other allies can gain insight into what resources would be most

helpful to women in alleviating some of the stressors they experience. Though undocumented immigrant women may not disclose their immigration status, it is essential that healthcare providers appropriately assess their immigrant patient's psychological health during healthcare encounters. This is a critical consideration in the current sociopolitical context that has clearly heightened undocumented immigrants' feelings of marginalization and vulnerability.

Variable	Mean
Age (23-55 y)	35.69
Length of Stay in U.S (2-22 y)	11.52
	n (%)
Marital Status	
Married	7 (29%)
Widowed	1 (4%)
Divorced	1 (4%)
Separated	3 (13%)
Never married	12 (50%)
Children	
Yes	14 (58%)
No	10 (42%)
Region of Residence in U.S	
Midwest	21 (88%)
South	2 (8%)
East	1 (4%)
Employment Status	
Full time (40 hours a week)	9 (38%)
Part time (< 40 hours a week)	1 (4%)
Casual worker (work when work is available)	7 (29%)
Unemployed	7 (29%)
Highest Level of Education	
High school	4 (17%)
Some college credits	2 (8%)
Associates degree	7 (29%)
Bachelor's degree	8 (33%)
Graduate degree	3 (13%)
Annual Household Income	
Less than \$10,000	4 (17%)
\$10,000 to \$19,999	9 (38%)
\$20,000 to \$29,999	5 (21%)
\$30,000 to \$39,999	4 (17%)
\$40,000 to \$49,999	1 (4%)
\$50,000 or more	1 (4%)

Table 1. Demographic data for women interviewed (n=24)

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Summary of Findings from Interview with Nurses

Consistent with a postcolonial feminist perspective, my primary objective was to deconstruct the experiences of undocumented immigrants. Interviews with nurses was intended to serve a second source of data and aimed to understand their perception of barriers to care for undocumented immigrants. Additionally, I also sought to examine their experiences providing care for undocumented patients. Of the 20 nurses interviewed, 8 worked at community clinics or public health settings and 12 worked large healthcare organizations. Only 3 of the nurses interviewed had personal experience caring for patients who were undocumented.

Three major themes emerged from the interviews with nurse- *it must be a hard time to be an immigrant, need more information* and *I wish there more I could do*. These themes represent the idea that generally, the nurses had some knowledge of the challenges that undocumented immigrants would encounter when trying to access health care. However, they felt like they could be better informed about the plight of this population. They also felt like they could be more intentional about taking action to help improve the experiences of undocumented patients. The theme “*it must be a hard time to be an immigrant*” has been incorporated into Manuscript 1. The other two themes will be explained further below.

Need more information

Most of the nurses interviewed believed that they were ill-informed on the challenges associated with being undocumented in the United States. They had very little knowledge on the immigration process and the nuances of undocumented status. In addition, most of the nurses working in large healthcare organizations had very limited knowledge of what community resources are available to undocumented immigrants. One nurse stated-

“Yes, if I ever had a patient who was undocumented, I would not know what resources to refer them to. Especially for follow-up visit and medications. I think we definitely need resources for undocumented women. Places we can refer them in their local communities, better access to interpreters if needed.”

This is particularly concerning as women’s narratives indicates that they sometime relied on healthcare providers to provide them information about assistive resources during their health encounters. Nurses did verbalize being able to seek out assistance from social workers in their practice who are more knowledgeable about social resources. Yet, because the nurses practiced in different settings and worked different shifts, social workers were not always readily available.

However, nurses working in community clinics that are likely to cater to large immigrant population had more knowledge about resources for undocumented patients. This is in part because they are more likely to interact with patients who are undocumented.

Wish there was more I could do

All the nurses interviewed expressed sympathy towards undocumented immigrants. They believed that immigrants have a right to have access to healthcare and that barriers to accessing the healthcare system were unjust. Resultantly, nurses’ belief and existing policy surrounding immigrants were at odds with each other. Thus, they attempted to reconcile the conflict between those personal belief and existing policy by being intentional about providing quality care for all patients and by envisioning ways through which they could be an agent of change. However, with the limited knowledge on the plight of undocumented immigrants, they were unsure on actions that were within their capacity that would impact change.

While the nurses empathized with undocumented immigrants, they acknowledged how the healthcare environment can contribute to patient's feelings of marginalization. Nurses discussed how colleagues and peers might share anti-immigrant sentiments during political debates. One nurse shared her experience with this-

“You know, I work night shift so sometimes we have downtime and we talk about things like social issues, politics and such. I know you're not supposed to talk politics and work...but sometimes it just comes up right. Well, we were talking and this nurse said that she agrees with what Trump is doing. That immigrants are stealing jobs and all...you know, that whole spiel. You have nurses that feel like this, and yet they might have a patient who's an immigrant. It just makes you wonder”

Though the nurses interviewed were overwhelmed by the complex nature of immigrants' rights as a social issue, they shared examples of way that they hope to drive change. These included countering anti-immigrant narrative within their workplace and seeking opportunities to engage in political and social advocacy.

