Understanding Health-seeking Decision-making Process and Behavior Among Haitian Immigrants: A Grounded Theory Approach

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UNDERSTANDING HEALTH-SEEKING DECISION-MAKING PROCESS AND BEHAVIOR AMONG HAITIAN IMMIGRANTS: A GROUNDED THEORY APPROACH

by

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ABSTRACT

Black people in the U.S. die at younger ages, have significantly higher rates of death from treatable medical conditions, are more likely to have late-stage breast and colon cancer diagnoses and more likely to die from these cancers, and are at higher risk for chronic illnesses compared to other racial and ethnic groups. Accessing healthcare is crucial to health and well-being; however, U.S. immigrants’ use of healthcare services is far less than native-born Americans. Haitian immigrants experience health disparities at the highest rate compared to other Black immigrants in the U.S. Given their unique history, culture, and immigration experience, it is necessary to understand the health-seeking decision-making process and behaviors among Haitian immigrants. This study thus explored the following research question: How do Haitian immigrants make decisions about their health-seeking behavior? In response, this qualitative study used the Grounded Theory approach, collecting data through semi-structured interviews and a focus group with adult Haitian immigrants living in Central Florida. This led to the development of a theoretical model which shows that Haitian immigrants engage in the following process: 1. Self-Diagnosing, 2. Self-Treating: Informal Health-seeking, 3. Self-Monitoring, 4. Considering Formal Health-seeking, and 5. Seeking Medical Services: Formal Health-seeking. The model also demonstrates how barriers impede the steps towards formal health-seeking; however, Haitian immigrants can bypass these barriers under specific conditions. Understanding this phenomenon of health-seeking decision-making has implications for culturally-appropriate interventions and healthcare and housing policies to address health disparities and promote well-being among Haitian immigrants.

Keywords: Haitian immigrants, health-seeking, health behavior, illness behavior, decision-making
This dissertation is dedicated to my entire family. Thank you for your prayers, for being my cheerleaders, and for lifting me up with words of encouragement. This one is for ALL of us!
Cadet and Alexis Strong!
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LIST OF ACRONYMS/ABBREVIATIONS

HSDM: Health-seeking decision-making

IRB: Institutional Review Board
CHAPTER ONE: INTRODUCTION

It is well known that health disparities exist among racial/ethnic groups in the United States. Among the racial/ethnic groups in the U.S., Black people in the U.S. die at younger ages compared to Hispanics and non-Hispanic Whites (Arias et al., 2021; Baumgartner et al., 2021) and have significantly higher rates of death from treatable medical conditions compared to American Indian Alaskan Natives (AIAN), Asian American/Native Hawaiian/Pacific Islanders (AANHPI), Hispanics, and non-Hispanic Whites (Baumgartner et al., 2021; Radley et al., 2021; The Commonwealth Fund, n.d.). Black people in the U.S. are also more likely to have late-stage breast and colon cancer diagnoses and more likely to die from these cancers compared to Hispanics and non-Hispanic Whites (Baumgartner et al., 2021; Radley et al., 2021). In addition, Black people in the U.S. are at higher risk for chronic illnesses compared to Hispanics, and non-Hispanic Whites (Baumgartner et al., 2021; Radley et al., 2021). It is also well known that factors contributing to the negative health outcomes for Black people include racism, poverty, affordability and healthcare access, and suboptimal care (Radley et al., 2021).

In addition to the racial/ethnic disparities in the overall U.S. population, studies show that although immigrants in the U.S. are often in better health than native-born persons in terms of higher life expectancy, lower rates of disability, and better overall perinatal and adult health (Singh & Miller, 2004), this health benefit diminishes over time (Acevedo-Garcia & Bates, 2007; Hamilton & Hummer, 2011; Singh & Miller, 2004). This phenomenon of immigrants being in better health than the native-born population is called the Healthy Immigrant Effect (Acevedo-Garcia et al., 2010; Anetecol & Bedard, 2006; Cho et al., 2004; Jasso et al., 2004; Singh & Miller, 2004). There are various reasons for this phenomenon provided in the literature. For
example, researchers indicate that this phenomenon can occur because of immigrants already being in better general health compared to the native-born population and those who remained in their home country prior to their arrival to the U.S.; immigrants’ health-enhancing behaviors such as decreased rates for drinking, smoking, and obesity, and having a better diet; and immigrants having greater social support compared to the native-born population (Acevedo-Garcia & Bates, 2007; Acevedo-Garcia et al., 2010; Hamilton & Hummer, 2011; Lucas et al., 2003; Singh & Miller, 2004). Unfortunately, this health advantage is not sustained, especially among Black Caribbean immigrants. Post migration, immigrants’ healthier status begins to diminish and mirror that of the native-born population (Acevedo-Garcia et al., 2010; Anetecol & Bedard, 2006; Griffith et al., 2011). This diminishing health can occur due to acculturation where immigrants adopt the health behaviors of the host country’s population, and downward assimilation (especially for racially/ethnically minoritized immigrants) based on experiences with blocked social mobility and discrimination (Acevedo-Garcia & Bates, 2007; Acevedo-Garcia et al., 2010). This is especially concerning for Haitian immigrants who are at the intersection of multiple marginalized identities/social statuses—being Black, immigrant, and Haitian. In addition, the decline in health with longer duration living in the U.S. and generational decline in health have been found to be significant among Black Caribbean immigrants (Griffith et al., 2011; Hamilton & Hummer, 2011).

It can also be argued that one reason for the post-migration health decline of U.S. immigrants is their lower access to and lower use of healthcare services compared to native-born Americans (Derose et al., 2009; Ku, 2009; Lucas et al., 2003; Pandey & Kagotho, 2010; Xu & Borders, 2008). Haitian immigrants are often excluded from studies that focus on Black immigrants (Etienne, 2020). Haitian immigrants are the second largest immigrant population in
U.S. (Anderson, 2015; Tamir, 2022). Their share of the burden of health disparities is greater than other Black immigrants, specifically diseases such as cancer, diabetes, and hypertension (Allen et al., 2013; Sanon et al., 2014). Health disparities within the Haitian immigrant population may be caused by numerous factors, including their history of discrimination and cultural beliefs about illness and the healthcare system, among others. For example, Haitian immigrants believe knowledge about a diagnosis will lead to early death and they prefer seeking health advice and treatment from their community (especially family and religious leaders), have a lack of trust in the healthcare system’s motives, have a disfavor of taking medications daily, and have a fear of a lack of privacy within the healthcare setting (Allen et al., 2013).

Accessing healthcare is crucial to health and well-being, and thus the unique history and experiences of Haitian immigrants makes it necessary to seek an understanding of the health decisions and behavior amongst this population on its own. Pardo et al. (2021) advocates for understanding the distinctiveness of communities, as they are critical to understand the barriers that are unique to them and to enable the creation and execution of effective interventions. In addition, the unique culture and history of community enclaves contribute to their social determinants of health (Pardo et al., 2021). Gaining this understanding enables the development of interventions that are not only culturally sensitive, but also effective in addressing the unique health needs and challenges of these communities, such as Haitian immigrants in the United States.

**Problem Statement**

Previous studies have examined factors related to health behavior among immigrants. However, there is a gap in knowledge regarding the decision-making process for health-seeking behavior from the unique cultural perspectives of immigrant groups, specifically Haitian
immigrants. This study aids in increasing knowledge of a minoritized and marginalized population, Haitian immigrants, who experiences greater health disparities than many other racial/ethnic groups in the United States.

**Significance of the Study**

Understanding the health-seeking decision-making process and behavior among Haitian immigrants has significant implications for health promotional interventions that target Haitian immigrants. This study aims to inform community-based and practice-based interventions that seek to reduce/eliminate health disparities and address the health concerns for this specific population. It aligns with and contributes to the social work profession, sociology, medicine, nursing, and public health. Three of the core values and ethical principles of the social work profession are: 1. Service, addressing social problems; 2. Social justice, by promoting knowledge about cultural and ethnic diversity; and 3. Dignity and worth of the person, enhancing their capacity for change and their ability to meet their own demands (National Association of Social Workers, 2017). This study reflects these core values through the ethical principles and actions of addressing the social problem of health disparities (service) by increasing knowledge about Haitian immigrants (social justice), and therefore leading to opportunities for action that enhance Haitian immigrants’ capacity and opportunities to address their own health goals (dignity and worth of the person). Thus, the goal of this study is not to change the processes and behaviors of Haitian immigrants, but to comprehensively grasp and establish a foundation of knowledge for culturally tailored approaches that enhance the decision-making process in ways that collaboratively meet the health goals of Haitian immigrants.
Study Overview

Research Question

This study explores the following research question: How do Haitian immigrants make decisions about their health-seeking behavior? Through the exploration of this research question, the researcher seeks to understand how Haitian immigrants come to decide on engaging in health-seeking behaviors. This includes, but is not limited to, the thought processes, influences, resources, supports, challenges, and barriers that may be involved in the experience of health-seeking to address a health concern. In addition, the researcher seeks to explore the informal and formal health-seeking behaviors among Haitian immigrants.

Study Approach

A qualitative research approach was used to understand the process of health-seeking decision-making and behavior among Haitian immigrants and to develop a theory that demonstrates this process. Based on the goal of theory development, this study utilized the constructivist grounded theory approach to collect and analyze the data (Charmaz, 2014). Grounded theory allows researchers to explore the antecedents and components of little-known phenomena, thus allowing for the exploration of processes (Strauss & Corbin, 1998). Data was collected through semi-structured, one-on-one interviews and a focus group, and was analyzed using three levels of coding: Initial, focused, and theoretical coding. Initial coding is where segments of the data are inductively labeled using gerunds (Birks & Mills, 2015; Charmaz, 2014; Saldaña, 2013). Next, focused coding occurs by categorizing the initial codes into abstract concepts (Charmaz, 2014; Chun Tie et al., 2019; Saldaña, 2013). Finally, theoretical coding occurs by integrating and synthesizing the categories into the theory (Birks & Mills, 2015; Charmaz, 2014; Saldaña, 2013).
CHAPTER TWO: LITERATURE REVIEW

History and Background

It has been noted that studies in the U.S. often combine all Black people into one group (Adebayo, 2020; Allen et al, 2013; Beattie et al., 2021; Cone et al., 2014; Sanon et al., 2014), which overlooks the complexities within this diverse racial group (Beattie et al., 2021; Constance-Huggins, 2021; Kratz, 2018; Sanon et al., 2014). Black people are a heterogenous racial group with varying cultures and experiences. Black people in the U.S. include native-born Blacks as well as immigrants. As with combining all Black people into one group, doing so with Black immigrants also does not consider the differences among this subgroup, including their languages, history, cultures, and pre and post migration experiences. For example, although the Caribbean is the birthplace of the largest groups of Black immigrants (Tamir, 2022), they vary in culture and history. In the U.S., Jamaica and Haiti are the top two countries of origin for Black immigrants (Tamir, 2022), and Haitian immigrants are a prime example of a unique history, culture, and immigration experience that is important to understand as it relates to health-seeking.

Haitian Immigrants

Haitian immigrants are the second largest Black immigrant group in the U.S., and they account for 15% of the Black immigrant population (Anderson, 2015; Tamir, 2022). Haitians increasingly immigrated to the U.S. in the 1960s after a change in the U.S. immigration policy (Anderson, 2015), and since the mid-1900s, Haitians immigrated to the U.S. due to economic crises, natural disasters, persecution, governmental collapse, and political instability (Dain & Batalova, 2023). For example, in 1980, about 25,000 Haitians fled their country due to poverty
and the traumatic dictatorship of Duvalier where they witnessed acts of violence and persecution (Desilver, 2014; Green et al., 2018). Haiti continues to be deemed the most impoverished nation in the Western world (Lopez, 2018), and this has an impact on the social status of immigrants from their country.

The U.S. is the top destination where Haitian immigrants have migrated, and Florida has the largest concentration of Haitian immigrants, reaching 49% (Dain & Batalova, 2023). Upon realizing the possibility of migrating to the U.S. by sea in a simple boat, Florida became an attractive destination for Haitians emigrating away from Haiti (Boswell, 1983). Given its proximity to Haiti, it is not surprising that Florida is the state with the highest concentration of Haitian immigrants. The largest Haitian immigrant community (over 30% of its population) resides in the Miami metropolitan area (Anderson, 2015; Dain & Batalova, 2023). The East Central Florida (e.g., Orlando) and West Central Florida (Tampa Bay) metropolitan areas are the second and third largest regions in Florida with Haitian immigrants, respectively (Dain & Batalova, 2023).

**Identity**

Cone et al. (2014) define identity as “an individual process of assimilating cultural ideas and then presenting and representing those ideas as part of oneself in a given context” (p. 267). Haitians have developed a unique ethnicity by way of post-independence traditions that other Caribbean groups do not share, and they are united through their language, ethnicity, and culture (Cone et al., 2014). Unfortunately, Haitian identity conflicts are negatively impacted post-migration due to their status as immigrants, as well as the lack of understanding among native-born Americans regarding Haitian culture and history, making Haitians initially difficult to differentiate from African Americans (Cone et al., 2014).
During the process of racial socialization, Haitian immigrant parents seek to cultivate an identity within their children that is immersed in history and culture, and they convey messages about race that is within the Haitian framework and with the goal of cultivating an identity that is not embedded in what it means to be Black in the U.S. (Duchatelier-Jeudy, 2015; Etienne, 2022). However, the act of bridging the connection of Haitian ethnic culture to their children is not to separate their children from African Americans, but “to offer an alternative sense of blackness” (Etienne, 2022, p. 882). On the other hand, Haitian immigrants can become insulted if they are mistaken as African Americans (Potocky-Tripodi et al., 2007). Haitians use the term “American” to not only refer to African Americans, but also to describe Haitians who they deem to have lost their culture by adopting the attitudes and behaviors that demonstrate a stronger connection to the U.S. instead of a stronger connection to Haiti (Etienne, 2020). Therefore, it is important to differentiate between the identities held by Haitian immigrants as Haitian, Haitian American, and American.

**Language and Culture**

The primary language in Haiti is Kreyol, a significant difference compared to other Black immigrants from the Caribbean- where English is commonly spoken (Anderson, 2015). Unfortunately, there is a dearth of healthcare providers with linguistic diversity (Allen et al, 2013; Potocky-Tripodi et al., 2007), and studies have found that healthcare providers lack in meeting the needs of patients with language barriers to provide linguistically appropriate service access (Diamond et al., 2010; Kale & Syed, 2010). Specifically, in a study with 135 hospitals throughout the U.S., Diamond et al. (2010) found that only 13% of hospitals met all standards for linguistically appropriate services in terms of providing interpreter services, patients being informed of their rights to language services, the competence of the interpreters, and written
materials provided in other languages. They also found that 19% of the hospitals met none of these standards (Diamond et al., 2010). This has significant implications for Haitian immigrants with limited English proficiency as they seek medical services, underscoring the ongoing need to pursue efforts to improve linguistically appropriate services in the healthcare setting.

Haitians highly value a sense of community. For example, in the Haitian community of West Palm Beach, FL, Potocky-Tripodi et al. (2007) found that the Haitian immigrant community formed cooperatives in which they shared a fund-pool to purchase homes, cars, and clothes. Haitians also deeply value education and racial equality, with racial equity being a value that has been fundamental to the culture since the movement towards independence (Cone et al., 2014).

Another strongly held value among Haitians is their religious belief systems. The heterogeneous religious experience of Haitians is both complex and ambivalent, and there are three major religious practices: Catholicism and Protestantism (the main branches of Haitian Christianity), and Vodou (Joseph, 2016). Christianity is a crucial element of the Haitian religious experience, with Catholicism being acknowledged as the state religion in several of Haiti’s constitutions and becoming Haiti’s official religion in 1860 (Joseph, 2016). Haitian vodou is an African spirituality-based religious tradition that is a present and powerful force in Haitian people’s identities (Martin, 2012; Nobles, 2015). This religious system’s worldview postulates that people see themselves being “nested and impacted by a larger spiritual and psychosocial context” (Auguste & Rasmussen, 2019, p. 1).

