

Introduction: Background and Purpose

One of the Healthy People 2030 goals is to improve access to comprehensive health care services (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). For the one in four women in the United States who identify as Latina (United States Census Bureau, 2020), this is a lofty goal. Latinas are more likely to be uninsured than any other group of women in the United States (Keisler-Starke & Bunch, 2020), making access to health care a significant issue for this group. These women are less likely to have an ongoing relationship with a health care provider and worry more about medical bills than their non-Latina counterparts (OASPE, 2021). Aside from the policy level issues that affect access, entering appropriate services in a timely manner can be difficult for many of these women (Schminkey et al., 2019).

Latina/Latino and Hispanic are terms that are often used interchangeably despite their different meanings, Latina denotes a woman of Latin American descent or origin, while the term Hispanic denotes Spanish speakers including those who are not from or descended from people living in Latin America (Austin & Johnson, 2012). It is important to note that many immigrants from Spanish-speaking countries do not primarily speak Spanish; rather, they speak indigenous languages other than Spanish as their first language. Both terms appear in the literature and thus both appear in reference to other literature even though our study population was exclusively Latina.

There are significant, persistent health risks in Latina communities in the United States (Boen & Hummer, 2019; Velasco-Mondragon, et. al., 2016). Rates of diabetes and obesity are increasing for Hispanics (Velasco-Mondragon, et. al., 2016). Severe maternal morbidity is more likely in Hispanics than Whites (Fingar, et al., 2018) In addition, there is a greater burden of both functional limitations and depressive symptoms in Latina communities than in the general

population (Boen & Hummer, 2019). And disturbingly, there are discrepancies between the reported rates of abuse disclosure in Latina populations: a recent review found prevalence of abuse ranged from 1-83% (Gonzalez et al., 2020). The association between intimate partner violence (IPV) and poor health outcomes is well established (Chandon et. al, 2020; Bacchus et al., 2018). Reports of increased risk of poor physical and psychological health in abused Latina women makes it clear that women experience disproportionate adverse consequences when they are abused. Furthermore, the authors' experiences in clinical practice demonstrate significantly less IPV disclosure in Latina populations in suburban health department settings than would be expected, particularly among recently arrived immigrants, corroborating findings from Zarza and Adler (2008) on disclosure rates for Latina populations in New Jersey. This lack of disclosure of violence highlights both a lack of understanding among practitioners and researchers regarding the screening tool validity and a gap in care access for the Latina women who currently experience abuse or have experienced abuse in the past.

These rates of chronic disease, disability and abuse suggest that it may be more difficult for Latinas to access care. Given that Latino immigrants in the United States comprise the fastest growing percentage of the rural population in the United States (Lichter & Johnson, 2020), outreach from the health care sector to this growing population needs to be strategic and must address the structural challenges that impede help-seeking from the health care system. The aims of this paper are two-fold: to describe the unique structural barriers faced by Latina women in rural areas of the eastern United States as they attempt to access the health care system, and, once they have gained access, to identify barriers to IPV disclosure.

Methods

Study Design

The study adopted a Heideggerian interpretive phenomenological approach to thematic content analysis. This allowed the researchers to capture the experience of rural Latina women who were first-generation immigrants to the United States as they navigated the health care system and were questioned about IPV by their health care providers. We sought to recognize our bias as health care workers and identify components of the interview in which we made judgments and assumptions.

Recruitment and Sampling

The University of Virginia Institutional Review Board approved the study recruitment process and interview protocol. Informed consent was obtained from study participants, and participants were offered a twenty dollar gift card for completing the interview. The participants were recruited over a six-month time frame using a purposeful convenience sampling strategy from advertisements placed in a convenience store serving the Latina community, and then concomitant snowball recruiting. All participants were selected to participate in the study if they met the following criteria: age 18-65, female, and of first-generation Latina families. Women were interviewed either in private homes or in a location that afforded privacy and was agreeable to the participants. The participants chose whether they preferred to be interviewed in Spanish or in English.