CHAPTER V: DISCUSSION AND SYNTHESIS

This descriptive, qualitative study describes the nuanced experiences of undocumented African women navigating barriers to accessing healthcare. It also reports on how women's attempt to navigate these barriers is complicated by a xenophobic and racist sociopolitical context. Despite the constraints of their sociopolitical context, women demonstrated agency by finding ways to self-manage their health, tapping into resources and knowledge within their social network and practicing self-advocacy within their healthcare interactions.

This chapter analyzes and synthesizes the findings reported in the three manuscripts and discusses their implications for research, policy and practice. Consistent with a postcolonial feminist perspective, emphasis will be placed on sociopolitical context during analysis and recommendation will be aimed at driving social change.

Synthesis of Findings

The overarching aim of the dissertation study was to center the voices of undocumented African immigrant women and thus, create transformative knowledge that increases awareness of the plight of undocumented African immigrant women and subsequently, impact social change. Based on a postcolonial feminist perspective, our analysis reveals how women's barriers to healthcare, experiences navigating new identities and bias within institutions, and their mental health concerns are a product of a racist and xenophobic sociopolitical context.

Women's experiences navigating their complex realities was embodied in the major theme *navigating complex realities*. This central theme captures the idea that women's realities comprised of navigating barriers to healthcare access, navigating bias, and coping with complex stressors.

Sociopolitical context. A postcolonial feminist framework offers an analytical lens to enhance our understanding of how women's experiences and challenges are a result of sociopolitical process. The critical analysis of policies impacting women discussed above illustrates the existence of structural racism embedded in immigration and public policy. Women's narratives also provided some insight into the nature of their sociopolitical environment. Women existed in a context where they experienced interpersonal racism and xenophobia and were also impacted by structural racism.

In this study, these experiences of discrimination extended to their encounters with the healthcare and criminal justice systems. Consistent with previous studies on the healthcare seeking experience of undocumented immigrants, women in this study reported mistrust of healthcare providers and experiences of discrimination or unfair treatment (Rodriguez, Bustamante & Ang, 2009; Cleaveland & Ihara, 2012). Women's sociopolitical context also shaped their perceptions of the criminal justice system. Generally, women were concerned about how bias held by representatives of institutions would impact their encounters.

The current sociopolitical climate and the functioning unjust structures of racism and xenophobia create and sustain an environment where undocumented African women experience restricted access to care. Aggressive policing, deportation and detention of immigrants also contribute to a context where undocumented immigrant are fearful. In addition to the discrimination that women experience, the use of inflammatory and hostile rhetoric in relation to undocumented immigrants further heightens women's sense of marginalization and isolation.

Access to healthcare and law enforcement. Women's sociopolitical context had implications for access to care, their healthcare experiences, as well as comfort with access to law enforcement. Previous literature has identified that undocumented immigrants experience

complex barriers to accessing healthcare and law enforcement (Dang, Giordano & Kim, 2012; Montealegre & Selwyn, 2012; Hacker, Anies, Folb & Zallman, 2015). For undocumented immigrants, access to healthcare is restricted by immigration and health policy. Consistent with previous studies, women also reported fear due to lack of documentation and economic barriers to accessing the healthcare system.

Women's ability to access care at safety-net health centers is an important finding. This finding uncovers the importance of federally funded health centers that cater to vulnerable populations at a time when there the political discourse is on enacting policies that cut funding to these agencies. Nevertheless, even within the health care environment (when access to care is attained), women experience discrimination and insensitive practices perpetrated by healthcare providers. Women also expressed concerns about how provider bias would impact the level of care they received and generally, their healthcare interaction. This reveals that women were not certain that a healthcare environment would be a safe space. Women's mistrust of healthcare providers and experiences of poor treatment while accessing the healthcare system could impact their willingness to utilize the healthcare system as evidenced by a prior study on healthcare seeking decision making for immigrants (Wafula & Snipes, 2013).

Women also were not comfortable accessing public safety services due to fear of detention and deportation and fear of racial bias. This is an expected finding considering the current context of aggressive policies and practices aimed at deporting immigrants and recent efforts at integrating law enforcement with immigration enforcement. Data reveals that in the first three months of 2017, sexual assault reports from a specific Latino community in Houston dropped nearly 43% compared to the previous year (Burnett, 2017). This illustrates the current

level of fear in immigrant communities in a context where immigrants seeking domestic abuse protection are being detained and deported at courthouses (Mettler, 2017).

Health implications. The barriers women reported to accessing culturally safe and affordable healthcare has implications for their health. Women reported self-managing acute symptoms by self-medicating and self-diagnosing, which can pose a danger to health due to potential risks such as inaccurate diagnosis, adverse medication reactions, drug interaction, masking of a severe disease (Ruiz, 2010). Self-medication using antibiotics also contributes to the global antibiotic resistance crisis which threatens the effectiveness of existing pharmacological treatments for potentially deadly pathogens (Gould and Bal, 2013).