**History of Discrimination**

Haitian immigrants have historically experienced greater discrimination compared to other Black Caribbean immigrants, as evidence by immigration laws (Lennox, 1993; Little,
Aranda (2017) notes that Haitian immigrants are positioned in an ethno-racial hierarchy where they are both outside and below African Americans because of unfavorable immigration policies, poor reception into the U.S., and governmental practices that portray Haiti as being “poor and diseased” (p. 2234).

When Haitian migrate to the U.S., they are surprised when they experience practices that are racially discriminatory (Cone et al., 2014). For example, disease-specific programs targeting Haitians were for illnesses that are highly stigmatized (e.g., HIV/AIDS and tuberculosis), and therefore, disease-specific programs are not received well (Allen et al, 2013). Even in the education system, Haitians are “perceived to lack the social and cultural capital necessary to enact a good student identity” (Cone et al., 2014, p.271) These historical factors reflect the lower social status of Haitian immigrants that Cone et al. (2014) mentions, and they can significantly impact the health-seeking decisions and behaviors of Haitian immigrants post migration.

Health Beliefs and Attitudes

Some Haitians believe that illness is the cause of supernatural phenomena and that one’s physical health reflects their spiritual health (Allen et al, 2013; Potocky-Tripodi et al., 2007; Colin, 2021), and once a diagnosis becomes known, they will die sooner (Allen et al, 2013). Haitians also believe that their diet, natural remedies, and religious practices provide for their need of healing (Potocky-Tripodi et al., 2007; Sanon et al., 2014). As it relates to the U.S. healthcare system, Haitian immigrants have beliefs and attitudes that impact health-seeking. Allen et al. (2013) sheds light on a number of these beliefs and attitudes as their study found that based on negative experience with treatments that were advertised as free but later were charged for a fee, there is a mistrust of free healthcare, and Haitians therefore believe that “health
providers are driven by ‘hidden motives and reasons’” (p. 110). Contrast to this finding, Joseph et al. (2012) found that 80% of Haitian parents and guardians in their study regarding vaccination expressed a high level of trust in their providers. There is also a belief among Haitian immigrants that there are inadequate privacy standards for administrative staff, such that there is a fear to go to the clinic as they may see someone they know (Allen et al., 2013). Also, Haitians believe taking medication daily is unfavorable as taking too much is harmful to their health, and thus, some may only take partial doses, skip doses intentionally, or prefer their herbal remedies (Allen et al., 2013; Sanon et al., 2014).

**Health Disparities**

Haitian immigrants are lagging behind other racial, ethnic, and immigrant groups as it relates to health (Cyrus et al., 2016; Green et al., 2018; Jean-Louis & Webb, 2021). Experiences during pre-migration affect the health status of Haitian immigrants and their health outcomes post-migration (Green et al., 2018). Haitian immigrants experience chronic illnesses at disproportionate rates. For example, Haitian men are one of two groups (the other being African Americans) with disproportionately high rates of colorectal and prostate cancer diagnoses and mortality (American Cancer Society, 2019; Jean-Louis & Webb, 2021; Pinheiro et al., 2016; St-Hilaire, 2019). Although morbidity and mortality for prostate cancer are high among Haitian men, they continue to have low participation in cancer screenings (Hill et al., 2017; Louis, 2019; Kleier, 2009; Pedersen et al., 2012). Hypertension is one of the chief chronic illnesses among Haitian immigrants (Sanon et al., 2014), and Allen et al. (2013) found that key informants in the Haitian community of Boston, MA were highly concerned about chronic illnesses (cancer, diabetes, and hypertension) within their community.
For health advise and treatment, Haitians are more likely to rely on their family members, friends, and faith-based leaders, and seeking a Western healthcare provider is a last resort after experiencing health issues that they cannot resolve anywhere else (Allen et al, 2013; Colin, 2021). Delayed medical attention can potentially lead to negative outcomes for Haitian patients (Colin, 2021). Thus, delayed medical attention may increase the burden of chronic and terminal illness in the Haitian community. Health disparities in the Haitian immigrant population may also be a cause of the lack of follow through with treatment recommendations for fear that Western treatment practice of taking daily doses of medication is harmful and an avoidance of healthcare facilities for fear of a lack of privacy (Allen et al, 2013; Sanon et al., 2014), factors previously noted.

Immigrant Health-seeking Behavior

There are several factors affecting the health-seeking behaviors of Haitian immigrants and their access to care (Potocky-Tripodi et al., 2007; Colin, 2021). Studies that have examined the health-seeking behaviors of immigrants include factors that are barriers to accessing healthcare services, such as health beliefs (Amin & Perez, 2012; Higginbottom et al., 2016; Hulme et al., 2016), fear of immigration issues (Crocker, 2021; Tefera, 2024), language barriers (Amin & Perez, 2012; Crocker, 2021; Dastjerdi et al., 2012; George et al., 2014; Gulati et al., 2012; Harrington et al., 2013; Hulme et al., 2016; Lee et al., 2014; Lum et al., 2016; Marshall et al., 2010; Ngwakongnwi et al., 2012; Pollock et al., 2012; Tefera, 2024; Woodgate et al., 2017), financial barriers (Crocker, 2021; Tefera, 2024), lack of transportation (Crocker, 2021), social networks/social support (Amin & Perez, 2012; Higginbottom et al., 2016; Hulme et al., 2016; Lee et al., 2014; Wang & Kwak, 2015; Woodgate et al., 2017), treatment practices (Crocker, 2021; Ou et al., 2017), and treatment preferences (Lum et al., 2016). What is still unknown is the
decision-making process as it relates to health-seeking behavior and the factors that are involved within this process, especially among Haitian immigrants.

Research on immigrant health-seeking behavior typically focuses on Asian and Hispanic populations (Crocker, 2021; Hulme et al., 2016; Gulati et al., 2012; Legowski et al., 2022; Lee et al., 2014; Marshall et al., 2010; Ou et al., 2017; Poss, 2001; Seo et al., 2016; Wang & Kwak, 2015); though there are recent studies that have focused on health disparities and health behavior among the Haitian immigrant population (Baeker Bispo et al., 2022; Allen et al, 2013; Joseph et al., 2012; Montfleury, 2022; Romelus et al., 2024; Sanon et al., 2014). Exploring health-seeking decisions and behaviors among Haitian immigrants is necessary to address health disparities that disproportionately affect this minoritized population. Such explorations can aid in identifying unique and/or additional barriers to health care access and use that have not been previously understood, whether they are structural or at the individual level. This can lead to future culturally relevant and culturally appropriate interventions and improved long-term health outcomes for Haitian immigrants.

Theoretical Perspectives

According to the Grounded Theory approach, the data gathered from this study will provide the foundation for the developing theory that will emerge, and its analysis will generate the constructed concepts (Charmaz, 2014). However, while this study aims to construct a theory employing a grounded theory approach to delve deeper into the research topic, there are several theories that provide context for this study very broadly as it relates to understanding the phenomenon of the health-seeking decision-making process within a specific racial/ethnic group. These theories include Symbolic Interaction Theory (Mead, 1934; Blumer, 1969), Social Construction Theory (Berger & Luckmann, 1967), Health Belief Model (Rosenstock, 1966),
Theory of Planned Behavior (Ajzen, 1985), Social Cognitive Theory (Bandura, 1986), and Social Network Theory (Barnes, 1954). The concepts of interest derived from the latter four these theories are ideas being explored based on prior exposure to the literature. They provide a starting point for inquiry in this study, but they are not the end point; they provide a guide, but they will not command the study (Charmaz, 2014). As Charmaz (2014) states, researchers must be willing to dispense of sensitizing concepts if they prove to be irrelevant.

As the data for this study is collected, a deeper dive into prior literature will take place to further understand the process of health-seeking decision-making among Haitian immigrants, leading to the construction of a theory that demonstrates this phenomenon. Thus, while it is anticipated that additional theories and perspectives may emerge as being relevant to this study, based on the grounded theory approach of delaying a literature review for the purpose of avoiding the imposition of preconceived notions onto the theory that will emerge (Charmaz, 2004, 2014), no literature review on topics and theories that are new to the researcher and/or previously unexplored will be investigated prior to data collection.

**Symbolic Interaction Theory**

Symbolic interaction theory has its origins in American pragmatism and is one “of the three leading micro-level theories in medical sociology” (Cockerham, 2020, p. 117). In the agency vs structure interface, agency is defined as an individual’s ability to choose their behavior and social structure being where consistencies in social interactions, systematic social relationships, and available resources are produced (Cockerham, 2020). Agency is emphasized in these micro-level theories, based on the perspective that society is developed by people constructing social structures through repetitive methods of social interaction (Cockerham, 2020). According to symbolic interaction theory, behavior is directed by self and is based on
communicated, manipulated, and shared symbolic meanings through social interaction (Denzin, 2017). When someone makes decisions about how to behave, they often think about the importance of others in their community, social group, or country—called the generalized other—and this influences their choices (Cockerham, 2020; Mead, 1934).

Symbolic interaction theory focuses on understanding individual consciousness, self-conversation, self-concept, self-definition of social situations, and behavior merged into collective expression (Blumer, 1969; Cockerham, 2020; Dennis et al., 2013; Denzin, 2017); and the theory does in fact acknowledge structure as individuals are preceded and constrained by society as well as society’s institutions (Charmaz & Belgrave, 2013). The greatest strength of symbolic interaction theory is its explanation of how an individual’s self-concept evolves through social experiences and comes to an understanding of the views of others and society, conveyed by significant others (socialization) and an awareness of the other (Cockerham, 2020). Primary and secondary socialization are emphasized as being where the awareness of self, other, and agency emerge (Cockerham, 2020; Mead, 1934). Primary socialization occurs through childhood experiences with others who provide a sense of identity and self-concept, followed by secondary socialization that occurs in adulthood after one enters into society with new roles and positions (Cockerham, 2020). One of the important concepts is the looking glass where self-concept emerges through social interactions in which people see themselves reflected in others (Cooley, [1902] 1962), and the reactions of others is the basis of one’s self-perception as a social object (Cockerham, 2020). This theory helps in discussing how an individual is socialized through their racial/ethnic group, as their social interaction with others include shared meanings. These shared meanings can include beliefs, attitudes, and values associated with various health and illness behaviors, including health-seeking behavior.
Several studies on primary socialization in health behavior have consistently found that health-related lifestyles such as physical activity, diet, sleep, alcohol use, smoking, and use of healthcare services are learned and adopted during childhood due to factors such as socioeconomic status (e.g., parents’ education and income), experiences such as food insecurity, parenting practices, school-level characteristics, and peers’ health lifestyles, and these health-related lifestyles continue into adulthood (Cockerham, 2020; Lee et al., 2018; Mize, 2017; Mollborn & Lawrence, 2018; Mollborn et al., 2014). According to Cockerham (2020), symbolic interactionism links micro to macro levels of behavior based on the concept of the generalized other, which represents the structural influence in individuals’ thoughts and decision-making. However, there is a gap in the literature regarding how racial/ethnic culture can serve as the social structure for socialization that influences the health behaviors of individuals from the specific cultural group. This study explored this cultural component in health-seeking decision-making and behavior.

**Social Construction Theory**

Social construction theory, another leading micro-level theory in the field of medical sociology, is centered on the idea that people’s interaction with one another socially constructs reality, thus defining the way they view the world and knowledge production about the world (Cockerham, 2020). Based on social construction theory, knowledge is formed through repetitive social actions, behaviors, and roles that become patterns, and this knowledge becomes reaffirmed and institutionalized overtime as an objective reality that is passed on generationally (Berger & Luckmann, 1967; Cockerham, 2020). Social construction complements symbolic interaction in that it begins with agency and social interaction, particularly socialization. This includes socialization through factors such as culture. According to Freund et al. (2003), culture, which is
defined as “the beliefs, values, practices, and material objects shared by a people” (p. 4), shapes what one eats, how one experiences stress, health behavior such as drinking alcohol, and one’s feelings about their body.

According to Gabe et al. (2004), social construction in medical sociology has “the view that scientific knowledge and biological discourses about the body, health, and illness are produced through subjective, historically determined human interests, and are subject to being change and reinterpretation” (p. 130). According to Cockerham (2020), based on this perspective, even the meaning of and beliefs about illness are socially constructed, and thus, a person’s illness, as defined by them, leads to illness behavior that is socially appropriate. This behavior includes what one does to get healing from their illness- health-seeking. This theory helps in discussing how the appropriateness of illness behaviors can become institutionalized over time based on knowledge that has been passed down, and engagement in or avoidance of certain behaviors can become a characteristic of culture, including the culture of a specific racial/ethnic group. The appropriateness of illness behavior can extend to the health-seeking decision-making process and behaviors of individuals who identify with a specific cultural group. It is expected that the findings from this exploratory study will reveal cultural perspectives about what is considered normalized (i.e., appropriate) health/illness behavior in terms of health-seeking, and how that plays a role in the decision-making process to address illness.

**Health Belief Model**

Psychologists Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegeles, and Howard Leventhal developed this model in the 1950s to explain health behavior and to predict it (Louis, 2019; Rosenstock, 1966; Rosenstock, 1974). The Health Belief Model posits that
people’s behavior change for disease prevention if they: 1. See themselves to be susceptible to a condition or disease, 2. Believe the condition or disease has serious consequences, 3. Feel the threat of the condition or disease, 4. Feel that it is beneficial to engage in specific behaviors to reduce their susceptibility to the disease and/or to reduce the disease’s severity, and 5. Believe that the benefits of behavior change outweigh the costs or the barriers (Rosenstock, 1966; Rosenstock, 1990; Scarinci et al., 2012). The variables in the Health Belief Model draws from and is adapted from socio-psychological variables that explain preventative health behavior, and it analyzes the motivation to act at the individual level for goal attainment (Maiman & Becker, 1974; Rosenstock, 1966). According to Rosenstock (1966), “the variables deal with the subjective world of the behaving individual and not with the objective world of the physician…” (p. 5). While Rosenstock acknowledges a relationship between these subjective and objectives worlds, he indicates that the model focuses on linking the individual’s subjective state and their current health behavior (Rosenstock, 1966).

The Health Belief Model has been used as a framework for health behavior within the Haitian population. Louis (2019) used the constructs from the Health Belief Model as a guide to predict intentions for prostate cancer screening among Haitian men living in Haiti. Louis noted that prior literature indicated that barriers to screening for prostate cancer among Afro-Caribbean men include the fear of having cancer, feeling embarrassed about the digital rectal exam, having a mistrust of the healthcare system (Cobran et al., 2014; Consedine et al., 2007; Kleier, 2010; McCree-Hale et al., 2012; Ng et al., 2013). In his study, the results demonstrated that perceived susceptibility to prostate cancer and the perceived benefits of screening for it significantly predicted Haitian men’s intentions to be screened (Louis, 2019).
The Health Belief Model helps to guide this study in that beliefs about health significantly influences the intentions of a behavior. However, the model is predictive in nature and focuses on the intentions. Thus, the model has limitations in terms of actual behavior, such as following through with seeking healthcare services. As stated by Louis (2019), while the findings of the study showed consistency with the tenets of the Health Belief Model, it did not match with previous literature regarding low rates of prostate cancer screenings among Haitian men. In addition, the model does not account for the thought processes and behaviors involved in health behavior, including health-seeking. The current study seeks to explore these nuances within the health-seeking process, as well as actual health-seeking behavior.