Data Collection

Nine women were interviewed using a semi-structured approach by one of the researchers at a location of the participants' choosing. (Table 1) If Spanish was the preferred language of the woman, a Spanish-speaking researcher conducted the interview in Spanish, which was later

Table 1

Summary of semi-structured interview guide questions

Primary Questions	Examples of Probes
Can you tell me about an experience accessing the health care system here	Probe for specific experiences patients have had in getting healthcare. Probe for details regarding how they understood the process, the emotions they experienced, and their sense of how well they were cared for
What kinds of difficulties have you encountered accessing health care?	Probe for specifics such as transportation, communication issues, payment issues, continuity of care.
What has helped make getting health care easier?	
Is most of your care received at the hospital emergency room/urgent care facility, or from a clinic or private office?	Probe for reasons why this is the site of most of their care
Can you tell me about the experience of being enrolled or registered for care in these facilities?	Is there one experience that sticks out to you? How did you feel about the process?
Have you ever been asked about whether or not your family relationships and intimate relationships are difficult, if you have troubles, or if you have concerns about whether the relationship is healthy when you are in a health care encounter?	<p>If so, can you tell me about how you felt about that? Did you answer truthfully? Why or why not?</p> <p>Depending on answer, may follow with a direct question about whether they have been screened for intimate partner violence.</p>

transcribed into English. Interviews ranged from 60-105 minutes in length. Reflexivity was necessary during portions of the interviews as some of the women discussed personal suffering, problem relationships, and vulnerabilities in seeking out health care in an unfamiliar system.

Four of the interviews were conducted by native Spanish speakers, both first-generation immigrants. The interview transcripts were sent to two Spanish translators for verbatim translation with each translator working independently. Afterwards the transcripts were reviewed by the original interviewers for accuracy.

Data Analysis

Following the initial read-through of each transcript, the researchers created reflexive notes about the overarching themes of the interviews as well as possible areas of bias. The analytic process started with eclectic coding as an initial, exploratory technique, followed by code mapping (Anfara, 2002). The researchers used eclectic coding initially to identify phenomena in the interviews and compare them to other participants as well as to what is currently understood about Latinas' access to health care.

The second stage of the coding process was code mapping. Anfara (2002) illustrated how initial codes can progress through several iterations of analysis. The first iteration included organizing the codes into a full list of all the codes used and then condensing the codes into central themes. Initial codes identified by the researchers were categorized into clusters of codes that could be linked and become our reduced central themes. The emerging themes were then subjected to theoretical coding, as the data was examined in terms of these new themes, rather than chiefly in descriptive terms.

Although all participants were invited to review the interview transcripts and given the opportunity to provide further comments only one participant chose to examine the transcript and clarify her thoughts with the research team.

As a team of health care and service providers, we recognized ourselves as social beings who bring our own previous experiences to the data analysis and interpretation. These experiences help us better understand the processes of interest but also create an inherent bias. Personal bias of the researchers was explored through journaling and memo writing during the data collection and analysis portions of the study. During analysis, we explored how our health care experience and IPV-related experiences influenced the data analysis.

Results

Seven participants in our study disclosed a history of IPV or current abuse during their interviews and two did not. One who did not report a personal history of abuse had witnessed it in her family of origin.

Our analysis identified several salient themes that represent de facto structural barriers to both care access and abuse disclosure. The overarching theme of “searching for dignity” is indicative of the women’s need to be treated as though they are worthy of honor and respect. The interview narratives describe Latina women’s experiences of care seeking and shed light on this ongoing search for dignity, which can be related to several emergent themes. Four sub-themes were identified which defined the experience that the participants reported while seeking health care and being screened for abuse. The subthemes were *no confianza* (lack of trust), having a voice, being marginalized, and navigating a dysfunctional system.