Women's complex realities and the stressors they experienced had a direct impact on their emotional wellbeing. Coping with economic vulnerability, uncertainty, isolation and discrimination resulted in women having increased feelings of anxiety and depression. This finding is corroborated by existing data that have shown that discrimination is a significant predictor of mental health symptoms for immigrants in the United States (Joseph, 2011). Though women were experiencing concerning mental health symptoms, issues of access to care and mistrust were barriers to seeking medical help for these symptoms.

Women's new identities and the experiences of discrimination they experienced have implications for their health status within a given racialized context plagued with disparate outcomes for ethnic minorities. In addition to mental health symptoms as discussed above, experiences of discrimination are linked to increased risk of heart disease, obesity, poor maternal child health outcomes and mortality. Racism can directly impact health status through several mechanisms including impeding access to resources, imposing chronic stress (Gee, 2016).

Access to healthcare and law enforcement for undocumented women is also essential considering their increased vulnerability to violence and exploitation. The healthcare system and law enforcement are integral components of evidence-based, multidisciplinary approaches such as the coordinated community response aimed at promoting and protecting victim safety (Sullivan, 2005). Yet, undocumented women might forego seeking help due to their mistrust of institutions that primarily stems from fear of deportation (Orloff & Garcia, 2013). This is concerning as violence, for instance, in the form of intimate partner violence has serious implications for women's physical and mental health (Ellsberg, Jansen, Heise, Watts & Garcia-Moreno, 2008).

Policy and Practice Recommendations

In addition to the policy and practice recommendations outlined in each manuscript, this section proposes broader changes based on the research findings. Findings from this study indeed have implications for informing practice and policy change. The discussion above illustrates the intersection of multiple structures that negatively influences the lives of undocumented women in the United States and how these structures are manifested in immigration policy. Gender, minority status, socio-economic status and immigration status are only a few of the contextual factors that impede access to care for undocumented immigrant women. A critical analysis of current policies reveals the need for comprehensive immigration reform particularly because the ease through which women can access health care hinges on immigration status. However, the immigration policy reform I propose is in opposition to the immigration reform used in US political rhetoric aimed at securing borders or granting conditional status to undocumented immigration. Impactful immigration reform should be conceptualized as a radical transformation of the reconceptualization of geo-political borders that exist to control movement and limit

migration as well as a reconceptualization of citizenship that determines who is accepted and who is not.

Evidently, policy changes need to be made at the global as well as the national level. This begins with advocating for the right to work where one resides, reside where one works, and the right to citizenship where one resides - three rights that are currently denied to undocumented immigrants. On a global level, policies set in place to sustain the “global apartheid” by restricting freedom of movement need to be dismantled. In a global society, restrictive and exclusionary policies in support of the right to free movement between nations for immigrants ought to be reconsidered. (Hosein, 2013). Freedom of movement should be viewed as an extension of individual autonomy, an ideal which is highly valued in Western society.

While freedom of movement facilitates the ability of immigrants to reach their desired destination, it does not guarantee that they are conferred the same opportunities and benefits given to citizens. There is, therefore, a need for policies that reconceptualize the notion of citizenship. The continuous naming of the oppressive structures embedded in these policies and in the notion of citizenship is required. Furthermore, it is essential that we acknowledge that policies that deny residents the right to accessing health care are unjust. The exclusion of undocumented immigrant from health policy benefits further highlights the need for a radical change of migration policies. Such radical transformation requires political and social action. The self-mobilization of undocumented immigrants has been made evident by recent movements across the nation that demand for immigration reform; however, such progress will take time.

It is important to acknowledge how a few immediate policy and practice changes can improve access to health care for undocumented immigrants. The most impactful immediate policy change that would facilitate access to healthcare for undocumented immigrants is the

granting of non-conditional citizenship to the millions of undocumented people currently residing in the United States. Granting citizenship to undocumented immigrants would ensure that they are afforded the same rights as current US citizens. With US citizenship, they would have access to the necessary resources and services, such as health insurance, increasing the ease through which they access health care. US citizenship would also eliminate the fear of deportation and could potentially increase their level of comfort with law enforcement or public safety.

Health care organizations are also culpable in the marginalization of undocumented immigrants within the health care environment. Their role in this regard therefore needs to be further examined, and any issues or concerns addressed. The idea that undocumented immigrants who enter the health care system might be treated with hostility needs urgent attention.

Healthcare organizations should foster an environment where undocumented immigrants feel safe and respected through the provision of culturally safe care. Safe spaces can be created by ensuring that members of health care staff are knowledgeable about the challenges associated with being undocumented as well as what community resources are available to undocumented immigrants that they might encounter.