Theory of Planned Behavior

The Theory of Planned Behavior was developed by Icek Ajzen, and the purpose was to extend a previous theory- the Theory of Reasoned Action- to explain and predict behavior within specific contexts (Ajzen, 1985, 1991). The Theory of Reasoned Action describes the associations between beliefs; attitudes, norms, and perceptions; intended behavior; and the behavior itself (Montano & Kasprzyk, 2008; Poss, 2001). The Theory of Reasoned Action theorizes that beliefs impact intended behavior, which then determines behavioral outcomes (Poss, 2001). This includes beliefs about behavioral outcomes, which then leads to attitudes about the behaviors, and normative beliefs, which involves codes of behavior that is customary within a group (including the context of culture) and leading to one’s subjective beliefs (Montano & Kasprzyk, 2008, p. 71; LaMorte, 2019). These attitudes and subjective beliefs then lead to behavioral intentions, which determines the behavior itself (Poss, 2001). The Theory of Planned Behavior adds to this with the concept of perceived control, which is a person’s beliefs about their ability to do the intended behavior- a concept drawn from the self-efficacy of Bandura’s prior work and
his Social Cognitive Theory (Ajzen, 1985, 1988; Montano & Kasprzyk, 2008; Taylor et al., 2006).

These Theory of Planned Behavior has been used as a theoretical framework in health-related studies regarding help-seeking for medical care (as is the focus of this study), psychological interventions, and adherence to healthcare treatment among minoritized groups, particularly Black Americans, Black Canadians, and Latinos (Cabassa and Zayas, 2007; Rogers, 2010; Taylor and Kuo, 2020; Vissman et al., 2011). For example, in a study with an immigrant population, Rogers (2010) used the Theory of Planned Behavior as a guide to understand the health beliefs and health-seeking behavior among Mexican and Mexican American older adults living in the U.S. The results of their mixed-method study found that in terms of behavioral, normative, and control beliefs, participants believed there are advantages and disadvantages to both traditional and Western healthcare, both traditional and Western healthcare were approved in their communities (none of these approaches were disapproved), and traditional healthcare was more accessible and affordable than conventional healthcare (Rogers, 2010).

According to Rogers (2010), the Theory of Planned Behavior places an emphasis on “the importance of beliefs about healthcare-seeking behaviors, which is an important step to understanding the complex interplay between cultural and individual factors that influence people’s care-seeking behaviors” (p. 583). This aligns with the goal of the current study, which seeks to understand the cultural factors that influence Haitian immigrants’ decision-making processes as it relates to health-seeking. This study provided the opportunity to highlight a culture that is often overlooked in research.
Social Cognitive Theory

Social Cognitive Theory, which began as Social Learning Theory, was created by Albert Bandura (Bandura, 1986). In Social Learning Theory, people learn within social contexts (Bandura & Adams, 1977). Social Cognitive Theory then emphasizes social influences, and reinforcements that are both internal and external (LaMorte, 2019). Social Cognitive Theory includes the concepts of observational learning, which is learning that takes place through modeling; outcome expectations, which are beliefs regarding the value the outcome; and self-efficacy, which is the individual’s confidence in their ability to perform the behavior (LaMorte, 2019; McAlister et al., 2008). Bandura applied his theory for health promotion and prevention of disease, where he emphasized knowledge of risks and benefits, perceived self-efficacy over an individual’s own health habits, outcome expectations regarding the costs and benefits of health habits, goals and the plans and strategies to realize them, and structural impediments as the core determinants of health behavior (Bandura, 2004).

Health research have used Social Cognitive Theory as a framework for studying health-related behavior (Bandura, 2004; Cortés et al., 2013; Janicke & Finney, 2003; Kocken et al., 2015; Stacey et al., 2016). Of particular interest related to this study based on a focus on health decision-making, Janicke & Finney (2003) examined the social-cognitive influences involved in parents’ decision-making regarding healthcare utilization for their children. The specific social-cognitive influence in their study included parents’ self-efficacy, parenting stress, and outcome expectations. The results showed that higher scores in self-efficacy for accessing services resulted higher the pediatric healthcare service utilization, and higher scores on outcome expectations correlated to more frequent visits to the healthcare provider (Janicke & Finney, 2003). However, there are gaps in understanding the cultural context of social-cognitive factors.
in decision-making. In addition, as with the Theory of Planned Behavior, social reactions also have a part to play in influencing behavior, because of approval or disapproval from the social network (interpersonal relationships). Humans tend to seek the approval of others within their social groups to which they belong. This study explores the influence of the cultural context in the decision-making process for health-seeking behavior.

**Social Network Theory**

The origins of Social Network Theory can be found in the works of 1800s sociologists, Émile Durkheim and Ferdinand Tönnies, whereas Tönnies asserted that social groups create ties that can connect people with shared values and beliefs, or create connections that are more formal, impersonal, and instrumental (Zhang, 2010). Social Network Theory became a coherent framework in the 1960s, with influences from three traditions of research: (1) Sociometric analysis, which relies upon the graph method from the field of mathematics; (2) Interpersonal relations, focusing on cliques that form among groups; and (3) Anthropology, which explores community relations structures in societies that are less developed (Liu et al., 2017; Scott, 1991). The foremost emphasis of Social Network Theory is that relationships within networks can both provide for and limit opportunities (Borgatti & Ofem, 2010). Social support, control, and influence are some of the functions of social networks (Heaney & Israel, 2008).

A systematic review of the literature (Ladonice et al., 2021) revealed that studies within the past decade that have examined the relationship between social networks and the use of healthcare services among Black immigrants with limited English proficiency found that social networks and social support are both a barrier and facilitator to using healthcare services among this unique population (Asgary & Segal, 2011; Blanas et al., 2015; Boateng et al., 2012; Merry et al., 2011; Sheikh-Mohammed et al. 2006; Woodgate et al., 2017). For example, a study by
Woodgate et al. (2017) explored African immigrants’ and refugees’ experiences with primary healthcare service access and found that a lack of social support negatively impacted participants’ ability to access healthcare services. There remains a gap in the literature regarding how social networks play a role within the process of making decisions regarding health-seeking. This study explores the role of social networks in that decision-making process in this immigrant population.

Each of these theoretical perspectives contribute to understanding the phenomenon of health-seeking decision-making. For example, Symbolic Interaction Theory addresses meaning making through social interaction, and meanings such as health beliefs become institutionalized realities overtime and predict behavioral intentions, as explained by Social Construction Theory and the Health Belief Model. Health beliefs can be learned through observation and are reinforced as behavioral codes (Social Cognitive Theory and Theory of Planned Behavior). The reinforcement of these health beliefs can occur through one’s social networks, which provide both informational and appraisal supports that can influence decisions and behaviors (Social Network Theory). However, these theories are inadequate in terms of the cultural context of these influences and the cultural factors involved in the health-seeking decision-making process.

**Definition of Terms**

The following are definition of terms are concepts of interest that may be relevant within this study to understand the phenomenon of the decision-making process of health-seeking behavior. According to Charmaz (2014), concepts of interests, or sensitizing concepts, are starting places for inquiry, but they do not command it nor are they the end. Thus, it is possible that they may not materialize as relevant concepts for the theory that emerges. These concepts of interest emerged over several years as the researcher worked with immigrant populations in field
work; spent time thinking about the problem of healthcare access and utilization; discussed ideas with faculty, peers, and social networks; and examined the existing literature. They have remained salient concepts of interest throughout the researcher’s academic journey. These concepts of interest include cultural factors, racial/ethnic identity, social networks, and health-seeking behavior, and they are described based on the literature.

**Cultural Factors**

According to Cone et al. (2014), culture can be described as the “collective sense-making about what is important within a given community” (p. 267). Culture is one of several factors that influence the use of healthcare services among immigrants (Airhihenbuwa et al., 2014; Archibald, 2011; Demeke et al., 2019), and it includes beliefs, values, norms, and traditions (Helman, 1994; Rogers, 2010). Based on the immigrant experience, cultural factors for this study also include acculturation and mistrust, which are described herein.

Acculturation is a cultural adaptation process that can include changes in cultural patterns (Potocky & Naseh, 2019; Rudmin, 2003). In this study, acculturation refers to an immigrant’s cultural identity, more specifically, it is whether one identifies more with either the Haitian culture, the American culture, or a balance between these identities. Rogers (2010) states that belief is an underlying factor for attitudes (described next). In the context of health, cultural beliefs can include the meaning ascribed to illness, the distrust in medications, and a hesitation towards medical treatment (Walcott, 2019). In this study, health belief describes the cultural beliefs about health and illness, Western medicine, traditional cultural medicine, etc.

Within the context of health-seeking behavior, attitude is described as the evaluation of a behavior as being either positive or negative (Sheeran et al., 2001; Zhang, 2018) or favorable or unfavorable (LaMorte, 2019). Attitude also describes the belief that engaging in a behavior will
produce positive or negative outcomes (Gerend & Shepherd, 2012). This study seeks to understand attitudes in from the larger Haitian cultural context, rather than simply at the individual level. Terrell & Terrell (1981) define cultural mistrust as distrust towards White people that have been developed among Black people, based on either direct or vicarious negative experiences with White people’s mistreatment towards Black people. Cultural mistrust has typically been studied in terms of mental health help-seeking and has been demonstrated to reduce the chances that Black people will use mental health services (Brooks & Hopkins, 2017; Taylor, 2018; Taylor & Kuo, 2020). However, cultural mistrust is a worthy concept to consider as a factor in health-seeking behavior as over 50% of U.S. medical doctors are White (Association of American Medical Colleges, 2019).

**Racial/Ethnic Identity**

Racial/ethnic identity is defined as race and ethnicity’s meaning and significance to a person’s self-concept (Phinney, 1996; Sellers et al., 1998). As separate concepts, racial identity is a people’s sense of collective identity that is based on the common racial heritage, and where their self-perceptions are partially influenced by systems of appraisals (Helms, 1990; Johnny, 2013). Ethnic identity is one’s sense of belonging as it relates to being connected through heritage, languages, traditions, and values (Phinney & Ong, 2007). Both racial identity and ethnic identity have been viewed as being social constructions (Cross & Cross, 2007; Helms, 2007; Markus, 2008; Omi & Winant, 2015).

Cornell and Hartmann (2007) define race as a group that is either self-defined or defined by others based on perceived common physical features, believed to be inherent. It is socially constructed as what is used to define it are choices made about self and others rather than something of based on human physiology (Cockerham, 2020; Cornell & Hartmann, 2007). From
a biological perspective, race is the physical characteristics of a person that can be observed, especially with skin color being the prominent determinant of racial identity (Cockerham, 2020; Monk, 2015). However, this too has social relevance, as seen with higher social status of lighter skin tones among darker-skinned people (Keith & Herring, 1991; Monk, 2015). According to Omi and Winant (2015), race is something that determines identity, but it is also susceptible to change by way of political means. Ethnicity is different from race in that ethnic groups are largely based on culture rather than race, and though they may either be of the same or different race, what sets them apart is culture, customs, national origin, and religion (Cockerham, 2020). The elements of both race and ethnicity interact as it relates to the lived experiences of people, and therefore, they should not be isolated from one another as with the example of exploring the features of ethnicity within the African American identity (Cokley, 2005; Cross & Cross, 2007).

Racial/ethnic identity is an important factor to consider in health-seeking decision-making and behavior. Particularly on the basis of symbolic interaction theory, an individual’s primary group is “fundamental informing the social nature and ideals of the individual” (Cooley, [1902] 1962, p. 23). By fusing oneself into a common whole that creates a mutual identification with members to create a feeling of “we” (Cockerham, 2020), racial/ethnic identity is relevant in decision-making as identification with one’s community or social group, especially as the group comes into one’s thinking, has influence over one’s behavior in certain circumstances (Mead, 1934). As it relates to health and health behavior, one’s identity as belonging to a racial/ethnic group can be critical. According to Harwood and Sparks (2003), group identity influences peoples “awareness of disease predispositions and preventive and treatment practices” (p. 140). In this study, the concept of racial/ethnic identity was explored in terms of participants identification as being Haitian, Haitian American, American, or some other racial/ethnic identity.
Social Networks

A social network is defined as “the web of social relationships that surrounds individuals…linkages between people that may or may not provide social support and that may serve functions other than providing support” (Heaney & Israel, 2008, p. 190). There are four types of social support that are provided within social networks: 1. Emotional support such as empathy, love, trust, etc.; 2. Instrumental support such as direct and tangible services; 3. Informational support such as giving advice, information, or suggestions to help with solving problems; and 4. Appraisal support, for example, affirmation, constructive feedback, etc. (House, 1981; Heaney & Israel, 2008). Social support can be provided by family members, friends, children, and community members (Heinze et al., 2015). In this study, social network refers to the linked relationships Haitian immigrants have that provide social support related to health-seeking decision-making and behaviors.

Health-seeking Behavior

Using the dictionary definition for “help” and “seek”, Cornally & McCarthy (2011) define help-seeking as searching for relief or a cure to meet a need. As it relates to health behavior, Gonzalez (2008) defines health-seeking behavior as one’s decision to seek healthcare to address health issues, one that is influenced by cultural beliefs and preferences. It is the action described in the Theory of Planned Behavior (Lin et al., 2017). In this study, health-seeking behavior describes not only the act of seeking either formal (professional medical services) or informal (traditional healers, religious leaders, etc.) healthcare, but also the decision-making process that leads to the act of health-seeking. In this study, the researcher is exploring the question of, how do Haitian immigrants make decisions about their health-seeking behavior?
CHAPTER THREE: METHODOLOGY

This chapter discusses the research design taken in this study, the population and sampling method, recruitment of the participants for the study, the methods used for data collection and data analysis, and the researcher’s role in the use of the qualitative research approach.

**Design**

This study utilized an exploratory descriptive qualitative design. Semi-structured in-depth interviews and focus group were conducted with Haitian immigrants in the United States to explore the health-seeking process and behaviors of the population.

Based on the gaps in knowledge regarding the topic of health-seeking decision making process among the specific population of Haitian immigrants and the goal of theory development, a qualitative approach is more aligned with the research project. The qualitative approach explores potential precursors and factors about phenomena that are little known and explored (Strauss & Corbin, 1998). More specifically, the qualitative method that is aligned with this research project is grounded theory. This decision is predicated on the perspective that theoretical propositions ought to be formed on the basis of acquired evidence and not be prematurely developed and founded on speculation (Cockerham, 2020; James, [1909] 1977). Theory is recommended to be grounded in the data by way of the discovery process (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

For the research project, using the grounded theory approach allowed me to take steps toward constructing a theory (Khan, 2014), one that demonstrates the health-seeking decision making process of Haitian immigrants. The constructivism approach by Charmaz (2014) is the
most appropriate for this research project. In her grounded theory approach, Charmaz (2014) asserts that the strategies of grounded theory can be used without endorsing the assumptions of objective reality, an observer who is passive and neutral, or an empiricism that is detached and narrow. Charmaz’s (2014) approach acknowledges and allows for subjectivity (the involvement of the researcher in constructing and interpreting the data). I have a personal connection to the population, and therefore subjectivity was accounted for in the research project.

Grounded theory was developed by Barney G. Glaser and Anselm L. Strauss, sociologists who studied death and dying (Charmaz, 2014; Chun Tie et al., 2019; Cockerham, 2020; Glaser & Strauss, 1965; Khan, 2014; Sebastian, 2019). In their study, they “gave their data explicit analytic treatment and produced theoretical analysis of the social organization and temporal order of dying. …they developed systematic methodological strategies” (Charmaz, 2014, p. 5). Grounded theory permits researchers to discover social experiences that were not evident at first, but the existence of these phenomena is discovered through the research process, ensuring that the developed theory represents the data from which it originated (Cockerham, 2020). The primary focus of grounded theory is data collection and its analysis (Khan, 2014). Grounded theory itself is not a theory (Punch, 1998). According to Charmaz (2014), the method of grounded theory is a systematic but flexible guideline for qualitative data collection and analysis to construct theories based on the data, and thus, grounded theory is a method in and of itself. Because the developed theories come from the data, they “are likely to offer insight, enhance understanding, and provide a meaningful guide to action” (Punch, 1998, p. 163).

