BARRIERS TO HEALTHCARE AND RESOURCES FOR IMMIGRANT WOMAN

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ABSTRACT

Health equity focuses on ensuring all individuals have equal access to care and resources, but not everyone has this opportunity, particularly immigrant women within the Riverside communities. This is a critical issue, as access to essential health resources should not be a concern, particularly in life-threatening situations. Female immigrants face significant barriers when seeking access to healthcare and other resources. By exploring how they are treated and the potential obstacles or delays they encounter, we can identify gaps in the system. To investigate, we conducted in-depth, one-on-one interviews with immigrant women and UCR students/faculty affiliated with Riverside clinics to capture their individualized experiences. The interviews explored their experiences and situations from their perspective. By receiving more detailed information and scenarios, we were able to get to the common root of the barrier. Certain complications that cause the gap can be things such as cultural barriers (hesitancy, comfort), language issues (translators), or systemic bias issues. Six interviews were conducted with six UCR women immigrant students. Results from the interviews revealed that immigrant women at UCR faced barriers that extended beyond simple access to appointments, including confusion with referrals, insurance, digital navigation, and inconsistent communication across the care process. Participants emphasized that feeling heard, respected, and guided was central to their evaluation of care, while mental health services were often perceived as especially difficult to navigate. These findings suggest that more equitable care depends on stronger coordination, clearer communication, and greater emotional safety throughout the healthcare experience, all of which are critical to developing accessibility, equity, enhancing health outcomes, and lead to an inclusive healthcare system.

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Introduction, Purpose, and Significance

Patient experiences during medical visits vary widely in terms of helpfulness, respect, and responsiveness to their needs. In some cases, patients receive the information and care they require, while in others, gaps in communication between patients and healthcare providers persist. These variations highlight ongoing challenges in achieving health equity. These issues are meant to encourage reflection on personal interactions within healthcare settings and to highlight how different factors can shape the quality of care one receives. They also serve as a starting point for examining whether healthcare systems are truly meeting the needs of all individuals, regardless of their background or circumstances.

Health equity focuses on ensuring all individuals have equal access to care and resources, but not everyone has this opportunity. Immigrant women, as a minority group, may experience challenges in accessing care and resources, sometimes influenced by differences in familiarity with the healthcare system, which can contribute to perceptions or experiences of limited support or treatment. This disparity can stem from a variety of social, economic, and institutional challenges that disproportionately affect marginalized communities (Braveman, 2011). Addressing these inequities is not only a matter of fairness but also a necessary step toward improving overall public health outcomes and strengthening trust in healthcare systems.

This study examines barriers to healthcare access and resources among immigrant women receiving care at UCR Health clinics. The objective is to determine whether significant barriers to accessing these resources exist for this population. This may include: language barriers, racism/discrimination, cultural barriers, and systemic biases. These barriers can create significant challenges that prevent individuals from seeking care, understanding medical information, or receiving appropriate treatment in a timely manner. By exploring how they are

treated and the potential obstacles or delays that they experience, we can identify potential gaps in the system and thoroughly investigate and understand the underlying causes of these gaps. This deeper understanding can help reveal patterns that might otherwise go unnoticed and provide a foundation for meaningful change.

Addressing these issues could improve the healthcare environment for students at UCR. Such improvements would not only benefit immigrant women but also foster a more supportive and inclusive healthcare experience for the broader campus community. This knowledge can play a critical role in the development of accessibility, equity, and quality of care in immigrant populations, enhance health outcomes, and lead to an inclusive healthcare system. Ultimately, these efforts can promote a more just and compassionate approach to healthcare, where every individual feels seen, heard, and valued.

Background

Existing research has documented immigrant women's experiences of struggles in accessing healthcare services and facing inequalities, highlighting how these challenges are deeply rooted and persist across different healthcare settings and populations. Discrimination remains a prevalent issue, continuing to shape the quality of care and access that many immigrant women receive. For example, Latino immigrants are disproportionately denied access to health care services and health insurance (Rivers, 2006), demonstrating how systemic barriers can limit even basic healthcare opportunities. Additionally, research has also indicated that women of color, or Latinas, also experience greater unmet healthcare needs than their white counterparts, due to because only 10% of Latinas report experiencing unmet medical needs, in contrast to 57% of white women (Teruya, 2010), further emphasizing disparities in healthcare outcomes and accessibility. A 20-person study (10 male, 10 female), which assessed experiences

of participants in interaction in care, trust in the system, and views of racism, resulted in several prevailing themes, which included racism in medical care, issues of trust in medical centers, communication, and demands for increased diversity in medical professionals (Williams, 2024), illustrating how interpersonal and systemic factors intersect to influence patient experiences.