Lastly, our findings indicate the need for inclusive health policies that address some of the structural barriers that impede access to health care for undocumented immigrants. At the very least, the continuous funding of safety-net health centers is essential in ensuring that individuals who are not documented have access to primary and preventive care.

Conclusion

The purpose of this dissertation was to understand the challenges that undocumented African women experience in accessing critical resources such as healthcare and how women

navigate these challenges. By deconstructing the experiences of undocumented African women using their own voices, healthcare providers, immigrant rights advocates and other allies can direct efforts to creating meaningful change taking into account women's lived experience and their realities.

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APPENDIX A: Institutional Review Board Approval Letters



Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3182 phone
(414) 229-6729 fax

Continuing Review - Notice of IRB Expedited Approval

<http://www.irb.uwm.edu>
harries@uwm.edu

Date: March 7, 2018

To: Lucy Mkandawire-Valhmu, PhD
Dept: Nursing

CC: Oluwatoyin Olukotun

IRB#: 17.154

Title: The Lived Experiences of Access to Healthcare Among Undocumented African Immigrant Women in the United States

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has received continuing approval as minimal risk Expedited under **Category 6 & 7** as governed by 45 CFR 46.110.

In addition, your protocol has been granted **Level 3** confidentiality for Payments to Research Subjects according to UWM Accounting Services Procedure: 2.4.6.

This protocol has been approved on **March 7, 2018** for one year. IRB approval will expire on **March 6, 2019**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a Continuation for IRB Approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found in IRBManager.

This study may be selected for a post-approval review by the IRB. The review will include an in-person meeting with members of the IRB to verify that study activities are consistent with the approved protocol and to review signed consent forms and other study-related records.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records, and promptly reporting to the IRB any adverse events which require reporting. The Principal Investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., [FERPA](#), [Radiation Safety](#), [UWM Data Security](#), [UW System policy on Prizes, Awards and Gifts](#), state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project!

Respectfully,



Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3182 phone
(414) 229-6729 fax

<http://www.irb.uwm.edu>
harries@uwm.edu

New Study - Notice of IRB Expedited Approval

Date: March 10, 2017

To: Lucy Mkandawire-Valhmu, PhD
Dept: Nursing

CC: Oluwatoyin Olukotun, RN

IRB#: 17.154

Title: The Lived Experiences of Access to Healthcare Among Undocumented African Immigrant Women in the United States

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been approved as minimal risk Expedited under **Category 6 and 7** as governed by 45 CFR 46.110. Your protocol has also been granted approval to waive documentation of informed consent for the immigrant women interviews as governed by 45 CFR 46.117 (c).

In addition, your protocol has been granted **Level 3** confidentiality for Payments to Research Subjects according to UWM Accounting Services Procedure: 2.4.6.

This protocol has been approved on **March 10, 2017** for one year. IRB approval will expire on **March 9, 2018**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a continuation for IRB approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found in IRBManager.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. It is the principal investigator's responsibility to adhere to the policies and guidelines set forth by the UWM IRB, maintain proper documentation of study records and promptly report to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., [FERPA](#), [Radiation Safety](#), [UWM Data Security](#), [UW System policy on Prizes, Awards and Gifts](#), state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project.

Respectfully,

Melody Harries
IRB Administrator



Leah Stoiber
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-7455 *phone*
(414) 229-6729 *fax*

<http://www.irb.uwm.edu>
lstoiber@uwm.edu

Modification/Amendment - IRB Expedited Approval

Date: May 30, 2018

To: Lucy Mkandawire-Valhmu, PhD

Dept: College of Nursing

CC: Oluwatoyin Olukotun

IRB#: 17.154

Title: The Lived Experiences of Access to Healthcare Among Undocumented African Immigrant Women in the United States

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has received modification/amendment approval for:

- Adding options to conduct interviews over the phone or via Skype
- Adding options for distributing gift cards to participants interviewed over the phone/Skype
- Granting doctoral students access to interview transcripts to assist with data analysis

IRB approval will expire on **March 6, 2019**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a Continuation for IRB Approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form in IRBManager.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., [FERPA](#), [Radiation Safety](#), [UWM Data Security](#), [UW System policy on Prizes, Awards and Gifts](#), state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project.

Respectfully,

A handwritten signature in cursive script that reads "Leah Stoiber".

Leah Stoiber
IRB Administrator

APPENDIX B: Screening Script for Women

Thank you for your interest in participating in the study. The goal of the study is to understand the health care experiences and barriers to accessing care for Undocumented African immigrant women. To make sure that you qualify for the study, I need to ask a few questions-

1. Are you an African immigrant?
2. Are you currently undocumented?
3. Are you 18 years or older?
4. Do you speak and understand English? French?

*Note- the individual has to respond “Yes” to all four questions to qualify for the study.