The research question for this study is, How do Haitian immigrants make decisions about their health-seeking behavior? To respond to the research question, this exploratory qualitative study utilized the Grounded Theory approach by using the iterative process of data collection and
data analysis. I conducted semi-structured interviews and a focus group with adult Haitian immigrants, and used initial, focused, and theoretical coding to analyze the data. Further details regarding the methods are provided in the subsequent sections of this chapter.

**Population and Sampling**

To understand the health-seeking decision-making process and behavior of Haitian immigrants, the data must come from the population themselves. Therefore, the unit of analysis is individuals and the population involved in this study include Haitian immigrants. The participant sample for this study included 16 adults currently living in the Central Florida region (Orlando and Tampa) and who were born in Haiti. Florida has the highest population of Haitian immigrants in the U.S. (Olsen-Medina, & Batalova, 2020). Participants must be age 18 or older, as minors in the U.S. do not typically have the authority to make healthcare decisions. For participants with limited English-speaking skills or who were more comfortable speaking in the native language, an interpreter was provided.

The initial sampling method used was convenience sampling, where participants were enrolled based on their availability to participate in the study (Creswell & Creswell, 2018). To gain access to the community, I partnered with local nonprofit organizations and social networks who have direct access to Haitian immigrants in the Central Florida area. The nonprofit organizations included a center that provides health education, resources, and events to diverse cultural groups; a local refugee taskforce; and a local coalition. The social network partners included my personal contacts. In addition, enrolled participants were encouraged to share information about the study with their social networks. Convenience sampling for this study included participants who either directly responded to the researcher after receiving the recruitment flyer (see Appendix A) through the nonprofit organizations, my social networks, and
enrolled participants; those who shared their contact information (phone number/email) during the coalition’s community awareness events; and those who shared their contact information with the researcher through enrolled participants. During the data collection and data analysis, I ceased recruitment when the data reached the point of saturation, based on no new properties or insights emerging from the data (Charmaz, 2014; Creswell & Creswell, 2018).

**Recruitment Method**

Based on evidence-based approaches to recruitment methods specifically for minoritized populations, I recruited participants through partnerships with existing institutions, community awareness activities, and peer recruitment (Larkey et al, 2002; Metayer et al., 2018; Rodriguez et al., 2006). According to Metayer et al. (2018), these methods include recruitment posters and fliers, public service announcements through local ethnic radio stations, partnerships with local churches representing the immigrants, and by encouraging enrolled participants to refer other potential participants through their social networks. Haitian immigrants are reported to respond well to media announcements and referrals through community partners and social networks (Metayer et al., 2018).

Participants for this study were recruited through three local nonprofit organizations (community-based agency, coalition, and refugee taskforce) which sent the recruitment flyer to their contacts through emails. The flyers were in both English and Haitian Kreyol to allow equitable access to information about the study (see Appendix A for English version). Due to funding, radio announcements were not used as a recruitment method. The relationship with the first nonprofit organization led to the researcher being connected to a second organization, a local coalition that organizes events targeted specifically to Haitian immigrants in the community. The coalition shared the recruitment flyers during community awareness meetings.
where they also invited me to attend. Although I attended the community awareness events, the coalition representative shared the flyer on my behalf and was determined to introduce me to attendees to bring awareness of who the researcher was so that potential participants would feel more comfortable with speaking to me if they were interested in participating in the study. Per the IRB protocol, I did not directly recruit participants for this study. The refugee taskforce sent the recruitment flyer to their community partners by email.

Partnering with these organizations led to the recruitment of 37.5% of the participants in this study. Recruitment flyers were also shared with my social networks who either attended a Haitian church or a church that includes members who are Haitian immigrants. An additional 37.5% of participants were recruited through this method. The remaining 25% of participants were recruited through enrolled participants who shared the flyer within their social networks before and/or after completing the interview. Individuals who reached out to me outside of a connection to any of the partnered organizations or social networks were asked to complete an online screener to determine their eligibility to participate in the study (see Appendix B). Participants who enrolled after screening in as eligible were later withdrawn from the study upon the researcher identifying they were not in fact Haitian immigrants during introductions before the interview would have taken place.

A $50 gift card was provided to participants after completing both the interview/focus group and an online demographic survey. This amount is higher than typical for participation in qualitative research; however, I strongly felt the amount must be commensurate with the recent increases in the cost of living. Therefore, the amount for the incentive is not coercive, but rather a demonstration of respect and appreciation for the time commitment to participate in this study.
Data Collection

This study was approved by UCF’s Institutional Review Board (IRB) through a Request for Exemption, based on this study involving minimal risk to participants. Data for this study was collected through semi-structured interviews and a focus group, as well as a demographic survey. Prior to the interview/focus group, participants were provided the Explanation of Research (see Appendix C) by email, and it was reviewed before starting the interview/focus group. The Explanation of Research were available in both English and Haitian Kreyol to allow participants with limited English proficiency the ability to review it independently - without the need of an interpreter. Participants provided verbal consent to both participate in the study, and for the interview/focus group to be audio recorded. The interviews were held one-on-one (along with an interpreter for those with limited English proficiency), and they took place in person (n=3) and virtually via the Zoom platform (n=9). One focus group (n=4) was held virtually on the Zoom platform. Based on challenges with recruiting enough participants to conduct at least two focus groups with participants assigned based on gender, one focus group was held and was inclusive of all genders (50% men, 50% women).

The interviews and focus group included open-ended questions to understand the participants’ experiences, meanings, and perspectives (Charmaz, 2014). Appendix D provides the questions from the interviews, and Appendix E provides the questions from the focus group. As previously indicated, the questions were guided by the concepts of interest; however, this left room for the participants to tell the story rather than forcing their responses to fit the researcher’s assumptions. At the end of the interview/focus group, participants were given their Participant ID Number to complete a brief demographic survey online via Qualtrics (see Appendix F). Participants could complete the survey at any time, and they were required to provide consent.
prior to completing the online survey. Nearly all participants completed the survey right away. The demographic survey was not translated into Haitian Kreyol; therefore, participants with limited English proficiency verbally provided their responses to the survey, which was then translated and entered by the researcher or interpreter.

In the demographic survey, participants were asked about their gender identity (Man, Woman, Non-binary/third gender, Another [please specify], or Prefer not to say), their current age, the length of time they have been living in the U.S. (years and months), the age when they moved to the U.S., the circumstances that led to them leaving Haiti (text entry), their highest level of education (Some high school, but did not graduate; High School Diploma/GED; Some college, but did not graduate; Professional School/Certification; Associate's (AA/AS) degree; Bachelor's (BA/BS) degree; Master's (MA/MS) degree; Advanced degree [M.D/D.O., J.D., Ph.D., or another advanced degree]; or Another [please specify]), their ethnic identity (Haitian, Haitian-American, American, or Another [please specify]), their marital status (Single Married, Widowed, Divorced, or Separated), and perceived health status. Using the 5-item health status scale from the National Health Interview Survey (National Center for Health Statistics, 2022), participants were asked to rate their perception of their overall health status (Excellent, Very Good, Good, Fair, or, Poor).

The interviews and focus group were audio recorded and stored in a secure folder. The recordings were transcribed through an auto transcription service, Trint. The transcripts were edited for accuracy and de-identified to protect the privacy of the participants. De-identification of the data occurred by redacting the names of people and specific locations (e.g., cities, towns, states) that could potentially be used to identify the participant. The edited transcripts were then
sent to participants for member checking, where they were provided an opportunity to add to, change, remove, or clarify any information they shared with the researcher.

**Data Analysis**

The grounded theory approach is an iterative process where data collection and data analysis occur simultaneously (Charmaz, 2014). The qualitative data analysis in this study included initial coding, focused coding, and then theoretical coding, and this was initiated through Atlas.ti, a web-based qualitative data analysis tool. During the analysis, I inductively labeled the data from the transcripts through line-by-line coding while examining similarities and differences within the patterns of the data to develop categories (initial coding), used the constant comparative method to categorize the codes and develop more abstract concepts (focused coding), and integrated and synthesized the categories to create the theory (theoretical coding) (Birks & Mills, 2015; Charmaz, 2014; Chun Tie et al., 2019; Saldaña, 2013). These successive levels of coding allowed categories to become more theoretical (Charmaz, 2014).

During focused coding, an Excel spreadsheet was created to delineate the emerging categories and subcategories. This helped me to see the relationships between the initial codes and the categories and subcategories. During theoretical coding, the categories and subcategories were printed on strips of paper, and I manually arranged them while actively engaging the data within Atlas.ti. This method provided me the flexibility to organize and reorganize the categories and subcategories by the steps in which they appeared to occur, and to identify the theoretical codes (major categories) that outlined the steps within the health-seeking decision-making process. This was especially helpful given that some categories and subcategories were repeated as the theory emerged. Memos that were created during both data collection and analysis were also reviewed and integrated during focused and theoretical coding. These memos included notes.
about what was recognized as common threads emerging during data collection and the theory that began to mentally appear, though being mindful to allow the data to speak for itself during the data analysis process. The results of this analysis provided and described in the next chapter.

**Role of the Researcher**

I identify as a Haitian American and a second-generation immigrant of two first-generation Haitian immigrant parents. This personal connection to the population lends itself to a co-construction and subjective interpretation of the data, and thus, methods were in place to reduce bias and improve the trustworthiness of this study. To do this, I engaged in reflexivity. Reflexivity in this study includes sharing information regarding cultural background and experiences and a discussion of how my position informs the data interpretation for this study (Creswell, 2013; Creswell & Creswell, 2018). In addition, reflexivity includes bracketing, where the researcher recognizes and sets aside prior knowledge and assumptions, without abandoning them, to attend to the data open-minded and avoid the negative effects of preconceptions (Chan et al., 2013; Charmaz, 2014; Gearing, 2004; Sokolowski, 2000; Starks & Trinidad, 2007; Tufford & Newman, 2010; van Manen, 1990), thereby increasing the rigor of this study (Tufford & Newman, 2010) and demonstrating validity in the process of data collection and analysis (Ahern, 1999). I engaged in bracketing through memoing (e.g., diary, journaling, notes) to note feelings, perceptions, and thoughts, which allowed me to examine their positionality and avoid preconceiving the data (Chan et al., 2013; Charmaz, 2014).

Another method used to improve the trustworthiness of this study is member checking, which is verifying the credibility of the findings with the participants through feedback (Creswell, 2013; Creswell & Miller, 2000; Ely et al., 1991; Erlandson et al., 1993; Glesne & Peshkin, 1992; Lietz & Zayas, 2010; Lincoln & Guba, 1985; Merriam, 1988; Miles &
Huberman, 1994; Padgett, 2008). Participants were provided with the transcripts of their interviews to provide feedback. Participants indicated the transcripts accurately captured the message they shared during the interviews and focus group. Member checking also occurred during data analysis for additional feedback to ensure accuracy of the data. Participants were provided with the initial proposed theoretical model along with a summary, and they were provided with an opportunity to share feedback regarding the accuracy of the proposed model. In addition, I engaged in regular consultation with the Dissertation Chair during scheduled weekly/biweekly meetings.
CHAPTER FOUR: RESULTS

This chapter discusses the results of this study. The first section describes the participant characteristics, and the second section discusses the findings from the semi-structured interviews and focus group. These findings led to the development of the Haitian Immigrant Health-Seeking Decision-Making (HSDM) Process Model, which is provided and described herein.

Participant Demographic Characteristics

A total of 16 adult Haitian immigrants participated in this study, with 37.5% of participants identifying as men (n=6) and 62.5% of participants identifying as women (n=10). Four of the participants joined a focus group, and the remaining twelve completed one-on-one interviews. In the focus group, 50% of the participants were men (n=4), and 50% were women (n=4). The ages of all the participants ranged from 22-70, with varying levels of completed education (from high school diploma/GED to advanced degree), marital statuses (single, married, and divorced). When asked about their identity ("How do you describe your identity?")
participants either identified as Haitian (81.3%, n=13) or as Haitian-American (18.7%, n=3). None of the participants identified themselves as American or some other identity. The identity categories reflect participants’ acculturation through identity, with Haitian reflecting a low level of acculturation, and Haitian-American reflecting an adoption of both Haitian and American culture. Majority of the participants perceived their health as either “Excellent” or “Very good”. None of the participants rated their health status as “Poor” or “Fair”.

In terms of their immigration to the U.S., the average age in which participants migrated was 32.56, and the average length of time that they’ve been living in the U.S. was about 18 years. Participants’ reasons for leaving Haiti also varied. Some participants left Haiti for
educational and/or work opportunities, to look for “a better life” (either themselves or by proxy from parents/grandparents), due to the political climate in Haiti, because of the 2010 earthquake, insecurity and violence, and to be closer to the majority of their family members. Table 1 displays the demographic data for all the participants in this study, with exception of their reasons for leaving Haiti (this response was provided by text entry).

Table 1 Participant Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Identity- n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Man</td>
<td>6 (37.5)</td>
</tr>
<tr>
<td>Woman</td>
<td>10 (62.5)</td>
</tr>
<tr>
<td><strong>Current age- mean (range)</strong></td>
<td>42.06 (22-70)</td>
</tr>
<tr>
<td><strong>Time in the U.S.- mean (range)</strong></td>
<td></td>
</tr>
<tr>
<td>Years</td>
<td>18.06 (5-40)</td>
</tr>
<tr>
<td>Months</td>
<td>3.25 (0-9)</td>
</tr>
<tr>
<td><strong>U.S. immigration age- mean (range)</strong></td>
<td>32.56 (5-47)</td>
</tr>
<tr>
<td><strong>Level of Education- n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>High School Diploma/GED</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Some college, but did not graduate</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Professional School/Certification</td>
<td>1 (6.25)</td>
</tr>
<tr>
<td>Associate’s (AA/AS) degree</td>
<td>4 (25.0)</td>
</tr>
<tr>
<td>Bachelor’s (BA/BS) degree</td>
<td>5 (31.25)</td>
</tr>
<tr>
<td>Master’s (MA/MS) degree</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td>Advanced degree (M.D./D.O., J.D., Ph.D., or other advanced degree)</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td><strong>Identity- n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Haitian</td>
<td>13 (81.25)</td>
</tr>
<tr>
<td>Haitian-American</td>
<td>3 (18.75)</td>
</tr>
<tr>
<td><strong>Health Status- n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>7 (43.75)</td>
</tr>
<tr>
<td>Very good</td>
<td>7 (43.75)</td>
</tr>
<tr>
<td>Good</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td><strong>Marital Status- n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5 (31.25)</td>
</tr>
<tr>
<td>Married</td>
<td>9 (56.25)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (12.5)</td>
</tr>
</tbody>
</table>
Findings

Based on the findings from this study, I developed the Haitian Immigrant HSDM Process Model, shown in Figure 1. This is a theoretical model that represents what participants described as Haitian immigrants’ process and behaviors that occur in each step, and it is characterized by repeated behaviors to address illness. Overall, these steps are embedded in the Haitian identity, which emerged as a broader theme called “Being Haitian”. This theme, which includes the values, norms, cultural beliefs about illness, and preferred treatment methods, significantly influences the health-seeking decision-making process and behavior of Haitian immigrants.

It is important to note that although the concept of “Consulting with Others” is a repeated behavior throughout the process, it is not a broad theme as is the case with “Being Haitian”. This is based on the behavior of consulting varying in nature in each step of the health-seeking decision-making process, which includes the type of consultation (talking with others, faith practices such as prayer and reading religious literature, or consulting online resources), as well as either initiating consultation by actively reaching out to others or engaging in consultation that is not initiated, such as unsolicited advice. In contrast, “Being Haitian” is a broader theme because the influence of identity is consistent throughout the process. The model and its characteristics are further described herein, and further discussion is provided in the next chapter.
Figure 1 Haitian Immigrant HSDM Process Model.