Searching for Dignity

Latina women's perceptions of being treated with dignity within the health care system was impacted by their belief that they were treated differently because of race or socioeconomic status. This perception contributes to an inherent lack of trust and sense of vulnerability within the health system. The perceived racism was often related to a language barrier or lack of resources to overcome the language barrier. The language barrier or even an assumption of language barrier on the part of health care personnel often intersects with a person's difficulty navigating the health care system, paying bills on time, and understanding directions or printed material. One woman said:

I have found many times that they are racist. They don't give sufficient information to the patient and I always feel they are trying to hurry me every time I go, or something in what is the service is missing. Information is always missing. (102, p. 2)

The same participant later talks about trying to obtain health care without insurance and the belief that she was not receiving the same treatment as others due to her insurance status.

...the service when there is no health insurance is poor. They put you at the bottom of the list and they have always been telling me 'there are services we can give you, but I don't think that you will be able to pay'. And I asked myself 'how do you know that I cannot pay for them?' She did not even tell me what is the service, what is the cost? Only because she has seen my (socioeconomic report), she assumes I would not be able to pay... (102, p. 3)

Women discussed not being able to pay their bills due to the fact that the bills are written in English and they did not understand how or where to pay. This creates a belief that the system is not designed to help them, and their lack of health system literacy leads to a sense of vulnerability among our study participants.

It's hard even with insurance because language barriers, documents sent in English by mail and bills sent in English. They can keep sending but when they go to collection you still don't understand them. You get forms from the doctor in English, how are you supposed to fill them out? (101, p. 1)

When these women encounter barriers in scheduling appointments, or navigating payment systems, and feel treated with disrespect they already have the impression that the health care system is itself abusive. These experiences identify for them that this is an unsafe environment for them to further expose vulnerabilities in their psychosocial life such as intimate partner violence or sexual abuse. These participants' perception of being undervalued is explicated by the four sub-themes no *confianza*, (lack of trust), having a voice, being marginalized, and navigating a dysfunctional system.

No Confianza

Confianza is a Latin American concept that embodies both trust and a sense that both parties in a relationship will look out for each other. When *confianza* is present, there is not only mutual honesty in sharing information but each person feels obligated to bring their best to the relationship. Lack of trust in health care providers and their office staff is a structural barrier to care and full disclosure of information. The issue of no *confianza* is heard throughout the interviews and describes the participants' lack of trust in their health care providers as well as the entire health care system. Their unwillingness to trust the providers is predicated on their perception that office staff and providers do not trust them with complete information. This subtheme, no *confianza*, represents women's impressions of the inability of their health care provider to care for them as individuals. The belief that the provider is just "reading questions from a screen" made them feel like they are just a job to the health care provider" and that the

provider did not “really care about them as a human” (101, p. 5). That sense of not caring made them hesitant to trust and vulnerable due to the perceived lack of empathy. It also contributed to their impression that it was not important to answer sensitive questions honestly as their complaints were not heard or were dismissed.

The participants shared many examples of what they perceived to be lack of caring by the health care workers they came in contact with. Several participants stated that they did not “know” their provider and would not disclose personal details about their history with them. This was particularly noted when they were asked to complete an IPV survey at the beginning of a health care visit. They were surprised to be asked those questions and did not always feel comfortable answering them (104). One participant reported that she did not complete it and “would just try to keep the form under the other papers and if they don't ask [her] to complete it then [she] would just skip it” (101, p. 13). Another reported that “I told them “no” [to all the questions] because it's not a topic you can discuss with the whole world” (103, p. 4).

The failure to promote trust was perceived by most participants. This was reinforced by the sense of being rushed by the health care provider through an overly structured visit. “They don't give sufficient information to the patient and I always felt that they are trying to hurry me every time I go, or something is missing. Information is always missing” (102, p. 1). Another participant believed that there was a lack of transparency stating “if I want to know something... if I want a copy of my xray... I have to ask, they don't show me, they don't speak or offer me a copy. They do just what they need to do” (108, p. 3). Dissatisfaction with the length of the health care visit was a frequent concern. Participants reported that health care providers walked out the door while they still had questions, dismissed questions or complaints, and did not have time to spend with them. “They say, ‘do you have any questions?’ but at the same time they are closing

the conversation. Then, even though you have questions, it is too late” (102, p. 3). The Latina women discussed the need for thorough communication to build trust, and that 10-15 minutes was not enough time during one appointment.