Lack of resources is another significant challenge, allowing healthcare inequities to persist and even worsen over time in underserved communities. Human resource shortages and interprofessional collaboration among healthcare providers have also been shown to play an essential role in tackling such challenges (Silva, 2022), indicating that both shortages and coordination issues contribute to ongoing disparities. Inadequacy of certain resources and professional expertise, especially in vulnerable communities, also adds to these challenges, rendering health disparities hard to resolve and sustaining efforts toward equity (Braveman, 2011). In cancer screening research, structural, health-care, and individual barriers are reported, indicating that multi-level interventions that address these barriers and build on community strengths are needed to eliminate disparities (Williams, 2024), which further reinforces the importance of comprehensive and coordinated solutions. This literature underscores the need for interventions against both discrimination and resource limitations in healthcare facilities, especially among immigrant women in Riverside clinics, and for system-level interventions to bridge these gaps while addressing both immediate and long-term inequities.

Previous efforts have attempted to address this issue, though they have varied in scope, effectiveness, and inclusivity. For example, national and local private health foundations have supported initiatives to assist a slow-moving state in expanding its Medicaid program; however, these efforts focused on select populations while excluding others (Fox & Kahn-Troster, 2022), illustrating how partial solutions can leave significant gaps in care. In addition, efforts to modify

a training program for low-resource nations, such as Brazil, need local expert input, adaptation depending on context, and adaptation of instructional material, demonstrating the importance of culturally and contextually relevant approaches (Botelho F, Reis E, Ribeiro K, 2022). Distance training of local instructors can be one of the ways of overcoming fiscal barriers, offering a scalable and cost-effective method to expand knowledge and skills. Equitable, locally designed training is one of the most important ways to reduce disparities in care of pediatric trauma and to facilitate global health decolonization (Botelho F, Reis E, Ribeiro K, 2022), highlighting how sustainable change often depends on empowering local systems and professionals while addressing broader structural inequities.

But what these efforts ultimately lack is a direct, grounded understanding of the lived experiences of the specific populations they aim to serve. Many initiatives operate at a systems or policy level, often relying on generalized data or broad target groups, which can overlook the nuanced barriers faced by marginalized communities, particularly immigrant women. Even when programs emphasize equity or local adaptation, they may still fail to capture the day-to-day realities, cultural dynamics, and trust barriers that shape how care is accessed and experienced. In contrast, this study addresses this gap by conducting one-on-one interviews with immigrant women from a minority population recruited through UCR Health clinics, enabling a more nuanced and human-centered understanding of the challenges they face. This approach not only elevates voices that are often underrepresented in policy design but also generates actionable insights that are directly tied to real needs, making proposed solutions more targeted, relevant, and effective.

Methodology

In terms of approach, the capstone project first started with research personnel posting flyers describing the interview opportunity at UCR Health clinics. Additionally, researchers posted flyers around campus and in the community (local coffee shops, Starbucks, etc.), with appropriate approvals obtained. Flyers were only posted on public community bulletin boards and followed each location's policies, including the Student Affairs Posting and Distribution Policy. Flyers were removed after recruitment goals were met. Snowball sampling/word-of-mouth referrals were used, as participants could refer people to the study. The flyer did not directly request that people forward the contact information, but we anticipated this could happen, as many students use the UCR Student Health Services and could spread the word to their peers.

The inclusion criteria were: participants must identify as a female immigrant, who immigrated in the last 10 years to the United States from another country (all countries of origin/ backgrounds were invited to join the study), must speak either English or Arabic (not only those who come from countries where Arabic is spoken), must receive healthcare in UCR Student Health Clinics, must be an Adult 18 or older. An interested participant could contact research personnel via the contact information provided on the recruitment materials. This form of recruitment took place only after IRB approval. This method of recruitment did not pose additional risk to potential participants for the following reasons. As a peer-to-peer approach, as the recruiter is a student peer rather than a person in a position of authority, the interaction was designed to feel informal, voluntary, and non-coercive. No disclosure required, as at the recruitment stage no personal or sensitive information, including immigration status, was requested or collected. Recruitment occurred in a neutral setting, as approaches occurred in a

public campus area with no link to immigration or legal enforcement entities, helping to minimize perceived risk. Participation was voluntary, as individuals could accept or decline a flyer without providing any explanation and there was no follow-up or pressure to participate. No research activity occurred during recruitment, as recruitment consisted solely of sharing study information and flyers and no interviews, consent, or data collection occurred until participants independently decided to contact the research team, and no interviews were conducted in a public setting. The script emphasized that participation was voluntary and that individuals were not being asked to disclose or confirm anything about immigration status at any point in the study. Together, these measures ensured that the face-to-face recruitment approach remained respectful, while allowing potentially interested participants to learn about the study in a direct and accessible way.