**Self-Diagnosing**

The first step in the process is Self-Diagnosing. During this first step, participants shared the preliminary thoughts and actions that guide how they address illness. This step includes three subcategories showing the thoughts and actions that are involved in the first step along the process: 1. Knowing My Body, 2. Assessing the Condition, and 3. Consulting with Others.

**Knowing My Body**

In this first step, participants emphasized having knowledge of themselves in terms of their general health status, as well as having the capacity to recognize when something is abnormal or more severe than basic illnesses such as a cold.
“I know how to really take care of myself. And I know how to listen to my body… But I'm pretty healthy. If I had a lotta health conditions, it'd be another story. But because I'm healthy and I know I'm healthy, things don't really scare me like that” -woman, 31yo.

“Okay. Let me give you one example. I believe it was last year. I can tell you, I know my body. I know I wasn't feeling right and then I drove myself to the emergency room. I went myself because the way- I know the way I feel. I know it wasn't normal, so I went to the emergency room where I live. And it was COVID… I still believe knowing my body is the first step to take care of myself” -woman, 70yo.

**Assessing the Condition**

Participants described that they are able to identify what is occurring in their bodies once they feel unwell. This is when they identify the symptoms that they are experiencing by checking their blood pressure, blood sugar, and/or temperature; examine how they feel in terms of being abnormal; and use prior knowledge and experiences to determine their next course of action: Whether the condition could be treated themselves or if it will require the attention of a healthcare provider.

“Imagine, for example, if you have diabetes or you have a blood pressure problem, okay. So what happens? If you have the machine and then you check it, you see it's not too high, maybe you'll take a little tea. If, for example, you don't have medication and so you can take a little tea, you have a couple of little things you can do. Or you manage it so you can lower it” -man, 60yo.
“It depends of what I'm suffering. If it's a simple cold, I pray and then, as Haitian, we do our teas. But if it's something that we cannot handle, while we are looking to get to the best doctor or the correct doctor, we pray and then we act wisely” -man, 42yo.

They investigate the cause of their illness by examining whether it was something they might have done to become ill/unwell.

“Like, self-diagnose myself to see what probably would cause me, for example, to have a stomachache. Did I eat late, or did I consume too much sugar? Because in the Haitian culture, we do not do too much sugar. If we do too much sugar- we know one of the consequence is to get stomach ache if we do sugar before we eat something salty. Just an example” -woman, 40yo.

**Consulting with Others**

Participants explained that they would share their health concerns with their social networks (e.g., spouses, parents, friends, personally known medical professionals) when they are not feeling well. This leads to receiving advice about how to address their illness.

“So sometimes we call outside people. Or she can call someone from the church, her friends. ‘My daughter is not feeling well. This is what she has. Do you know what to do?’” -woman, 25yo.

“Sometimes you have people in the community that you can call for first impression… I will discuss it with my husband if it's something that has to do with respiratory care because he's a respiratory therapist, I would share with my son who's a nurse, and I'll ask them for advice. If anything, they will tell me, ‘Well, wait for a few days. If this continues, let's just call your doctor’ and stuff like that” -woman, 57yo.
Participants also described engaging in “Doing Research” by searching online (Google) and reading medical journals to identify what they are experiencing and how they should address their health concerns.

“Well, another thing that I've learned that I started to do two years ago, I started to Google stuff. Symptoms- sign and symptoms to see, okay, if you have a headache over your head, if you have this, if you have this kind of marks coming on you, or whatever. So you would just describe it in Google and then it will tell you if this is this and that, what to do and this is what it may be, and you have to go see a doctor. Yes, I will go to Google also” -woman, 57yo.

“When I watch them, the signs, if I see I have these signs, I'll already know what I have. I'll already search to learn what remedies I need to make to catch it earlier or I'll go to the doctor's office” -woman, 41yo.

**Self-Treating: Informal Health-seeking**

The second step in the health-seeking decision-making process is called Self-Treating, and informal method of health-seeking behavior. In this step, participants described the behaviors that are involved in addressing an illness on their own, outside of formally seeking the attention of a healthcare provider. This step includes two subcategories showing the thoughts and actions that are involved therein: 1. Doing Home Treatment, and 2. Consulting with Others.

**Doing Home Treatment**

Participants explained that they begin to address illness by treating their symptoms at home. This includes “Using Natural Remedies” such as tea, medicinal foods (lemon, garlic, etc.), or other forms of natural remedies that they learned while they were in Haiti or learned
from their parents while growing up. In some cases, the natural remedies will be provided by others such as parents or household members.

“First thing, I would think about home remedies… Depending on what it is, I'll see what I have at home to see if I can treat it… I remember growing up, she would always make me drink garlic and lime. She would put in the spoon. So even now, when I feel like I'm going to get sick, I'm like, ‘Let me get some garlic and lime’ because that's what my mom did, and drinking the different teas” -woman, 31yo.

“You're supposed to go see a doctor, but sometimes, us as Haitians, sometimes if, for example, you have people in the house, mommy or papi- there's several people in the house, sometimes they can make a little tea…” -man, 60yo.

Of particular interest is the resourcefulness of participants as they are finding ways to access plants. Participants stated that Haitian immigrants will do whatever it takes to use natural remedies. They will plant the herbs and trees they want to use for medicine when they have enough land, they will plant herbs in pots, or they will access it through their social networks.

“And also, if you have enough land, you can also plant your own leaves and people in Haiti can bring stuff when they go. They can bring it fresh and you can plant it, or you can do, like, pot planting with that if you don't have enough land for that” -woman, 50yo.

“…we had neighbors who would grow plants, like medicinal plants from Haiti and stuff. So you could go to your neighbor, ask them if we could get a couple plants to make some medicine for your child or for yourself…” -man, 23yo.

Home treatment also includes taking over-the-counter medication and vitamins, using whatever resources they have available or that are attainable within the community.
“Or if I feel tired and then feel dizzy, I said, ‘Oh, let me take some vitamin B complex or multivitamins to help’” -woman, 40yo.

“Usually after those tea- it depends if they have the pill at home, they know what to give you. If they have it available, they will give it to you... it vary based on the situation, based on what we have available” -woman, 25yo.

Participants also engage in “Taking Better Care of Self” by avoiding the possible causes of their illness such as excessive sugar, fast food (chemicals such as GMO), and lack of exercise.

“Haitian people, anything that has to do with chemicals, they try to stay away from those. Even you will see Haitians don't even like fast food unless they have to- although we've got fast food in our culture, but it's different than other cultures' fast food. …most Haitian will try to eat home as much as they can, unless they are in a situation they have to. So I think, it's cultural” -woman, 40yo.

“Cause I maintain my weight, 155 lbs. 155-160. And it's been 17 years since I'm keeping it the same way. And that's how I go about taking care of myself and live a better lifestyle. Relax. And I do enjoy exercise” -man, 49yo.

**Consulting with Others**

In addition to using their prior knowledge about natural remedies, Consulting with Others comes into the play again in this step as participants described seeking the advice of others, specifically as it relates to the remedies that they should use to address their illness.

“They would already tell me, ‘Here is what's good.’ I would tell them and they'd tell me, ‘Here's this remedy.’ This is what I am to take for this remedy for this illness. Once I say I feel a way, my aunt says, ‘Take this leaf’” -woman, 41yo.
“So let's say you say, ‘I will do cinnamon, ginger.’ Someone will say, ‘Oh, put some thyme in it.’ Another person would say, ‘Put some black pepper in it.’ Other will say, ‘Ah, you need to put a piece of pineapple in it.’ So at the end of the day, you have a cocktail. Just for the cold, you have a cocktail that you can take. That's, that's the way it is” -woman, 55yo.

Similar to Self-Diagnosing, participants reported “Doing Research”. However, in this step, participants shared that they search through Google, watch YouTube videos, and read books to search for home remedies to treat themselves.

“…my grandma, if she watching YouTube and then she see that someone say, ‘Oh, that-this medicine is good for that…’ she's not gonna even ask no one questions. She's gonna do it and drink it. That's basically it” -woman, 22yo.

“…if I have a cold that's very excessive, before I go to the hospital, I would check on YouTube or on Google. Especially YouTube, Haitians will look for plant-based medicine. They always tell you ‘Here's what's good for these things’” -woman, 41yo.

Participants also reported “Incorporating Faith” by reading the Bible and other religious materials as a guide for addressing illness, and by praying.

“And if you go in the book of Ezekiel, I believe it's chapter 47, verse 12. I'm not sure. I probably off. It does mention that we use whatever the trees produce as nutrition, as food for our body, and we use the leaves as medicine. That's why I mentioned the great book, which is the Bible” -man, 49yo.

“I start praying and do my own thing to see if it will work” -woman, 50yo.
Self-Monitoring

The third step in the process is “Self-Monitoring”. During this step, participants explained that they monitor their symptoms (the severity, how long they last). This step includes three subcategories describing the behaviors that are involved: 1: Waiting it Out, 2. Assessing the Condition, and 3. Consulting with Others.

Waiting it Out

Of special interest is where participants described a period of “waiting it out”, and in doing so, they delay seeking medical attention by trying everything that they can to deal with their illness.

“My first thought is really just lay down and wait until the way I'm feeling, I'm feeling better… I don't think about I'm having anything high importance for me to go to the doctor right then” - woman, 70 yo.

“I know for sure that the waiting it out time for me, it's not necessarily based on having the time or not having the time. It's a matter of waiting to see what's gonna happen before I actually feel the need to go” - woman, 50 yo.

Participants shared that Haitian immigrants believe that going to the doctor is for when someone is “really sick”, and the assumption in the Haitian community is that going to the doctor means something is wrong (“Stigmatizing Healthcare Use”). In addition, it is expected that one should engage in self-treatment first before going to the doctor, which can delay the process of seeking medical attention.

“…in our culture, if you say, ‘Oh, I have a doctor's appointment.' ‘Are you okay? Is everything good?’ It's a taboo. Going to the doctor is only for sick people. You have to be
sick to go to the doctor. Why would you go to a doctor if you're not sick? That's the way it is in the culture” -woman, 40yo.

“But at the end of the day, we don't really wanna go if we are not really sick because it's just on our mind that when we seek- as Haitian, in our country, we really go to see the doctor when we are really sick. Not just for fun, not just for follow-up” -woman, 25yo.

Participants are discussed “Avoiding Healthcare Service Use” as they dislike going to the doctor and would prefer to handle the situation on their own. In this step, they engage in “Prioritizing Family and Work” to save time and money by using their natural remedies rather than the inconvenience of having to go to the doctor.

“Personally as an immigrant, the last place I wanna go is a doctor” -woman, 25yo.

“I don't like going to the doctor's very much so I would, in a way, just wait it out until I'm better… It's just the doctor in general. I don't know. You could say it's a part of not wanting to get up and commute to the doctor's office, but I just don't like the doctor whatsoever” -man, 23yo.

Based on their competing priorities, “Prioritizing Family and Work”, participants discussed focusing on avoiding missed time at work or school, as they have a strong value for work ethic and want to provide for their families.

“… I currently have three jobs. So for me, if I feel sick and I have to go to the hospital, that means I have to call off from almost three of my jobs and, most likely, I'm gonna be in that hospital for at least two or 3 hours, depending what I'm feeling. Meanwhile, I can just have my mom make the tea for me and she can even bring it to my job, so that will save me a lot of time and money as well” -woman, 32yo.
“I mean, I have sick days, but I'm the type of person that likes to work. I wanna go to work and I pride myself in having great attendance at work, so I think about that. I'm like, ‘Damn! I have to call in sick and all of this stuff. I'll be okay’” -woman, 31yo.

**Assessing the Condition**

In this particular step of Self-Monitoring after engaging in self-treatment, participants explained that they examine the state of their condition to determine if they have reached a point to where they are no longer able to manage the illness themselves (the illness has gone on for too long and isn’t getting better or has gotten worse) or their functioning is now being negatively impacted (bedridden, unable to go to work, struggling with pain).

“After trying everything on my own and then try over-the-counter medicines and still having the same symptoms, that's when I would seek for medical professional help” -woman, 40yo.

“…anything that will require me to not being able to work, anything that I feel that would be contagious towards the people that's around me. Anything that would keep me in bed. I think besides a small headache or soreness, anything outside of that, I am straight to the doctor's and making an appointment. I'll be the first” -man, 30yo.

**Consulting with Others**

In the Self-Monitoring step, participants shared that they would receive advice from their family or friends to now go and seek medical services (“Encouraging Healthcare Use”). Participants described consulting about the progress of their condition either actively by reaching out or passively by others giving them advice.
“I reached out to a Physical Therapist Assistant. 'Cause I'm like, ‘Is it a bone thing?’ But after a while, I'm like, ‘Let me see if this person can give me some advice.’ … And it's not until three weeks later when it wasn't getting better, and I had nurse friends who told me I should go get an x-ray. That's when I decided to go” -woman, 31yo.

“Um, I'm sure my daughter. She doesn't live with me, she's in [city]. And she will ask me how do I feel, and I will relay the symptom to her and then she said, ‘Mommy, if I was you, I will go to the doctor or I will go to the emergency room’” -woman, 70yo.

**Considering Formal Health-seeking**

Participants stated that they recognize there can be limitations in treating themselves. They explained that their next step in the health-seeking decision-making process is “Considering Formal Health-seeking”. In this step, participants described pausing to consider several factors before actively seeking medical attention to address illness. This step includes two subcategories: 1. Conducting an Analysis, and 2. Consulting with Others.

**Conducting an Analysis**

Before seeking medical attention, participants described how they engage in “Conducting an Analysis” as they analyze whether there is a need to seek a doctor’s attention based on the severity or seriousness of their situation, whether they need stronger medication to address it (a prescription), or whether their condition can negatively affect others.

“Sometimes, the one I really need, you have to get a prescription from the doctor to get it. So in this case, sometimes you have to go to the hospital because otherwise you cannot-nobody's gonna sell it to you. So if the natural thing you know cannot work, you have to go” -man, 46yo.
“So my thought process is always other people… I always think about other people. Just in case, if I have it (COVID), I don't wanna give it to no one else. Let me go get tested” -woman, 31yo.

“…sometimes it requires you to have the synthetic [medication] because the dose is stronger than just doing the natural, because you don't know how much of this and that your body needs to recover” -woman, 40yo.

Participants also expressed engaging in a cost-benefit analysis, examining their insurance benefits (copays, where they can go), considering the financial investment that is required (having already paid for health insurance), and considering whether they have the resources and the appropriate services to see a doctor.

“But if I really needed it, I will make the effort of going. But sometimes, even the copay. We just think before we go… But, like I said, if I have the $10 copay or I don't have to pay a copay, I'm most likely to go” -woman, 25yo.

“Taking the decision is saying, ‘Okay, take a look over my insurance or what kind of plan I have.’ Do research to see if you got your primary care doctor. Or if you don't, what emergency room gives people better services? What the hospital give people better services? And what language do I speak? Can I find those kind of people who speak and understand my concern?” -man, 46yo.

**Consulting with Others**

Participants shared an interesting factor that can influence Haitian immigrants’ in taking the next step of seeking medical attention. They stated that when pastors and churches are
“Encouraging Healthcare Use”, especially as it relates to health screenings, Haitian immigrants are more likely to follow through as they revere and trust their religious leaders.

“But pastors, the leaders, are the key in getting people to the doctor. So, if the pastor say, ‘Oh! Sister so and so, you are feeling like that? Go to the doctor!’ That person will go without thinking it. I don't think she or he would call anybody else, will go straight to the ER” -woman, 55yo.

“There is usually a portion where they will do health talks, and in the health talks is where they will explain to people to help motivate them to see the necessity or obligation to do what they need to do, whether it’s going to the hospital, and routinely getting a checkup to know how their health is doing. This helps them. That often leads to many people beginning to become aware of how normal it is to go see the doctor, to continue consulting your provider so you can remain in good health” -man, 60yo.