Having a Voice

Difficulty with communication is a major structural barrier. The ability to speak and understand is of utmost importance in a patient – provider relationship. This communication is essential in building trust as well as establishing a healthy and safe environment for the patient. The Latina women in this study all believed that they encountered barriers at one time or another in receiving care because of their cultural heritage and language. Many found that they had difficulty finding a Spanish-speaking practitioner or obtaining an appointment with one. Those who could not secure a Spanish-speaking health care provider or who sought care in an emergency room or clinic encountered communication barriers that negatively impacted their confidence in their providers.

Some who had limited English language skills were offered interpreters for translation but as one participant said “Interpreters are not enough” (103, p. 2). One woman reported that she has “some” English skills, so no interpreter was used; this resulted in her having a poor understanding of what the health care provider told her. The ability to be understood was further complicated by the lack of written Spanish text used for communication. This can be particularly frustrating when trying to read information in the office or sent to the home, interpreting test and radiology results, and taking care of billing issues. Once the provider visit was concluded because no interpreters were available and no one in the office was able to translate. One woman stated that the “interpreter is only there during the consultation – they are not there to help with the bill or the results but I didn’t want to bring my family member to help me” (103, p. 2).

Another stated in her interview that she had “to be paying someone who can translate for me from my own pocket who is of legal age and knows how to speak the language well” (106, p. 3) in order to deal with the health care system outside the exam room.

Participants explained how their communication difficulties both contributed to their own loss of power and control in health care situations, and to how sometimes communication policies and strategies utilized by providers and office staff exerted power and control in ways that discouraged full patient disclosure during their visits.

Being Marginalized

Being marginalized was another subtheme identified as a structural barrier, which included experiences of racism and implied bias as well as the lack of respect from health care providers and staff. One woman, while attempting to register for care at a provider’s office, experienced the feeling of being marginalized, stating “they treat you like you are an invader in this country” (106, p. 5). A second woman said, “I have found many times they are racist” (102, p. 2). A third woman said “I just feel like you know, discriminated... I don’t feel, myself, that they treat you right....You can tell that when they see the Spanish people, you just see the change in the way they feel and treat you” (108, p. 2). In addition to overt racism, one participant noted bias in disparate medical care when she compared her treatment to other non-Latina patients.

I had a co-worker who had the same surgery and she told me how they treat her and how they explained it to her; but for me, I need to ask, ask, if I want to know something I need to ask. If I want a copy of my xray or something, about my knee. I have to ask, they don’t show me, they don’t speak or don’t offer me a copy....No matter who is coming to see them they need to be equal, you know, for everybody. (108, p. 3)

These experiences of being marginalized are critical contributors to these women's perception that their human dignity was not recognized or respected.

Navigating a Dysfunctional Health Care System

Obtaining health care in a dysfunctional system was noted to be a laborious and confusing process for the women. The dysfunctional system described by participants is itself a major structural barrier to care. Multiple factors, such as health care system literacy, the lack of financial transparency, gatekeepers denying access to care, the extensive wait times to both obtain an appointment and while sitting in waiting rooms contribute to the subtheme of navigating a dysfunctional system. The women expressed frustrations at receiving bills in English and for amounts that were higher than the initial quoted cost. Lack of ability to pay for care, or the assumption that patients did not have the resources was a concern for some women. Unfamiliarity with health insurance led another woman to be bewildered when she had a co-payment after visiting her provider.

Understanding how to navigate the health care system itself was difficult for the women in this study. This was most apparent with gatekeepers and/or telephone conversations. One woman related this incident:

“the ultrasound, when the test come back I just get a phone call from a nurse saying “the test is negative.” I say, “what are we testing for?” And she say, “I don't know, the doctor didn't tell me” I say “ can we ask the doctor?” and she say “no way, he's in appointments” (101, p. 4.)

After an Emergency Department (ED) visit, another woman was told to follow-up with her doctor's office for care. She did not get that follow-up because the only access points into the system she was aware of were the ED and her obstetrician/gynecologist's office. Doing as instructed, she called that office for an appointment and was told, “we don't take care of that

problem here”, and the receptionist hung up the phone without directing the woman to another resource for care (103, p. 10).