APPENDIX C: Recruitment Letter for Women

Dear Sir/Madam

My name is Toyin Olukotun, a nursing doctoral student at University of Wisconsin- Milwaukee. For my dissertation research, I will be studying the topic of access to health care and health care experiences of undocumented African immigrant women in the United States. This will be a qualitative study that would interview women about the experiences when seeking health care in the United States. I am hoping to recruit a total of thirty women who I would interview for my study. I am reaching out to you obtain permission to come speak to members of your church/ organization regarding the studying. I am willing to meet with you to discuss further about the study and procedures or to clarify any questions.

Thank you,

Toyin Olukotun

olukotun@uwm.edu

414-807-2131

APPENDIX D: Interview Guide for Women

1. How did you move to the United States?
 - a. How were things for you after moving here? What challenges did you face?
2. When you first got to the United States, in which city and state did you live?
3. What city and state do you live in now?
4. How does it feel being an African immigrant in the United States?
 - a. How does being a Black woman impact your experiences in this country? How does it impact your access to healthcare? Your health?
5. Where do you go when you are not feeling well?
 - a. Where do your children go when they are not feeling well?
6. How does being undocumented affect your ability to get health care? How?
7. Have you ever had to use the health care system for a health need?
8. Could you tell me about a time when you had a good experience while trying to get health care?
 - a. How were treated by the health care workers?
9. Could you tell me about a time when you had a bad experience while trying to get health care?
 - a. How were treated by the health care workers?
10. Do you have any concerns about your health? Your emotional well-being?
11. What do you do when you are feeling stressed?
12. Do you currently have any concerns about your safety?
 - a. What would you do if you felt like you were in danger or if you were a victim of a crime?
13. Have you ever been in a situation where you felt like you were being treated unfairly because of your immigration status? Your gender? Your race? Your nationality?

APPENDIX E: Interview Guide for Nurses

1. In what setting do you practice?
 - a. What is your current position?
2. Describe the process within your health care organization for a patient who would like to receive healthcare?
 - a. What challenges do you anticipate that an undocumented immigrant who might present to receive health care would face?
3. Would you describe your health care setting as a safe place for undocumented immigrants?
4. Please share your perception of the experiences of undocumented immigrant women in the United States?
 - a. Do you believe they experience hardships?
 - b. In your opinion, how does the current socio-political climate influence their ability to seek care?
 - i. How does it influence their ability to receive good quality care?
5. What experiences have you had with African immigrant women accessing the health system?
6. What experiences have you had with undocumented women accessing the health care system?
7. Do you experience specific barriers in caring for women who are undocumented? If so, please describe.
8. What level of care do you think undocumented African immigrant women receive compared to the general population?
 - a. What are your thoughts on the types of resources or practices needed to improve access to care?
9. Are you knowledgeable about social or health community resources that exist for undocumented women who might present to your setting?

APPENDIX F: Demographic Questionnaire for Women

Participant ID Number: _____

Demographic Questionnaire

1. How old are you?
2. What is your marital status?
 - a. Do you have children?
 - i. How many?
3. In what country were you born?
4. What is your current visa status?
5. How long have you lived in the United States?
6. What state do you live in?
7. Are you currently working?
 - a. How many hours per week?
8. Highest level of education?
9. Your annual household income?

APPENDIX G: Study Informational Sheet for Women

UNIVERSITY OF WISCONSIN – MILWAUKEE CONSENT TO PARTICIPATE IN RESEARCH WOMEN STUDY INFORMATION SHEET/CONSENT

[THIS CONSENT FORM HAS BEEN APPROVED BY THE IRB FOR A ONE YEAR PERIOD]

1. General Information

Study title:

The Lived Experiences of Access to Healthcare Among Undocumented African Immigrant Women in the United States

Person in Charge of Study (Principal Investigator):

Dr. Lucy Mkandawire-Valhmu, PhD, RN, an Associate Professor in the College of Nursing at UW-Milwaukee.

2. Study Description

You are being asked to be in a research study. You can choose to be a part of this study or you can choose not to be in the study. You can leave the study at any time.

This study is being done to understand whether undocumented African women are able to use the health care system when they need it. It is important that nurses study this topic so that they can come up with ways to make the health care system a safe place for undocumented women.

The researcher will be interviewing 30 women and 20 health care providers.

3. Study Procedures

What will I be asked to do if I participate in the study?

If you choose to be in the study, you will meet with the researcher for an interview. The interview will last about 1-3 hours. The interview will happen in a private location of your choice and at a date and time that is convenient for you. During the interview, you will be asked questions about your experiences with the health care system in the United States. You will also be asked questions about where you go for care and how you feel about your health.

The interview will be audio-recorded so that the researcher can listen to and type out what was said. You can still participate in the study if you choose not to be audio-recorded. In that case, the interviewer would take notes as you speak instead of audio-recording the conversation.