**Barriers to Formal Health-seeking**

Although Haitian immigrants may contemplate seeking formal healthcare, a significant factor that can impede the path towards formal ways of healthcare use is an issue of barriers. Participants described how Haitian immigrants can encounter barriers primarily associated with resources, fear, and competing priorities. This category includes three subcategories that depict the factors impeding the next step towards seeking medical attention: 1. Lacking Resources, 2. Being Afraid, and 3. Prioritizing Other Things.
Lacking Resources

Participants described how “Lacking Resources” can be a barrier to seeking medical attention. Such resource barriers include lacking the finances to pay for medical services, lacking insurance coverage or adequate insurance coverage to where the cost of copays is too expensive.

“I think it's the hospital bill because most of them, they really work hard to get the money. They got bills to pay… then if they go to the hospital, that bill, one paycheck, they can give it to hospital just for one emergency. It's not making any sense. So I think that's why. Yeah. It's the hospital bill. It's pretty expensive” -woman, 22yo.

“And sometimes it's also because of money issues because there is a co-pay, there's also sometimes a coinsurance” -woman, 50yo.

In addition, participants shared that Haitian immigrants may lack resources such as English-speaking skills, literacy, knowledge of how to navigate the healthcare system, and transportation.

“…just not knowing how to set up an appointment, or even having access- transportation to go to an appointment” -man, 30yo.

“…sometime you have an older Haitian generation. Those are the ones really sometimes they rely on their children to seek care. Some of them, they don't know how to read or write, so another family member has to bring them. So to seek care, somebody has to bring them” -woman, 70yo.

While they may have available supports from family to help with transportation and interpretation, participants shared that Haitian immigrants, especially older adults, want to avoid
being a burden to their families, and thus, they may keep their illness a secret. In some cases, the desire for privacy can also prevent them from engaging formal health-seeking.

“I guess they have their own barrier of privacy. They don't like people in their business…

So coming in here, they have a certain mindset to kinda work, pay your bills, and handling your business without allowing any outsiders in…” -man, 30yo.

*Fearing Negative Outcomes*

Fear is another barrier that impedes that pathway to formal health-seeking. Participants stated that Haitian immigrants fear that if they go to the doctor, they will receive a diagnosis, and they do not want to face the reality of a significant illness such as cancer.

“…there is the trust also. Some people- I've had people telling me, "Ah!" Let me say it in Kreyol and then in English. ‘Oh, ou al kay doktè yo jwenn ou malad. When you go to the doctor they will find something.’ So that idea, ‘Oh, if I go to the doctor, ah! They will say that I have something”’ -woman, 55yo.

“So yes, being afraid would be a reason why you don't go see a doctor, why you don't wanna find out if you are sick. When you have symptom that you are very aware that is a problem because you were not like that before, but you just afraid of facing the reality…you will not seek medical advice because you would be afraid to get a result that you would not want to have at the moment that you were looking for the doctor's advice. So Haitians do that. We do that” -woman, 57yo.

Participants discussed Haitian immigrants also experiencing fear of having issues with immigration in several ways. On the one hand, Haitian immigrants without a legal status are afraid they may run into an Immigration and Customs Enforcement (ICE) officer, especially
given the new law asking for citizenship status in hospitals. On the other hand, newly arrived Haitian immigrants with Medicaid are concerned that using their benefits will reflect poorly on them by appearing to be a burden on the government.

“Most likely, some of the immigrants just don't want- 'specially if they're not legal in here, they don't wanna go to the hospital and putting everybody in their businesses. 'Specially with the new law that just passed, like, where they have to declare their status in here, so I feel like they just don't wanna expose theirself to the government like that” -woman, 32yo.

“And then sometime, they are in the process of getting their immigration paper and they know you cannot be a burden for the U.S. government. They will not seek care because of that. That's why most of the time people wait so late to get access. It's too late to do whatever needs to be done for them” -woman, 70yo.

Participants also described other fear-related factors that can impede formal health-seeking, such receiving an expensive medical bill, which is connected to the lack of financial resources experienced by some Haitian immigrants.

“And that's also how, for example, when the person has a little problem and they go to the emergency room, there's a price they charge them. So there are people who are sometimes afraid of the bill, and that makes them become a little hesitant for them to go and see a doctor. There are a lot of people who don't have insurance” -man, 60yo.

“…even me sometimes thinking about it. Not only me. There's a lot of people put that in mind. They're afraid of the hospital bill. When they don't have insurance, they don't know if they have copay, what kind of plan…” -man, 46yo.
Prioritizing Family and Work

Participants discussed how “Prioritizing Family and Work” can also be a barrier to seeking medical attention. Within this context, participants explain how competing priorities is a barrier based on Haitian immigrants focusing on going to work to make enough money so they can provide for their families (both in the U.S. and in Haiti) and pay bills, and they (particularly the women) are taking care of their spouses, children, and the household. These priorities can keep them from formal health-seeking, and not just delay it.

“…some of us taking care of family here and taking care of family in Haiti, they are so focused in getting the money, getting the hours, some of them, they don't even think that you can get a sick day, ask for a day off” -woman, 55yo.

“And they worry about losing workday because they need their money to pay their bills. And then sometimes, they don't have the time to get to see a doctor because not only they have to work to provide for their kids, they have to take care of their kids and their husband, and then plus, they have to take care of their homes” -woman, 57yo.

Being Desperate

Amid the barriers that can impede the path towards formal health-seeking, participants stated that when Haitian immigrants feel desperate, they can bypass barriers such as lacking finances by borrowing money from others so they can go to the doctor/hospital. “Being Desperate” is when the illness has become severe to the point where Haitian immigrants can no longer bear the illness, they have tried everything they can, and they are at the point of needing to use their last resort, which is going to the doctor/hospital.
“So, I would go to see a doctor if I'm feeling like I really can't bear the pain. Yeah, I would like to see a doctor” -woman, 22yo.

“Compared to a lot of people who maybe that's live without insurance, low income, so they would- it would be very hard. That would be the very last, last decision they will make about going to the hospital. They need to see the person is about to die when they feel- to take that step forward... But in case they are losing their teeth, if the thing is very serious, they gonna go borrow some money to go. You know, they gonna do something to go” -woman, 25yo.

**Seeking Medical Services: Formal Health-seeking**

The final step in the process is “Seeking Medical Attention”, a formal method of health-seeking. Participants described that in this step, they seek medical attention by going to the doctor’s office or the emergency room through urgent care or a hospital. This step includes three subcategories that demonstrate the behaviors and attitudes involved in utilizing healthcare services: 1. Consulting with Others, 2. Preferring Natural Remedies, and 3. Feeling Conflicted Towards the Healthcare System.

**Consulting with Others**

In this particular step of the health-seeking decision-making process, participants shared that they engage in “Consulting with Others” by reaching out to their social networks to seek for advice specifically about doctors that are recommended/trusted within their community. They seek this advice from their family, their friends, and even their pastors.

“So the people around me, like Haitian people who live there before me, so I talked to them to see, ‘When you get something, so where you go?’ ... At least I have two or three
doctor, a family doctor and then, okay, I start with my wife and then decide which one we gonna go to” -man, 42yo.

“I'm not afraid to ask if I know a friend. I got a pastor, I can say, ‘Hey, do you know what's the best place because I never get sick? I appear to get sick. What's a better place you think I can go to? What kind of hospital I can go?’” -man, 46yo.

Participants shared that when they are seeking for a medical provider, they also engage in “Incorporating Faith” by asking God to lead them to the right doctor, praying that God leads the doctors so they can provide the best care, and believing that it is God Who gave the doctors the knowledge and skills to provide medical services.

“If God says it's something you really need to go and get a doctor. Sometimes God can just do things, but sometime He can lead you to someone. So if He leads me, if I feel that peace to go to see a doctor…” -man, 42yo.

“And the first thing too, you shouldn't forget either, before, you pray to God first so He can speak to the doctors because God is first. It's the leading of God to help the doctor to do more advances, more research to help you, give you good medication. We pray to God first so He takes the lead, and so He convinces the doctor, to speak to the doctor and tell them about good research, about good medication. Sometimes, the devil also participates in everything” -woman, 41yo.

**Preferring Natural Remedies**

Of particular interest is that even when participants shared that they although they are willing to seek medical attention, they still have a preference for using natural remedies because they believe that it is the best form of treatment for illness, they have witnessed its ability to treat
illness, and using natural remedies is their cultural norm. Participants stated that they would take synthetic medication when it is prescribed; however, they would continue to take their natural remedies at the same time. They prefer to not take prescription medication long-term.

“It's to tell you, even though I have that medical background, I have that medical training, my culture- I don't know for other people… but me, I will go first to my culture, to what I've known since I was growing up in Haiti. Then I will go to what I have learned in my twenties when I was going to university” -woman, 55yo.

“It's not that I don't trust the doctor. I'm saying once you've gotten your body used to the pills, sometimes it can even create other illnesses… I always tell the doctors that I always take natural remedies myself when I'm taking their medication because natural remedies are very important. The doctors also know this. They know the natural one is very important” -woman, 41yo.

**Feeling Conflicted Towards Healthcare System**

It is important to note that participants expressed conflicting feelings towards the U.S. healthcare system. Based on previous experiences, what they have witnessed, and what they believe about the healthcare system, while participants have a level of trust and respect for doctors’ knowledge and expertise, there is an element of distrust based on the belief that the healthcare system is run like a business. Participants believe that the U.S. healthcare system is the most advanced and has the capacity to do “great things” for people’s well-being; however, they are concerned that doctors are pushing drugs and are focused on paying off their student loans to where patients become more like customers.
“America, I believe- well, part of my belief, it's not a full belief. But they push, especially since I've worked in the pharmacy, it's a big industry. It's like it's a business. So they are-sometimes you don't really need what the doctor is prescribin’… I've seen and talked to pharmacists, so not necessarily need it, but because the drug rep might have stopped by a few days ago and... So they push drugs” -woman, 31yo.

“Here in the U.S., I believe we have the best medical system here. But… we are in a capitalist country… the doctor here, they spend a lot of money to become a doctor and sometime after the degree, they have a lot of debt. And the system, the connection with the pharmaceutical people, sometime, if God does not lead you to a good doctor- hmph! …I trust the system in a way. In the other way, I don't trust it because of the business part… If they are focused on helping people, U.S. will be the best, the BEST place to come and get result. But if they are focusing on the business part, it's gonna be a problem. So that's why me, as a person, I am very cautious, to be sincere” -man, 42yo.

Participants also shared that they feel Western medicine has its limits, and one participant shared a story of how natural medicine in Haiti performed healing while medical providers in the U.S. took 10 years of treatment without results.

“Sometimes, the doctor themself, they have their expertise, but you also sometimes- I'm giving you a true situation. A man who had an accident, he was paralyzed… He went through doctors here, all the therapy. They did everything for him, and he was still in a wheelchair. There was a Haitian who said, ‘I'm not saying the doctors’ medications aren't good or the people's therapies aren't good. Why don't you go to Haiti and get herbal medicine to get you results?’ He went. He didn't even spend three months, and when he
returned, he left the wheelchair… the doctor has his own expertise, but herbal medicine
has its expertise too” -woman, 41yo.

Participants expressed the feeling that doctors do not engage in caring and clear
communication with patients, which impacts their experiences with formal health-seeking. As
they shared their feelings and attitudes towards the U.S. healthcare system, they were
“Emphasizing the Responsibility of the Healthcare System”, where they stressed the need for
better communication with patients where they can feel heard, understood, and validated
regarding their health concerns. In addition, participants expressed that healthcare providers
should assess the need for interpretation and provide interpreters by hiring staff who speak their
language. Some Haitian immigrants seek Haitian doctors to avoid the communication barrier.

“…a woman said they are complaining of having headache, headache, headache,
headache each time. Yep, they have to listen to them. People, they want to be listened to.
Seeking access is one thing, but the provider need to listen. Somebody is seeking health
services, they want to feel validated about what they feel, the way they feel” -woman,
70yo.

“There is a lot of people going to the doctor, they have a problem. Based on
miscommunication, the diagnosis is taken by the doctor wrong. So the doctor don't
understand what they say, what they really need, how they can address the problem. But
that's why, if somebody catch and understand that the patient don't really speak good
English, they don't really understand it, they have to make sure, what is their nationality,
what is the best language you speak, and put some people there to assist him that day, or
somebody can translate to assist him to get better services. That's my concern. That's one
of the things that's really important for me in our community… That's why it's really
important for the provider to get enough people in different languages to help give people services” -man, 46yo.

Of note, one participant shared that Haitian immigrants are eager for natural medicine to be incorporated into the U.S. healthcare system so that they can choose alternative methods for treating illness that align with their cultural norms and practices. Another participant shared her experience with being taught the importance of providing culturally appropriate care in medical school.

“…and that's why I can say Haitian people gonna really need- cannot wait to see when the OMS [World Health Organization] can take a decision to involve other training, other naturalist people, make people get choice to choose. ‘Oh, I wanna go to the naturalist,’ then there is a special part in all the hospitals. ‘Oh, I wanna go to the emergency’ or ‘to treat my sickness on the naturalist’ or ‘I prefer the drugs.’ …for me, I think it's time OMS can put that in the medical system here. So, use natural stuff to save people's lives better” -man, 46yo.

“I had one of my professor, he said, ‘If a patient say that “I am taking”, let's say, “cinnamon tea.” Say, “Okay. Take the cinnamon tea with the medication.” As long as, you know, there is no contraindication for both of them.’ So he said, ‘You have to respect the culture. If you want your patient to follow your advice, you have to respect their culture’” -woman, 55yo.

Table 2 shows the categories and their associated subcategories that emerged during the data analysis process. It is important to note that “Being Desperate” is not a main category. Rather, it serves as an axial code based on its characteristics. “Being Desperate” shows the
conditions under which participants are able to move from one point to another (bypassing barriers after “Considering Healthcare Service Use” to “Seeking Medical Attention”) along the health-seeking decision-making process (Charmaz, 2014; Saldaña, 2013). “Being Desperate” is therefore not listed in the table; however, it was described in the Haitian Immigrant HSDM Process Model.

Table 2 Categories and Associated Subcategories

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<td>Self-Diagnosing</td>
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<td>Assessing the Condition</td>
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<td>Doing Research</td>
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<td>Self-Treating</td>
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<td>Barriers to Formal Health-seeking</td>
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<td>Fearing Negative Outcomes</td>
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<td>Emphasizing the Responsibility of the Healthcare System</td>
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CHAPTER FIVE: DISCUSSION

This chapter provides a discussion of the findings from this study, including its relevance and contributions to the current literature and its implications for policy and practice. In addition, this chapter discusses the limitations of the study and provides suggestions for future inquiry.

The aim of this study was to explore the health-seeking decision-making process and behavior among Haitian immigrants living in the U.S. and develop a descriptive theory that demonstrates this process and its embedded behaviors. The findings from this study generate a greater understanding of the second largest Black immigrant population in U.S. (Anderson, 2015; Tamir, 2022) that experiences significant health disparities (Allen et al., 2013; American Cancer Society, 2019; Cyrus et al., 2016; Green et al., 2018; Jean-Louis & Webb, 2021; Pinheiro et al., 2016; Sanon et al., 2014; St-Hilaire, 2019), yet one that demonstrates significant strengths as well. Using the Grounded Theory approach for this study provided the avenue to elevate the voices of the participants to a position of educating the researcher, rather than forcing their responses into an existing theoretical framework where the nuances of the Haitian culture might have been lost.