The timeliness of the health care visit was considered to be another obstacle in navigating the health care system. Women stated that despite having a scheduled appointment, they were frustrated and confused when they had to wait to be seen. One woman stated, “And you have to take time from work, and your boss expects you when you told them what time your appointment was, and you know it is a lot of time to wait” (108, p. 2). Participants identified that their time was not valued in the same way as the health care practitioners or English speaking patients who were apparently seen more quickly.

Still Searching for Dignity

Throughout this study participants described routinely experiencing a number of interconnected barriers to care that illustrated to them that they were not in a safe care environment for disclosing IPV and other sensitive health information. The conditions that create a lack of trust and confidence in their care providers, communication barriers, the experience of being marginalized and the dysfunctional system coalesce in ways that leave these women feeling as though their basic human dignity is not acknowledged. Their care is more disjointed, and they do not disclose sensitive information to care current care providers because they are waiting and searching for a place within the health care system where they feel their common humanity and dignity is recognized and respected. The onus is not on the patient but upon those who comprise the system; health care organizations, administrators and providers, to ensure that patients who are the most vulnerable can trust, communicate and successfully navigate unfamiliar systems in ways that build their confidence in and capacity to utilize the health care system to maximize their health.

Discussion

The study participants all had a basic need and desire to be treated with dignity and respect. When this did not happen, it created a barrier to both health care access and IPV disclosure for these Latinas. Whether they were still seeking a health care provider or choosing to disclose or withhold information about their safety in intimate partner relationships participants reported being assailed rather than supported in their search for health care. Until human dignity is affirmed in these interactions, basic expectations for a therapeutic relationship will not be met, which means our participants will not provide candid answers to IPV screening questions, or report unsafe environments to providers who may be able to provide resources and assist with strategies to help them move towards safety. The basic principle of esteem is found in Maslow's Hierarchy of Need (McLeod, 2020) and includes respect as well as dignity. Dignity is derived from being treated with respect (Zirak et al., 2017) and is an expectation of all client interactions in a health care relationship (Barclay, 2016; Beach, et al., 2017). Barclay (2016) and Beach et al. (2017) both found that individuals reported the perception of being respected and having dignity when their providers engaged with them and were transparent in their interactions. This was reported as missing by the women in our study.

Further, in other studies, Hispanic individuals reported having dignity and respect when their providers were honest, prompt, maintained eye contact, acknowledged family members, did not rush them in their interactions, respected their privacy, and sought to build a trusting relationship (Barclay, 2016; Beach et al., 2017; Bridges et al., 2021; Roncoroni et al. 2021; Williams et al. 2016; Zirak et al., 2017). Unfortunately, the experiences reported by the women in our study did not reflect the efforts of health care providers to provide dignity and respect as suggested in the literature.

Women in our study did not always report their history of or ongoing IPV to their providers. Alvarez and Fedock (2019) found that while Latina women are not more likely to experience IPV, they are less likely to report it. The decision to report abuse and IPV to providers is influenced by the perception of being treated with dignity and respect (Alvarez & Fedock, 2019; Burnett et al., 2016). The perception of a lack of respect and dignity was a factor in the women in our study failing to disclose abuse and traumatic experiences. It is crucial for individuals to believe that they are respected and treated with dignity to provide the safe space to reveal abuse or IPV, but it is also crucial following disclosure (Burnett et al., 2016). Further, the judgmental response from providers and staff can shut down conversations instead of facilitating diagnosis and treatment of Latinx patients (Lightfoot et al., 2019). Hymal et al. (2018) reported that implicit bias and ascertainment bias, defined as, “looking for what one expects to find only in patients where they expect to find it and not in other patients,” (p. 198) obstructed the discovery of trauma and abuse in patients. While providers are aware of the need to build a strong rapport with patients that would provide dignity and respect during interactions, many identified that time constraints and language barriers impacted their ability to do so successfully (Portnoy et al., 2020). Those same barriers reported by providers were noted by the women in our study which caused them to feel disrespected and lacking dignity.