At the end of the interview, you will receive a \$30 Walmart gift card to thank you for your time. Participants whose interviews are conducted via skype or over the phone will have two options for obtaining the gift card funds. 1) The gift will be mailed to you. If you choose to have the gift card mailed to you, the researcher will ask for your name and address over the phone or via skype. Your name and address will be written directly onto an enveloped and mailed to you. No other information regarding the study will be included in the mailing. 2) For participant who would rather not provide their name and address, the gift card number and pin will be provided verbally to you immediately after the interview is completed. This means that you would be limited to having to use the gift card for online shopping. Lastly, participants have the option to decline the gift card if they do not want to receive the code for online shopping and do not want to provide their name and addresses.

4. Risks and Minimizing Risks

What risks will I face by participating in this study?

There is a risk that your immigration status will be disclosed. To reduce this risk, your legal name will not be stored at any time during the study. Identifying information such as your legal name and address will only be collected if you would like the gift card mailed to you. You will create a fake name that will be used throughout the interview.

Additionally, the audio recording will be deleted as soon as the interview is typed out by the researcher. Also, audio-recordings and other research documents will be stored in a password protected computer and forms will be locked in a file cabinet.

5. Benefits

Will I receive any benefit from my participation in this study?

There are no benefits to you other than to further research

However, the research study could be beneficial to society. Findings from this study could help improve access to care for undocumented immigrants.

6. Study Costs and Compensation

Will I be charged anything for participating in this study?

You will not be responsible for any of the costs from taking part in this research study

Are subjects paid or given anything for being in the study?

After the interview, you will receive a \$30 gift card to Wal-Mart to thank you for your time

7. Confidentiality

What happens to the information collected?

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. We may decide to present what we find to others, or publish our results in scientific journals or at scientific conferences. Information that identifies you personally will not be released without your written permission. Only the PI and other members of the research committee will have access to the information. However, the Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records.

Your responses will be anonymous. The data collected will be stored in a password protected computer. All the information collected for this study will be destroyed when the study is complete in 2019.

8. Alternatives

Are there alternatives to participating in the study?

There are no known alternatives available to you other than not taking part in this study.

9. Voluntary Participation and Withdrawal

You can choose to be a part of this study or you can choose not to be in the study. You can leave the study at any time.

What happens if I decide not to be in this study?

Being in this study is all up to you. Not being in this study will not affect you in any way.

If you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee.

If you choose to withdraw during the interview, we will ask your permission to use the information collected to that point.

10. Questions

Who do I contact for questions about this study?

For more information about the study or the study procedures or treatments, or to withdraw from the study, contact:

Toyin Olukotun, RN- BSN
University of Wisconsin-Milwaukee College of Nursing
P.O. Box 413
Milwaukee, WI 53201
Email: olukotun@uwm.edu
Phone: 414-229-6098

Lucy Mkandawire-Valhmu, PhD, RN
University of Wisconsin-Milwaukee College of Nursing
P.O. Box 413
Milwaukee, WI 53201
Email: mkandawi@uwm.edu
Phone: 414-229-6098

Who do I contact for questions about my rights or complaints towards my treatment as a research subject?

The Institutional Review Board may ask your name, but all complaints are kept in confidence.

Institutional Review Board
Human Research Protection Program
Department of University Safety and Assurances
University of Wisconsin – Milwaukee
P.O. Box 413
Milwaukee, WI 53201
(414) 229-3173

APPENDIX H: Consent Form for Nurses

UNIVERSITY OF WISCONSIN – MILWAUKEE CONSENT TO PARTICIPATE IN RESEARCH HEALTHCARE PROVIDER'S CONSENT

[THIS CONSENT FORM HAS BEEN APPROVED BY THE IRB FOR A ONE YEAR PERIOD]

1. General Information

Study title:

The Lived Experiences of Access to Healthcare Among Undocumented African Immigrant Women in the United States

Person in Charge of Study (Principal Investigator):

Dr. Lucy Mkandawire-Valhmu, PhD, RN, an Associate Professor in the College of Nursing at UW-Milwaukee.

2. Study Description

You are being asked to participate in a research study. Your participation is completely voluntary. You do not have to participate if you do not want to.

Study description:

The purpose of this cross-sectional qualitative study is to gain an understanding of how historical, social and political processes impact access to health care as well as the health care experiences of undocumented African immigrant women in the United States. Additionally, the study aims to understand health care providers' beliefs and attitudes towards undocumented immigrants. To accomplish this aim, the following research questions will be examined-

1. How do undocumented African immigrant women navigate barriers to accessing healthcare when facing a health need?
2. What are the experiences of undocumented African immigrant women when accessing the health care system?
 - A. How are these experiences shaped by social, political and economic factors?
3. How do social, political, and economic factors affect the health care experiences of undocumented African immigrant women?
4. What attitudes and beliefs do health care providers have about undocumented immigrants?