The Haitian Immigrant HSDM Process Model

In response to the research question for this study (How do Haitian immigrants make decisions about their health-seeking behaviors?), the theoretical model that I developed based on my analysis of the data demonstrates that Haitian immigrants draw from their Haitian identity and cultural upbringing when making decisions and engaging in behaviors to address a health concern. The cultural upbringing occurs in various ways, including direct teaching from parents and experiences while growing up in Haiti, vicarious experiences through the lives of others in the Haitian community, and being socialized into Haitian cultural norms related to dealing with
illness. As seen in the Haitian Immigrant HSDM Process Model, the overarching theme is “Being Haitian”, which is weaved into each of the steps in of the health-seeking process in terms of the Haitian cultural beliefs, values, norms, attitudes, and preferences that come to the forefront when dealing with an illness. For example, participants often began their responses with phrases such as “as a Haitian”, demonstrating that their thought processes and behaviors are embedded in alignment with their cultural identity. In the context of identity formation, Cone et al. (2014) describes this identity representation as an individual presenting and representing their cultural ideas “as part of oneself in a given context” (p. 267).

In addition, participants often drew upon their cultural norms and recollected direct and vicarious experiences with traditional methods for dealing with illness- especially with regard to the use of natural remedies as the first step to addressing illness. Though the act of attempting to treat oneself before seeking medical attention is not unique to the Haitian culture, participants consistently associated the practice of using natural remedies such as teas with their identity as a Haitian. For example, as described in the results, participants spoke of the remedies they learned directly and indirectly while growing up in Haiti. When they were faced with illness, they would make the same remedies they remembered seeing their parents or grandparents making in the past, or what their parents and grandparents explicitly taught them to make. This demonstration of meeting cultural expectations throughout the health-seeking decision-making process can be described by the fourth dimension of identity as seen in the Multidimensional Model of Racial Identity. This dimension of identity is ideology, which is an individual’s belief about how racial/ethnic group members should act and thus influences behavior (Sellers et al., 1998; Schnittker & McLeod, 2005). Both consciously and subconsciously, participants in this study
described their thought and behavioral processes as being in alignment with what they believe Haitians in general do.

Other theoretical models such as those adapted by the Health Belief Model and Theory of Planned Behavior position ethnicity as one of several demographic variables, and demographic variables is one of several background factors that influence beliefs, perceptions, and attitudes, which then influences health behavior (see Etheridge et al., 2023). These theoretical models position culture as a distant influential factor in health behavior. However, the theoretical model that was developed based on the findings from this study shows that for Haitian immigrants, ethnic identity is the umbrella under which every step of the health-seeking decision-making process and associated behaviors are directly influenced or impacted.

One of the most used models in studies regarding the access and use of healthcare services is Andersen’s Health Behavior Model (Andersen, 1968, 1995; Akresh, 2009; Cabassa et al., 2006; Derose et al., 2011; Yang & Hwang, 2016). This model has undergone several phases and posits that individuals’ healthcare service use is based on predisposing factors such as demographics (e.g., age and gender), social structure such as ethnicity and education, and health beliefs; enabling factors including resources such as income, health insurance, and a source of regular healthcare; and a perceived need (Andersen, 1995, 2008; Yang & Hwang, 2016). In addition, the model recognizes “an additional type of health behavior- personal health practices such as diet, exercise, and personal health practices- that interact with the use of health services to influence health outcomes” (Andersen, 2008, p. 652). While Andersen’s model reasonably predicts help-seeking, it becomes problematic when the model is then applied to immigrant and refugee populations as it neglects to account for their pre- and post-migration contexts (Portes et al., 1992). For example, the model does not account for Haitian immigrants’ pre-migration
experiences with enabling factors such as health insurance and access to a source of regular healthcare, nor does it account for pre-migration meanings of need that shape their perceived need in the post-migration context. This study provides examples of how Andersen’s Health Behavior Model is not the best fit model to explain health-seeking among immigrants. As stated above, findings from this study show that the most salient factor in the health-seeking decision-making process for Haitian immigrants is not just the social structure of ethnicity, but their Haitian identity, such that this cultural identity crosses the boundary of a predisposing factor into the perceived need, which is influenced by cultural beliefs and norms in terms of when medical attention is warranted. Also, Andersen’s Health Behavior Model focuses on personal health behaviors in terms of its influence on the health outcomes of individuals. It does not account for self-treating as a form of health behavior. Haitian immigrants’ personal health behavior outside of the use of healthcare service is seen in the informal health-seeking stage where they engage in self-treatment. Thus, the Haitian Immigrant HSDM Model serves as a more comprehensive and culturally-specific model demonstrating the health behavior and process of decision-making among the Haitian immigrant population. Andersen’s Health Behavior Model is limited as it relates to explaining and predicting health behavior among cultural groups such as immigrant and refugee populations.

**Social Networks and Social Support**

The most repeated behavior along the health-seeking decision-making process was participants engaging in consultation with family, friends, and religious leaders, primarily within the Haitian community. As described by Social Network Theory, the connections participants described were with people who shared the same values and beliefs, who provided social support, and who had influence in their decisions (Heaney & Israel, 2008; Zhang, 2010). These
repeated consultations within participants’ social networks denotes the value of community and the level of trust within the Haitian community, the space where various forms of social support are frequently sought and at times received unsolicited, though mostly welcomed.

Participants discussed a variety of types of social support they received from their social networks: informational support, instrumental support, appraisal support, and emotional support. Participants described receiving information regarding the ingredients to use for natural remedies, advice on actions to take next (both active by request and passive by unsolicited advice), and- when they’ve decided to seek medical attention- recommendations on healthcare providers they should go to. Participants described instrumental support in terms of either getting remedies from others such as parents, as well as receiving plants from family, friends, or neighbors to make the remedies themselves or to grow the plants themselves at home. In terms of appraisal support, although mostly unsolicited, participants receive feedback on current health-seeking behaviors, such as whether they’re taking too long with their illness and need to see a doctor, whether they should be trying other things to get better, or even subtle disapproval for using healthcare services and thus stigmatizing the use of healthcare services- which is discussed next.

Social networks and social support are critical for immigrant and refugee populations in the post-migration context. Strong and supportive social networks that consist of others from the same culture provides a safety net and helps to reduce acculturative stress (Morey et al. 2020). In terms of health-seeking decisions and behavior, social networks can facilitate the connection between immigrants and the healthcare system through social support. Previous studies show that social networks among immigrant and refugee populations affect healthcare access as they play a role in helping immigrants and refugees navigate the healthcare system and access
healthcare services (Blanas et al., 2015; Boateng et al., 2012). Even among the participants who stated they made decisions about health-seeking independently, social networks played a role in their decision-making and behaviors. For example, the expectation that others such as siblings and parents would disapprove their lack of attempting natural remedies first played a role in participants choosing to engage in self-treatment through natural methods first. In addition, receiving comments from others about their need to seek medical attention encouraged participants to move from informal to formal health-seeking. This can be deemed reflected appraisal, a component of appraisal support described as the perception of how one is viewed by others, whereby others’ feedback shapes behaviors and decision-making (Johnson, 2016; Matsueda, 1992).

The cultural value of community also plays a significant role in bypassing barriers to formal health-seeking. According to Zhang (2018), people’s intentions to carry out behavior is negatively affected when they lack the capacity, the necessary resources, and the opportunities to act on the behavior, and the behavior in this context within this study is formal health-seeking. Based on the findings in this study, participants discussed how lacking financial resources and fear of immigration issues are significant impediments to seeking medical services. In the context of community support, accessing social support by borrowing money from social networks is a method for bypassing this barrier when Haitian immigrants feel desperate based on their assessment that their condition needs the attention of a medical provider. Thus, the social networks within the Haitian community can provide social supports that can facilitate formal health-seeking behavior when necessary. However, this does not remove the need for more affordable access to healthcare services for all. Patients should not have to find themselves in a
situation where they feel desperate for medical attention due to lacking the finances to seek medical attention earlier.

**Stigmatizing Healthcare Use**

Stigma is most often associated with accessing mental health services. What was interesting in this study is the cultural stigmatization of non-mental health-related healthcare service use. Participants discussed the belief among the Haitian community that seeking medical care is only for when someone is very sick, or when the sickness has gone beyond their control to where they either can no longer bear the pain from their illness, or the illness has begun to impact their daily functioning - including their ability to work. Thus, formal health-seeking is seen as a last resort. These findings are similar to a study by Hassan et al. (2021) with East African immigrants, where the cultural belief among the participants is that seeking medical attention was for when there is the presence of illness, when one was “very sick”, or when illness negatively impacted daily functioning; and this belief leads to the avoidance of using preventative health services such as health screenings and wellness visits. This study shows that the stigma held by Haitian immigrants through their belief of healthcare service use being last resort plays a significant role in their health-seeking decisions and behavior even in the presence of symptoms of illness, not just for preventative health. Instead of seeking medical attention, Haitian immigrants engage in preventative healthcare by focusing their efforts on avoiding the causes of illness, such as poor dietary practices like eating fast food and excessive sugar. The lack of preventative healthcare through medical attention can have negative consequences in terms of early identification of illness and disease, as well as early intervention. Implications are further discussed in this chapter.
In addition, this stigma towards using healthcare services was seen in participants’ expectation of receiving disapproval for not using natural remedies as the first method for treating illness, and the assumption among social networks that if you are going to see the doctor, something must be wrong. This stigma is one of the drivers for Haitian immigrants’ leaning towards their traditional cultural methods for treating illness, and inadvertently, it can lead to delays for seeking medical attention. Thus, while the use of natural remedies itself may not be harmful, the stigma associated with formal health-seeking can sustain health disparities and higher morbidity and mortality within the Haitian immigrant population.

**Conducting an Analysis**

Participants also discussed that as they consider seeking medical attention, they conduct an analysis of their resources and the benefits of seeking medical attention (addressing their need for more than natural remedies). This analysis can be described by Rational Choice Theory. According to Scott (2000), Rational Choice Theory was built upon the notion that “all action is fundamentally ‘rational’ in character and that people calculate the likely costs and benefits of any action before deciding what to do” (p. 126). Thus, the decision Haitian immigrants take to engage in formal health-seeking is a rational act on the basis of determining that seeking medical attention is a benefit that outweighs the cost of taking time off from work and spending money. Participants discussed the priority of going to work and to make enough money to support their families both within the U.S. and in Haiti.

**Fear of Immigration Issues**

The concern for potentially facing immigration issues has been cited as a concern that leads to reluctance to seeking healthcare in previous research, a concern not only for those without legal status, but also for those who are not U.S. citizens (Ryan et al., 2004). After nearly
20 years since the study by Ryan et al. (2004), this continues to be the concern among Haitian immigrants, highlighting the need to provide clarity on immigration policy as it relates to the use of Medicaid for healthcare services, as well as increased protections for vulnerable populations in need of medical attention, including undocumented immigrants. The new Florida immigration law, Senate Bill 1718 (2023), which requires hospitals receiving Medicaid funding to ask patients their citizenship and immigration status and to submit reports on this data to the State’s Agency for Health Care Administration on a quarterly basis, simply validates this fear of immigration issues for those who desire to seek medical services.

**Attitudes Towards the Healthcare System**

Participants in this study demonstrated conflicted attitudes of trust towards the healthcare system. On one hand, participants valued the expertise of healthcare providers and believed that conventional medicine could provide the treatment they needed if they sought medical attention. On the other hand, participants expressed concerns of distrust towards the healthcare system based on direct and vicarious experiences with poor communication regarding treatment that led to excessive use of prescription medication, feeling the U.S. healthcare system is ran like a business more than a system that focuses on the patient’s well-being, observed issues with medication errors and “pushing drugs”, and feeling unheard. Prior literature showed contrasting results of Haitian immigrants’ trust towards the healthcare system (Allen et al., 2013; Joseph et al., 2012). However, this study demonstrates that the attitudes of Haitian immigrants is a conflict of feeling both trust AND mistrust towards the healthcare system, rather than a trust OR mistrust. This conflict impacts not just the intentions or speed of which they engage in formal health-seeking, but also in their preferences for treatment after seeking medical attention.
Implications

The findings from this study have implications for current and ongoing consideration to address health disparities among the Haitian immigrant population. The theoretical and policy implications of this study also lead to considerations for practice, not just within the healthcare system. These implications are discussed herein, and recommendations for policy and practice are also provided.

Theoretical Implications

The Haitian Immigrant HSDM Process Model that emerged from this study demonstrates that culture should not remain as one component that is considered when making decisions. While an individual may not engage in a behavior that is completely in alignment with their culture (e.g., avoiding natural remedies when treating symptoms of illness), it does not mean that cultural norms and expectations are not present in their thought process. Therefore, when working with minoritized populations such as Haitian immigrants, it is critical to consider culture as the framework within which beliefs, attitudes, values, and preferences lie. Culture is beyond one of several demographic factors that influence health-seeking among Haitian immigrants. Rather, Haitian immigrants’ cultural identity and experiences are infused into every step of the health-seeking decision-making process.

Policy Implications and Recommendations

This study as implications for policy reform that can promote social justice in terms of reducing health disparities and supporting cultural inclusiveness in both healthcare services and within the community. As such, policy reform can take place within the healthcare system, as well as in housing development.
Healthcare Policy

Providing culturally appropriate healthcare services is crucial for reducing and eliminating health disparities among the Haitian immigrant population. Through Title VI of the Civil Rights Act of 1964, individuals who have limited English proficiency are provided the right to receive language assistance services, which includes the requirement to provide language services within the healthcare system (Chen et al., 2007). To comply with this Act, the U.S. healthcare system developed the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS), which serves as a guide for healthcare providers (Diamond et al., 2010; Office of Minority Health, n.d.). According to the Office of Minority Health (n.d.), the aim of the CLAS Standards is to “advance health equity, improve quality, and help eliminate health disparities by establishing a blueprint…” (p. 1). The primary standard within this blueprint is for the healthcare system and healthcare organizations to “Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs” (Office of Minority Health, n.d., p. 1).

Unfortunately, the CLAS Standards has not been fully realized in terms of its name. To meet the CLAS standards, healthcare service provision needs to focus not only on providing linguistically appropriate services to reduce communication challenges; they must put forth concerted effort to provide culturally appropriate services as well. This means that there needs to be increased awareness among healthcare providers of how culture plays a significant role in the behaviors, attitudes, preferences, and experiences of the patients they serve. Medical schools, nursing schools, and other allied health educational programs throughout the U.S. are in the
position to teach cultural assessment to the healthcare taskforce and should take up the mantle of teaching future practitioners to incorporate culture into treatment plans as much as possible.

Haitian immigrants value and prefer natural remedies over synthetic prescription medication. This has implications for immediate and long-term treatment for illness among this population. Health insurance coverage, which includes prescription drug coverage, plays a significant role in medical treatment as it relates to this. To align with providing culturally appropriate healthcare services, health insurance policies can include ingredients for natural remedies as a form of prescription, especially for herbs and specialized foods that may not be readily accessible due to their limited availability in grocery and health food stores and high costs. This leads to more culturally inclusive healthcare services that can lead to better health outcomes for Haitian immigrants.

**Housing Policy**

While this study focuses on health-seeking, the findings have implications for policy in terms of housing development as it relates to supporting the health and well-being of people through gardening. Participants in this study highlighted the Haitian cultural practice of growing plants wherever they live, whether in the ground or in pots. Planting herbs and foods are important to Haitian immigrants as this provides easy access to natural medicine for healing. This has unique implications for the development of apartment buildings, where Haitian immigrants would not have access to a front yard or backyard for planting. As new housing developments continue to sprout throughout the country, it is important to include green spaces that allow for gardening, whether as a designated space for community gardening, or in individual spaces embedded within the floorplan of each home (e.g., patios).
Practice Implications and Recommendations

This study also has practice implications for healthcare providers. To provide culturally appropriate healthcare services, healthcare providers need to take the time to explore culture beyond asking about racial/ethnic and religious backgrounds in intake forms and ensure culturally appropriate services are provided to patients throughout the course of the patient-provider relationship, and throughout the course of their medical treatment. For example, there should be conversation regarding the use of natural remedies such as herbs and various types of food that may provide the same or similar benefits as synthetic medication such as pills, or regarding the possible contraindications of combining certain natural remedies with synthetic medication, as one participant noted from her medical training. In addition, healthcare providers can provide culturally appropriate healthcare services by being inclusive when prescribing medication. For example, based on Haitian immigrants’ preference for natural remedies, doctors can prescribe the use of herbal teas that are comparable to the medication they would have otherwise prescribed- at least as a first plan of action to address illness. This shows patients that their cultural values are being respected.