The overarching theme of “searching for dignity” by the women in this study aligns with previous literature. The intersection of four sub-themes contributed to their sense that they had not yet found a health care home in which they were treated with respect and dignity. These subthemes are discussed individually below.

No Confianza

The lack of trust in their health care providers negatively impacted the participants' satisfaction in their care as well as their willingness to disclose what they believed to be personal information. This is not novel to the Latina population. Distrust of health care providers by persons from different racial and ethnic groups and of providers is found in the literature with the level of trust between provider and patient impacting outcomes (Birkhauer et al., 2017; Mouslim et al., 2020). Further, Beach et al. (2017) identified that Caucasian, Black, and Latino patients all equally reported the need to be treated with respect with the perception of being disrespected impacting their ability to build trusting relationships with their providers. Trust was also impacted in our study by the perception of a lack of caring by the provider. This lack of caring was exemplified by providers not being respectful of the participants time, not providing enough time for the participants questions, and dismissive behaviors such as poor eye contact and talking to the computer screen. These same qualities are described in the literature with authors also adding that exposure to unfriendly office staff, being provided with information about their visit, and concerns that the provider is not "hearing" what they are saying decreased the level of trust in Latina patients (Amirehsani et al., 2017; Beach et al., 2017; Choi et al., 2016; Magana, 2020; Vargas Bustamante et al., 2019; Williams et al., 2016).

In this study, the lack of trust further impacted the participants' willingness to disclose sensitive information about IPV. Williams et al. (2016) also identified that for Latina women in their study, the perception of rapport and trust in their provider was essential before disclosing any experiences of IPV. A study by Burnett et al. (2016) not specific to Latina women supported this finding adding that women from rural settings who have been treated with dignity and respect both before and after disclosure of IPV were more likely to be open about their experiences. Unfortunately, few other studies have explored trust as a barrier to sharing

experiences with IPV in rural Latina women in the U.S. A great deal of literature explores the methods used to conduct the IPV screening although studies specific to the Latina population are lacking. There is also much literature that supports the need for a trusting relationship between health care professionals and Latina women to improve patient satisfaction; however, there is a dearth of literature that focuses on the need for a trusting, respectful relationship as a Latina cultural consideration for sharing sensitive information with health care professionals.

Having a Voice

The ability to communicate with the health care provider is crucial for patients, more so for those in unsafe environments. In this study, the perception of not being “heard” by their provider was a common theme. Language is often perceived as a barrier to building trust for Latinx persons (Amirehsani et al., 2017; Choi et al., 2016; Gonzalez et al., 2018; Vargas Bustamante et al., 2019). Latinas from our study were very clear that the breakdown in communication began before they even saw their provider. This same theme is found in other studies with patients having difficulty in making appointments due to the lack of Spanish-speaking office staff as well as the failure of the provider to offer required patient information forms and discharge instructions in Spanish (Calo et al., 2015; Sawin et al., 2017; Steinberg et al., 2016; Topmiller et al., 2017; Torres-Aguilar et al., 2016).

The inability to discuss concerns and respond to questions can be frustrating and depersonalizing (Vargas Bustamante et al., 2019). The women in our study sought out Spanish-speaking providers but few were available and those they located were not taking new patients. Steinberg et al. (2016) also identified that Latinas in their study preferred a Spanish-speaking health care provider but often had to settle with alternative methods of communication. Offices did not always provide interpreters for the women in our study; aside from not being standard of

care, expecting family members to attend visits and interpret is an invasion of the patient's privacy and inhibits their ability to honestly answer sensitive questions. The inability to converse directly with a provider in either case affects a woman's ability to address the questions related to their experience with IPV.