The sample will consist of 30 women who share a common experience in being undocumented African immigrants in the United States, and 20 health care providers or personnel. Data will be collected using one-session semi-structured in-depth individual interviews. Each interview will last approximately 1 to 3 hours.

3. Study Procedures

What will I be asked to do if I participate in the study?

If you agree to participate you will be asked to the researcher will meet with your at a private space of your choice. The interview date and time will be mutually agreed upon by you and the researcher. The interview will be audio-recorded so that the interview can be transcribed for data analysis. You can still participate in the study if you choose not to be audio-recorded. In that case, the interviewer would take notes as you speak instead of audio-recording the conversation.

During the course of the interview, you will be asked questions your experiences with undocumented immigrants and African immigrants in your health care setting. You will also respond to questions about the care delivery process for patients who access your health care organization for health services.

4. Risks and Minimizing Risks

What risks will I face by participating in this study?

There are no foreseeable risks for participating in this research study

5. Benefits

Will I receive any benefit from my participation in this study?

There are no benefits to you other than to further research

However, the research study could be beneficial to society. Findings from this study could inform policy and practices that would improve access to care for undocumented immigrants.

6. Study Costs and Compensation

Will I be charged anything for participating in this study?

You will not be responsible for any of the costs from taking part in this research study

Are subjects paid or given anything for being in the study?

You will not be compensated for taking part in this research study

7. Confidentiality

What happens to the information collected?

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. We may decide to present what we find to others, or publish our results in scientific journals or at scientific conferences. Information that identifies you personally will not be released without your written permission. Only the PI and other members of the research committee will have access to the information. However, the Institutional Review

Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records.

Your responses will be anonymous. The data collected will be stored in a password protected computer. All the information collected for this study will be destroyed when the study is complete in 2019.

8. Alternatives

Are there alternatives to participating in the study?

There are no known alternatives available to you other than not taking part in this study.

9. Voluntary Participation and Withdrawal

What happens if I decide not to be in this study?

Your participation in this study is entirely voluntary. You may choose not to take part in this study. If you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee.

If you choose to withdraw during the interview, we will ask your permission to use the information collected to that point.

10. Questions

Who do I contact for questions about this study?

For more information about the study or the study procedures or treatments, or to withdraw from the study, contact:

Toyin Olukotun, RN- BSN
University of Wisconsin-Milwaukee College of Nursing
P.O. Box 413
Milwaukee, WI 53201
Email: olukotun@uwm.edu
Phone: 414-229-6098

Lucy Mkandawire-Valhmu, PhD, RN
University of Wisconsin-Milwaukee College of Nursing
P.O. Box 413
Milwaukee, WI 53201
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Institutional Review Board
Human Research Protection Program
Department of University Safety and Assurances
University of Wisconsin – Milwaukee
P.O. Box 413
Milwaukee, WI 53201
(414) 229-3173

11. Signatures

Research Subject's Consent to Participate in Research:

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read or had read to you this entire consent form, including the risks and benefits, and have had all of your questions answered, and that you are 18 years of age or older.

Printed Name of Subject/ Legally Authorized Representative

Signature of Subject/Legally Authorized Representative

Date

Research Subject's Consent to Audio/Video/Photo Recording:

It is okay to audiotape me while I am in this study and use my audiotaped data in the research.

Please initial: ____Yes ____No

Principal Investigator (or Designee)

I have given this research subject information on the study that is accurate and sufficient for the subject to fully understand the nature, risks and benefits of the study.

Printed Name of Person Obtaining Consent

Study Role

Signature of Person Obtaining Consent

Date

APPENDIX I: Recruitment Flyer for Women



Recruiting African Immigrant Women for a Research Study

University of Wisconsin- Milwaukee

***Study Title: The Lived Experiences of Access to Care for African
Immigrant Women in the United States***

Purpose of the Study- To understand the barriers to health care and the experiences of African immigrant women

Eligibility- African Immigrant women

Eligible women will participate in an in-person or a skype/ telephone individual interview and will receive a \$30 Walmart gift card upon completion of the interview.

Contact Information

Toyin Olukotun, Registered Nurse/ Doctoral Student

Cell: 414-807-2131

Email: Olukotun@uwm.edu

APPENDIX J: Recruitment Email for Nurses

Subject: Request for participation in research study

My name is Toyin Olukotun, a nursing doctoral student here at UWM. I am seeking health care providers to participate in my dissertation study. My study aims to understanding the barriers to accessing care and the health care experiences of undocumented immigrant women.

Additionally, I hope to gain an understanding of health care providers' beliefs and attitudes towards undocumented immigrants. This is a qualitative study that will require one individual interview that will be scheduled at a time that is convenient for you.