Collaboration with faith-based organizations should also be considered as an approach to help reduce and eliminate health disparities among Haitian immigrants. Haitian immigrants perceive formal health-seeking as a secondary option and last resort (Colin, 2021). Based on this perception and the stigma of healthcare service use, seeking preventative healthcare services is less likely to be common practice among the Haitian immigrant population. However, participants noted the powerful influence of the church for introducing and supporting the normalcy of seeking medical services that is not limited to the presence of illness. Partnering with faith-based organizations can include providing preventative healthcare services such as
health screenings and annual exams through mobile clinics at local Haitian churches. This approach can provide opportunities for health education and the early detection of health issues such as chronic illness, thus providing opportunities for illness prevention and early intervention. Given the high level of trust for religious leaders, partnering with faith-based institutions can also include training religious leaders such as pastors, elders, and other trusted individuals in the faith community as community health workers to serve as advocates and liaisons for Haitian immigrants.

**Strengths and Limitations**

While heterogeneity in this sample may first seem to be a limitation, it eventually becomes a strength as diversity within the sample gives voice to Haitian immigrants from various ages and different genders. Participants identified as both men and women, and their ages were at various stages across the lifespan. Based on the U.S. Census guidelines for defining age groups, participants in this study can be classified across all the following categories: Young Adulthood, Middle Adulthood, and Older Adulthood (Lindemann et al., 2018). This diversity allowed the data to be richer and the findings more inclusive of the experiences and perspectives of the Haitian immigrant population. Another strength is the methodology used in this study-grounded Theory. Using this the Grounded Theory approach provided an opportunity elevate the voices of members from a specific cultural group, allowing this study to feature their unique characteristics, strengths, values, and experiences which might not have otherwise been noticed using a different methodology.

This study also has limitations, specifically related to the recruitment of participants, location, and the implications of the findings. In terms of recruitment, the researcher attempted to include participants from various backgrounds in terms of formal education. To do this, local
community partners shared the recruitment flyer with Haitian immigrants from different socioeconomic backgrounds, which included sharing the flyer at community events that were held in lower-income neighborhoods in addition to sharing it with a wider audience through email. However, although some participants were living in neighborhoods with lower income statuses, all the participants who responded to the recruitment efforts completed some level of formal education, and they all engaged in educational opportunities beyond high school. For example, the one participant who completed high school is currently a college student. Education is highly valued in the Haitian culture; thus, when they can access educational opportunities, Haitians take advantage of it. Thus, while the researcher attempted to obtain the perspectives among a variety of educational backgrounds, the outcome was that all participants acquired some level of formal education. Based on the location of the sample being limited to Central Florida, the Haitian Immigrant HSDM Process Model is limited to the experiences of Haitian immigrants in this particular region of the U.S. Including participants from other parts of the U.S. may reveal additional data that can be included in the current theoretical model. However, the goal of this study was not to generalize the findings to the entire Haitian immigrant population.

**Future Research**

Additional research can be conducted to test the developed theory— the Haitian Immigrant Health-Seeking Decision-Making Process Model. In addition, research should be conducted to further explore structural and network factors that affect the health behaviors among Haitian immigrants, and to develop culturally appropriate interventions to address the health disparities within the community. For example, it is worthwhile to explore the impact of religion and religious leaders on the health behaviors of the Haitian community. In terms of research related to healthcare intervention, a community-based participatory research (CBPR) or community
engaged research approach should be conducted to develop evidence-based online educational content (e.g., YouTube and Google) in Haitian Kreyol to provide information that both aligns with the Haitian culture (e.g., home remedies), as well as provides guidance on how to safely engage in self-treatment in ways that do not negatively impact their health if they have any chronic illnesses, how to self-monitor in ways that do not delay necessary medical attention, and how to communicate with healthcare providers about treatment plans. In addition, future research should focus on building evidence for alternative treatments such as natural remedies.

It is important to note that future work on the development of interventions and programs that seek to address health disparities among Haitian immigrants should not abuse the trust Haitian immigrants have towards their community by exploiting community members and leaders for the purpose of changing the cultural values, practices, and preferences of Haitian immigrants. Rather, future work on developing interventions and programs should leverage the cultural values, practices, and preferences as a guide and as a sign of respect for the Haitian culture, and they should focus on the goal of providing psychoeducation to increase the capacity of Haitian immigrants to make informed decisions regarding their health, thus also maintaining the social work value of the right to self-determination.

**Conclusion**

This study used the Constructivist Grounded Theory approach to respond to the research question, “How do Haitian immigrants make decisions about their health-seeking behaviors?” Upon conducting data collection through one-on-one interviews and a heterogenous focus group with adult Haitian immigrants living in the Central Florida area, and inductive coding using the Grounded Theory data analysis approach (initial coding, focused coding, and theoretical coding), a theory emerged that demonstrates the thoughts and behaviors involved in the health-seeking
decision-making process. The Haitian Immigrant Health-Seeking Decision-Making Process Model provides a visual representation of this theory, which shows how Haitian immigrants draw upon their identity and frequently obtain support from their social networks to address a health concern. This study has implications for healthcare and housing policy and healthcare practice, including the development of culturally appropriate healthcare programs and interventions; teaching culturally aware practices in medical schools, nursing schools, and other allied healthcare programs; and the provision of green spaces in housing developments.
June 7, 2023

Dear Shelleta Ladonice:

On 6/7/2023, the IRB determined the following submission to be human subjects research that is exempt from regulation:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study, Category 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Understanding Health-Seeking Decision-Making Process and Behavior Among Haitian Immigrants: A Grounded Theory Approach</td>
</tr>
<tr>
<td>Investigator:</td>
<td>Shelleta Ladonice</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00005621</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
</tbody>
</table>

Documents Reviewed:
- Communication Scripts, Category: Recruitment Materials;
- Explanation of Research, Category: Consent Form;
- Explanation of Research- Translated, Category: Consent Form;
- Focus Group Protocol, Category: Interview / Focus Questions;
- Interview Protocol, Category: Interview / Focus Questions;
- Qualtrics Demographic Survey, Category: Survey / Questionnaire;
- Recruitment Flyer, Category: Recruitment Materials;
- Recruitment Flyer- Translated, Category: Recruitment Materials;
- Recruitment Script- Community Referral, Category: Recruitment Materials;
- Recruitment Script- Self-Referral, Category: Recruitment Materials;
- Request for Exemption, Category: IRB Protocol;
This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the human research, please submit a modification request to the IRB. Guidance on submitting Modifications and Administrative Check-in is detailed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Sincerely,

Renea Carver
UCF IRB
APPENDIX B: RECRUITMENT FLYER
Share your thoughts about how Haitian immigrants make decisions to seek healthcare!

Shelleta Ladonice, a doctoral student at the University of Central Florida, is conducting a study to better understand how Haitian immigrants make decisions about seeking assistance or services to address a health need or concern.

You are eligible to participate in a one-on-one interview or a focus group if you:

- Are an immigrant who was born in Haiti,
- Are age 18 or older,
- And currently live in Central Florida.

What can I expect?

- Interviews will be in person or on Zoom and will take between 60-90 minutes.
- Focus groups will be on Zoom only and will take between 90-120 minutes.
- If you need a translator, one will be provided.
- You will be asked questions about how you make decisions about seeking healthcare.
- You must complete a brief online demographic survey.
- You will receive a $50 gift card as an appreciation for your time.

How will this affect me?

- Your participation is completely voluntary.
- Your contact information is kept entirely confidential. Focus groups are encouraged to maintain group members' privacy.
- Participating in this study will not affect any services you are receiving, nor will it affect any involvement with immigration.

If you are interested in participating or for additional information about this study, please contact the Principal Investigator, Shelleta Ladonice, directly by email at shelleta.ladonice@ucf.edu, or by phone at 813-702-9947.
APPENDIX C: ELIGIBILITY SCREENER
Thank you for your interest in this study. Please complete this screener to determine your eligibility to participate. Click on the next button on the bottom right of the screen to answer the screening questions.

In which country were you born?

- United States
- Bahamas
- Canada
- Dominican Republic
- Ghana
- Haiti
- Nigeria
- Sudan
- Other (please specify) __________________________________________________

What is your age?

▼ Under 18 ... 85 or older

In which state do you currently live?

▼ Alabama ... Wyoming

What is the zip code for the address where you currently live?

__________________________________________
Please provide your contact information below.

- Name (e.g., Jean Charles)

- Email Address (e.g., jeancharles@ymail.com)

- Phone Number (e.g., 222-333-4444)
Title of Study: Understanding Health-Seeking Decision-Making Process and Behavior Among Haitian Immigrants: A Grounded Theory Approach

Principal Investigator: Shelleta Ladonice, MSW

Faculty Supervisor: Asli Yalim, PhD

You are being invited to take part in a research study. You can choose whether you want to take part. The purpose of this study is to better understand how Haitian immigrants make decisions about seeking healthcare. Understanding the process of health-seeking decision-making and behavior among Haitian immigrants can guide interventions that seek to address the health issues among Haitian immigrants.

You are being asked to participate in a one-on-one interview or a focus group and complete a brief demographic survey online. Interviews will be in person or online via Zoom and will take between 60-90 minutes. Focus groups will be online via Zoom and will take between 90-120 minutes. We will discuss your thoughts and experiences about making decisions to address a health concern. A translator will be provided if needed, or you may choose to have an adult translator that you provide yourself if you prefer.

You will be audio recorded during this study. If you do not want to be recorded, you will not be able to participate in the study. The audio recording will be transcribed (a typed version of the interview). Per UCF policy, the data, which includes the audio recording, will be kept for a minimum of five years after this study is completed.

Identifiable data collected includes your contact information (e.g., name, email address, phone number), audio recording, and signature/initial for the gift card. De-identified data collected includes the transcript of the recording and your survey responses. Any identifiable information that may come up in the recording (e.g., names, specific location) will be removed from the transcript to protect your confidentiality. The de-identified transcript will be accessible by myself, you as the participant, and my faculty supervisor; will be kept indefinitely; and could be used for future research studies without your additional informed consent. To ensure confidentiality, the de-identified data will be stored separately from identifiable data. All data will be stored in a password protected folder.

To take part in this research, you must be an immigrant who was born in Haiti, be 18 years of age or older, and currently live in Central Florida. Participating in this study will not affect any services you are receiving, nor will it affect any involvement with immigration.

After completing the interview/focus group, you will receive a $50 gift card. Based on availability, you can choose from a variety of gift cards (e.g., Amazon, Walmart, Wawa, Visa). The gift card will be provided in person (in-person interviews only), by mail, or electronically by email. If you receive your gift card in person, you will be asked to sign/initial as proof of receipt. You can choose to not provide your signature/initial. You must complete both the interview/focus group and the survey to receive the gift card.

Study contacts for questions about the study or to report a problem: If you have questions, concerns, or complaints, please contact Shelleta Ladonice, Principal Investigator, Graduate Student, Doctoral Program in Public Affairs- Social Work PhD Track, College of Community Innovation and Education at (813) 702-9947 or by email at shelleta.ladonice@ucf.edu; Dr. Asli Yalim, Faculty Supervisor, School of Social Work, College of Health Professions & Sciences at (407) 823-4660 or by email at asli.yalim@ucf.edu.

IRB contact about your rights in this study or to report a complaint: If you have questions about your rights as a research participant, or have concerns about the conduct of this study, please contact Institutional Review Board (IRB), University of Central Florida, Office of Research, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901, or email irb@ucf.edu.
APPENDIX E: SEMI-STRUCTURED INTERVIEW QUESTIONS
1. When it comes to sickness, can you tell me the steps you would typically take if you started to feel sick? (Prompts: What is the first thing you would do? Under what conditions would you reach out to someone about your symptoms? Who would you reach out to about your symptoms?)

2. Who or what would help you decide what to do if you were feeling sick? (Probe: In what ways would they be helpful? E.g., information, advice)

3. When would you decide whether you should see a doctor? (Prompt: What circumstances would lead you to see a doctor?)
   a. Probe if they wouldn’t see a doctor: What would keep you from seeing a doctor?
      What would you do instead of seeing a doctor?

4. How would you decide whether you would see a doctor? (Prompt if needed: Would you think about any resources or barriers you might have?)

5. What would you do differently if you started feeling sick while you were in Haiti?
   (Probe: What makes the difference between what you would do in Haiti vs. in the U.S.?)

6. Research shows that immigrants in the U.S. are less likely to seek medical services than those born in the country. What are your thoughts about that?

7. Is there anything else you would like to share that would help me better understand how you make decisions about seeking health? Is there anything I might not have asked about, but you feel is important to for me to understand? (Prompt: Any suggestions?)

8. Would you be willing to talk with me again if I have more questions?

9. What questions do you have for me?
APPENDIX F: SEMI-STRUCTURED FOCUS GROUP QUESTIONS
1. When it comes to sickness, what do Haitian immigrants typically do if they started to feel sick? (Prompts: What are the normal actions that are taken within the Haitian culture? What have you seen or heard your peers or family members do?)

2. What resources do Haitian immigrants consider if they are feeling sick? (Prompt: Who would they talk to? What resources within or outside of the Haitian community do they use or try to use?)

3. Probe: In what ways would they be helpful? (E.g., information, advice, help)

4. What are the non-medical methods used within the Haitian culture to address sickness?

5. When do Haitian immigrants use these methods?

6. What barriers exist to using these methods within the U.S.?

7. When do Haitian immigrants decide whether they should see a doctor? (Prompt: What circumstances would lead them to see a doctor or consider seeing a doctor?)

8. Probe if they wouldn’t see a doctor: What keeps Haitian immigrants from seeing a doctor?

9. Research shows that immigrants in the U.S. are less likely to seek medical services than those born in the country. What are your thoughts about that?

10. Is there anything else anyone would like to share that would help me better understand how you make decisions about seeking health? Anything I might not have asked about, but you feel is important to for me to understand? (Prompt: Any suggestions?)

11. Does anyone have questions for me?

12. Would anyone be willing to talk with me again if I have more questions?
APPENDIX G: DEMOGRAPHIC SURVEY
Thank you for participating in the study about how Haitian immigrants make decisions about seeking healthcare. Please complete this brief demographic survey. If you have any issues completing these questions, please let me know.

Please provide consent to participate in the study by responding to the statement below.
I have read the Explanation of Research document and I agree to participate in this study.

- Yes
- No

Participant Number (check your email):
________________________________________________________________

What is your gender?

- Man
- Woman
- Non-binary / third gender
- Another (please specify) ________________________________________________
- Prefer not to say

What is your age?
________________________________________________________________

How long have you been living in the U.S.?

- Number of years ______________________________________________________
- Number of months _____________________________________________________

At what age did you move to the U.S.?
________________________________________________________________
What are the circumstances that lead to you leaving Haiti?
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

What is your highest level of education?

- Some high school, but did not graduate
- High School Diploma/GED
- Some college, but did not graduate
- Professional School/Certification
- Associate's (AA/AS) degree
- Bachelor's (BA/BS) degree
- Master's (MA/MS) degree
- Advanced degree (M.D/D.O., J.D., Ph.D., or another advanced degree)
- Another (please specify) ____________________________________________

How do you describe your identity?

- Haitian
- Haitian-American
- American
- Another (please specify) ____________________________________________
In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

What is your marital status?

- Single
- Married
- Widowed
- Divorced
- Separated
LIST OF REFERENCES


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health care. Think Cultural Health.

https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf


https://doi.org/10.1007/978-1-4419-7142-5_1