The use of interpreters to aid the health care provider to communicate with their patients is recognized as a convenient alternative to Spanish-speaking health care providers; however, the participants in our study did not always find the practice to be helpful. Several issues are associated with interpreters. As in our study, other researchers learned that the lack of availability of interpreters for many offices was an obstacle to communication with health care providers (Calo et al., 2015; Schminkey et al., 2019; Wilson, et al., 2015). One participant in our study questioned if she would have to pay out of pocket to bring her own interpreter. She did not have to resort to this; however, participants in a study by Steinberg et al. (2016) did. There can also be long wait times associated with the use of interpreters if more than one Latina patient is waiting which further impacts the perception of being heard and building trust with the Latina population (Calo et al., 2015; Cheng et al., 2018; Magana, 2020).

The use of an interpreter can also impact the level of trust between the patient and provider. Women in our study were hesitant to disclose personal information through an interpreter. Allison and Hardin (2020) found that using interpreters could also impact the building of trust between the Latino patient and their provider when social niceties such as small talk, apologies, words of empathy, and humor were not included in the translation. The accuracy of the translation was also questioned by Latina participants in our study; they were unsure if what they were saying was accurately or completely communicated. Other studies have had similar findings (Lightfoot et al., 2019; Steinberg et al., 2016; Vargas Bustamante et al., 2019).

Furthermore, Vargas Bustamante et al. (2019) found that patients perceived that they received incomplete information when using interpreters, negatively impacting adherence to treatment. Steinberg et al. (2016) also identified this, as well as Latinas reporting distrust of interpreters even if they had personally had little or no experience with using an interpreter. If the use of an interpreter is in question by the Latina population, then it is doubtful that they will disclose sensitive details required by the IPV screening. As noted in our study, participants provided safe and negative answers to IPV questions rather than attempting to report IPV through an interpreter. Ultimately, as found by Sawin et al. (2017), a barrier to IPV intervention is impacted by the language barrier between the Latina patient and the provider.

Being Marginalized

Feeling discriminated against was a common theme voiced by the Latinas in our study. This perception of discrimination is reflected in other studies of Latinos as they seek health care in the U.S. (Becerra et al., 2015; Calo et al., 2015; Gonzalez et al., 2018; Schminkey et al., 2019). The perception of being marginalized has potential negative consequences on health outcomes. Calo et al. (2015) suggested that this perceived discrimination leads to reduced levels of health care utilization including a hesitance to seek care and the reluctance to complete treatment when care is eventually obtained. Becerra et al.'s (2015) secondary analysis of over 4,000 surveys of Latinos suggested that participants' perceptions of discrimination in encounters with the health care system led to dissatisfaction with care, instances of delays in care, and reluctance to follow or complete treatment recommendations. Further, Beach et al. (2017) reported that Latinos believe that they received unequal treatment compared to non-Hispanic patients. Amirehsani et al. (2017) and Gonzalez et al. (2018) noted many of the same themes regarding Latino perceptions of discrimination in the health care system, including delays in care

or a failure to seek care altogether. Lightfoot et al. (2019) identified that some Latinos felt judged by their providers. Another study by Wilson et al. (2015) added that feelings of shame and embarrassment were experienced by Latinas reporting IPV. The sense of being discriminated against, judged, or shamed can severely impact a victims willingness to disclose experiences of IPV with their providers. The belief that they were being discriminated against led to similar disruptions in care from the Latinas in our study, impacting the participants' willingness to disclose sensitive information during visits and becoming a barrier to reporting IPV disclosure.

Navigating a Dysfunctional System

Critics across the political spectrum have described the U.S. health care system as dysfunctional (McAneny, 2018; Abendshien, 2019). These critics point to the high cost of care, complex coverage issues, access to care, disparities in care, governmental regulations, care fragmentation, short visit times, and the limited number and geographical availability of primary and specialty care providers (Abendshien, 2019). These issues can be intensified when seeking health care in rural areas. In 2018, then president of the American Medical Association, Barbara McAneny (2018), bluntly stated at a national meeting that the system itself “often gets in the way of actual health care”. The system is even more complex when the person seeking health care has poor English skills and limited knowledge of the health care system.