Individual interviews were conducted, questions are in Appendix A. Each participant was interviewed once, for around 60 minutes. Research personnel organized the interviews to be held in-person at the UCR campus conference rooms, quiet rooms with no distractions, or via Zoom online. Research staff reviewed the consent forms and obtained verbal consent and consent to audio-record the interviews. Audio was recorded on UCR-encrypted Zoom computers. Recording through Zoom began after the consent procedure and just before the interview began, and ended once the interview concluded. The Zoom audio portion was saved for transcription.

Arabic speaking research personnel led the Arabic interviews and ensured that monolingual Arabic-speaking participants fully understood the study and the voluntary nature of their participation. Arabic speaking research personnel engaged participants in a dialogue similar to that used with English-speaking participants, using open-ended questions to explore their understanding of the study's purpose, potential risks and benefits, and the fact that participation

was entirely voluntary. Researchers did not ask participants whether they were legally documented or not. While not explicitly asked of participants, researchers recognized that interviewees could state during the interview their immigration status. Participants were reminded at the beginning of the interview that they should not/ were not required to reveal any information about their immigration status. There were no follow-ups, no post-study procedures, or additional data collection at later timepoints.

Risks of this study were minimal. Some of the foreseeable risks or discomforts of participation included the physiological risk of emotional distress when recalling unpleasant experiences. The audio recordings were deleted once transcribed and were no longer necessary for study data collection. Transcriptions were stored on password-protected research laptops, and quotes were extracted for thematic analysis. To protect participant data, we did not share recordings or transcriptions outside of the study team. Providing transcriptions to study participants were not feasible, as we did not retain emails or mailing addresses to send the transcriptions to participants.

To minimize risk, we implemented the following protections. First, we did data collection where no questions were asked about documentation status or details that could identify participants as undocumented. Second, de-identification was done by interview transcripts being stripped of names and any other direct identifiers that could be disclosed by the participant during the interview process. Third, for data storage, audio files and transcripts were stored on secure, encrypted, password-protected servers accessible only to the research team. Fourth, to ensure confidentiality participants were informed that their responses were confidential, participation was voluntary, and that they could decline to answer any question.

Lastly, for external disclosure data was not shared with immigration officials or any outside agencies under any circumstances.

Participants were provided information in the verbal consent informing them that they may withdraw from the study at any time. We informed participants that all data collected up until the point of withdrawal would remain in the study during the consent process unless participants decided during the interview to stop their participation. If a participant decided not to continue mid-interview, they could choose what happens to any data collected up to that point. If a participant decided after the interview to withdraw their data, this was not possible. If a participant wished to withdraw after any information was shared, i.e., interview data, the ability to remove their data was not possible due to the de-identified nature of the data collected. A participant's data did have no identifying characteristics to identify it, and will be removed from analysis.

The 1:1 interview wss designed with women immigrants and me to explore their experiences and situations from their point of view. A 1:1 interview is the right research method in this research since it enables a rich, individualized examination of a participant's thinking and experience. The one-on-one situation invites openness, and as the researcher, I can pose more individual questions to obtain more illuminating data. We conducted both English-speaking and monolingual Arabic-speaking interviews, as we anticipated that some participants might speak only Arabic or feel more comfortable responding in Arabic. Our goal was to speak with patients who have visited clinics in UCR Student Health Clinics and received care there. Through these conversations, we aimed to better understand their experiences and strengthen the relationship between patients and faculty at the health center.

The data analysis focused on determining recurring issues of issues in care, issues of linguistic type, issues of discriminative type, and issues of cultural type, and the extent to which they impacted the care experience of the participants.