If you are interested in participating, please contact me via email or phone. Email- olukotun@uwm.edu. Phone- 414-807-2131

Thank you,

Toyin Olukotun

Oluwatoyin Olukotun
Curriculum Vitae
2018

EDUCATION

University of Wisconsin- Milwaukee

Ph.D. in Nursing

Dissertation: Navigating complex realities: Barriers to healthcare, law enforcement and mental health concerns of undocumented African immigrant women in the United States

Expected Graduation Date: December 2018

University of Wisconsin-Milwaukee

Bachelor's of Science- Nursing

Graduation Date: May 2013

LICENSURE

Registered Nurse, Wisconsin Board of Nursing

PROFESSIONAL EXPERIENCE

Froedtert Community Physicians Urgent Care

Registered Nurse

January 2018- Present

Triages patients after careful assessment of patient condition

Plans and implement nursing care for assigned patients

Implements nursing interventions

University of Wisconsin- Milwaukee

Research Assistant

Principal Investigator- Dr. Julie Ellis

Project Title- Medication Self-Management in African American Older Women

August 2016- December 2017

Responsibilities included recruitment, data collection, data entry, data analysis and contribution to data-based manuscript

Ascension Columbia St. Mary

Phone Triage Nurse

May 2016- Present

Triage patients' calls based on reported symptoms

Offers healthcare advice and education using assessment skills

Directs caller to appropriate level of care

University of Wisconsin- Milwaukee

Teaching Assistant

August 2014- May 2018

Courses: Cultural Diversity, Growth and Development, Perspective on Health Care Systems

Taught an undergraduate course titled “Perspective on Health Care Systems” (Spring 2016 at UW- Parkside)

Responsibilities included teaching, proctoring exams, tutoring students, testing students on fundamental nursing skills

Aurora Sinai Medical Center- Emergency Department; Milwaukee, Wisconsin

Registered Nurse

June 2013- September 2016

Triages patients after careful evaluation of patient complaints and assessment of patient condition

Plans and implement nursing care for assigned patients

Prioritizes care for patients appropriately

Implements nursing interventions and nursing skills

Aurora Sinai Medical Center- Cardiovascular Unit; Milwaukee, Wisconsin

June 2008- June 2013

Patient Care Assistant/ Telemetry Technician

Assisted patients with activities of daily living.

Obtained patient’s vital signs.

Monitored patient’s ECG telemetry rhythms and alerted appropriate Nurse to ECG changes.

Trained new employees on ECG monitoring

PRESENTATIONS

2018 Transcultural Nursing Society Conference

Poster Presentation – *Exploring the healthcare seeking experiences of undocumented African women in the United States*

2016 United States Conference on African Immigrant Health

Oral Presentation – *Cultural Safety in Higher Education: A Critical Ethnography to Assess Student Attitudes towards Cultural Diversity*

2016 National Black Nurses Association Conference

Oral Presentation – *Barriers to Accessing Health Care for Undocumented Immigrants in the United States*

2014 Building Bridges to Research Based Nursing Practice

Poster Presentation - *Exploring Dietary Intake of Low-Income African American Children Using Mobile Phones*

2014 University of Wisconsin Global Health Symposium

Oral Presentation – *Barriers to Accessing Health Care for Undocumented Immigrants in the United States*

PUBLICATIONS

Olukotun, O., Mkandawire-Vahlmu, L., Kreuziger, S. B., Dressel, A., Wesp, L., Sima, C., ... & Kako, P. (2017). Preparing culturally safe student nurses: An analysis of undergraduate cultural diversity course reflections. *Journal of Professional Nursing*.

Mkandawire-Valhmu, L., Lathen, L...**Olukotun, O.**, Washington, R., Jordan, L., and Hess, A. (2018). Enhancing Healthier Birth Outcomes by Creating Supportive Spaces for Pregnant African American Women Living in Milwaukee. *Maternal and child health journal*, 1-8.

Seal, N., & **Olukotun, O.** (2015). Perceptions of Using Smartphone Technology for Dietary Assessment among Low-Income African-American Mothers. *Journal of Mobile Technology in Medicine*, 4(2), 12-20.

Olukotun, O., & Seal, N. (2015). A systematic review of dietary assessment tools for children age 11 years and younger. *ICAN: Infant, Child, & Adolescent Nutrition*, 7(3), 139-147.

Mkandawire-Vahlmu, L., Weitzel, J., Neiman, T., Hafez, S., Dressel, A, **Olukotun, O...**(2018). Nursing Students Learning from Documentaries. *Nursing Inquiry*.

HONORS AND AWARDS

2012-2013 U.S. Department of Health and Human Services Maternal Child Health Pipeline Training Program

2013 Induction to Sigma Theta Tau Nursing Honor Society

2013-2015 Dr. Harriet Werley Fellowship

ACADEMIC AND PROFESSIONAL ACTIVITIES

Sigma Theta Tau- Eta Nu Chapter, Member

National Black Nurses Association, Member

Midwest Nursing Research Society, Member

Transcultural Nursing Society, Member

CERTIFICATIONS

American Heart Association BLS for Healthcare Providers

Advanced Cardiac Life Support