Complicated payment systems were noted by the Latinas in our study to be a structural barrier. This sentiment was congruent with findings from other research (Becerra et al., 2015). Steinberg et al. (2016) and Topmiller et al. (2017) found the cost of health care to be a significant barrier. Lacking funds to pay for care or being uninsured was another barrier to both seeking or obtaining health care (Lightfoot et al., 2019; Schminkey et al., 2019). Additionally, difficulty understanding and traversing multiple payment structures was found by Leon et al. (2020). Our

study adds that even the perception by health care system employees that you lack funds to pay is itself a barrier to care.

Navigating the office visit itself can result in patient frustration and contribute to negative patient outcomes. Researchers have noted that challenges making appointments, long periods sitting in waiting rooms followed by brief provider visits (Oguz, 2019), awkward information gathering and screening by providers and office staff, lack of translators and insufficiently clear discharge instructions are common complaints voiced by Latino patients (Amirehsani et al., 2017; Calo et al., 2015; Schminkey et al., 2019). Many of these complaints were similarly voiced by our participants. Our study affirms the work of Portnoy et al. (2020) that found these struggles can be impediments to building engaged and honest relationships between patients, providers, and clinic staff that are crucial to providing a space for women to share their experiences with IPV.

Maneuvering through the health care system left many of our participants with a sense of powerlessness and loss of agency. Other researchers (Burnett et al. 2016; Gonzalez et al., 2018; Martinez et al., 2015) also found these beliefs expressed by marginalized patients in health care. Especially when a patient is naive to the health care system they may not recognize the system itself is dysfunctional; their experience of dysfunction can feel personal. Navigating a dysfunctional health care system directly contributes to no confianza; the experience leads to frustration and discouragement, impacting a person's trust in their providers and the health care system and interfering with disclosures that are critical to maximizing the patients' safety and health.

Limitations

Our participants reside in rural Virginia; these findings may not be generalized to Latinas in other rural areas. There could be a selection bias present, in that women who volunteered to be interviewed may have experiences that are fundamentally different from those who did not volunteer. The single interview itself may be considered a limitation. A second interview with participants may possibly have engendered a deeper level of trust, allowing further disclosures. Although member checking was offered to participants to validate the credibility of the results, only one participant chose to review her transcript. This also may have impacted the results. Additionally, the interviews were conducted by four interviewers, which given the nature of the semi-structured interview format, may have led to differently-biased follow-up questions being asked.

Conclusion and Recommendations

This study identifies unique structural barriers to the delivery and receipt of health care for rural Latina immigrants. These barriers help account for the wide discrepancy in reported rates of IPV in the Latina/Hispanic population in the United States. Taken together these findings suggest that the perceived lack of dignity on the part of these Latina immigrants affects their entire health care experience.

There is clearly a need for health care providers/organizations to explore with the communities they serve each other beliefs about appropriate care and understandings of how to access care. A shared agenda of mutual trust and understanding needs to be developed within local care systems to provide dignity in health care. This must include strategies to pull the newest community members in from the margins and coach them on how to navigate the system appropriately. Ten- or fifteen-minute appointments with culturally sensitive providers will not suffice when multiple indignities have been suffered enroute to the exam room. That these

women in our study did not feel comfortable talking about IPV or disclosing their safety status with their providers is a systemic, not an individual level issue. Solutions to these structural issues need to be developed and evaluated on organizational and systems levels. One promising approach is Trauma and Violence Informed Care (TVIC), which is aimed at addressing health inequities and structural violence such as that experienced by the women in this study. TVIC shows promising results improving trust and encouraging disclosures of violence when caring for women in indigenous communities (Cullen, et al., 2022). Health care systems providing care for immigrant communities should consider implementing equity-oriented approaches such as TVIC, to help identify feasible approaches to improve access and trust for first generation immigrants in need of health care. Despite multiple failures during continued interactions with the health care system, the Latina women in our study, and perhaps in other communities, continue to hope that their search for dignity and understanding will one day be fulfilled. Health care providers must be willing to examine individual and systemic assumptions and practices from initial contact through ongoing case management through a more equity-oriented lens to form partnerships that will provide this population with more satisfying and comprehensive care.

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