Results

The interview findings revealed that immigrant women students at UCR experienced patient care at UCR Student Health as uneven, layered, and deeply shaped by both interpersonal treatment and institutional systems. While several participants described portions of their care as respectful, efficient, and supportive, others reported frustration, dismissal, confusion, and emotional discomfort. The most important overall pattern is that participants did not describe one single barrier in isolation. Rather, their experiences were shaped by the interaction of staff tone, provider responsiveness, referral systems, insurance confusion, digital navigation, and the ability or inability of the clinic to make them feel heard. This matters because the capstone project is not simply asking whether care exists, but whether care is accessible, understandable, and humane for immigrant women navigating a university health system.

The stories participants shared showed that even when one part of the clinic experience worked well, another part could undo that sense of trust. For example, one Syrian participant described the staff, nurses, and doctors as “amazing, very helpful,” and said on-campus services were “pretty clear and good,” yet she still encountered problems when she needed referral help through the app and had difficulty navigating off-campus resources. Other participants described how things become more confusing and less supportive. These accounts show that the issue was not simply whether an appointment was available, but whether the entire care experience remained supportive from beginning to end.

Table 1. Participant Demographic and Experience Overview

Participant	**Background**	**Time in the U.S.**	**Primary Barriers Mentioned**	**Overall Impression of Care**
Participant A	Syrian woman	10 years	Referral/app navigation difficulties	Positive toward staff but frustrated with off-campus coordination
Participant B	Egyptian woman	11 years	Front-desk communication and lack of support	Mixed experience with respectful providers but stressful administration
Participant C	Hispanic woman from immigrant family	Born in U.S. but English as second language	Language barriers, referral confusion, dismissive communication	Strong frustration with healthcare navigation and CAPS
Participant D	Egyptian woman	Not specified	Emotional safety, poor organization, dismissive treatment	Negative and emotionally stressful
Participant E	Hispanic Mexican woman	5.5 years	Insurance confusion, delayed treatment, lack of guidance	Avoids returning due to mistrust and fear of costs

A major theme across the interviews was the mixed nature of access to care. Some participants described UCR Student Health as relatively easy to access for routine needs such as vaccinations, blood draws, minor injuries, and scheduled visits. One participant who visited "almost monthly" described being able to go as a walk-in, call in, or use the website, and emphasized that on-campus services were "pretty clear and good." Another participant who visited twice reported that scheduling online was manageable, and another said her overall experience was okay despite some frustrations. These accounts show that the clinic can function effectively for straightforward, limited, or procedural forms of care. At the same time, those

more positive accounts were often qualified by later problems involving referrals, follow-up, or communication. In other words, basic entry into care was not always the central problem; rather, the quality and continuity of that care became much more complicated once patients needed explanation, coordination, or specialized services.

This came through clearly in the stories participants told. One participant went in for routine vaccinations and school paperwork, repeatedly returning for approvals, and this visit was generally fine. However, another participant said when she later came in because her foot was swollen and wanted to do a walk-in, she was told to use the screen to make an appointment and felt that the front-desk worker was “rude” and not fully paying attention. Another participant described going in without an appointment when her skin condition worsened; at first, she had to become visibly emotional before she was finally taken in, and she was then told to go to urgent care, given cream and ibuprofen, and later referred to dermatology only after the issue had progressed. Another participant went in after falling off a scooter and used student health for frequent injuries and routine care, showing that the clinic could be relied on for basic needs, but once more advanced or follow-up care was needed, the process became harder to manage. These stories show that initial access may exist, but access alone does not guarantee effective care.

Table 2. Major Themes and Representative Quotes

Theme	Summary of Findings	Representative Quote
Access to Care	Participants could access basic care, but follow-up and specialist coordination were difficult.	“The app didn’t help.”
Validation and Listening	Many participants felt dismissed or not taken seriously.	“They don’t take you seriously.”
Language and Communication	Communication problems involved tone, impatience, and lack of flexibility.	“I can’t understand you, follow the instructions.”
Systemic Navigation	Students struggled with referrals, insurance, and off-campus services.	“Big lack of communication.”
Mental Health Support	Mental health services were described as fragmented and difficult to navigate.	“CAPS don’t care like that.”
Emotional Safety	Participants evaluated care based on whether they felt safe and respected.	“The doctor can smile, to make the patient feel comfortable.”
Emotional Consequences	Negative experiences caused fear, avoidance, and frustration.	“I would rather bear with the pain.”

Friendliness

Another strong theme was the contrast between surface-level friendliness and deeper dissatisfaction with patient care. Several participants described staff as “friendly,” “organized,” “respectful,” or “amazing very helpful,” especially at the front desk or with individual nurses and doctors. However, this positive language often existed alongside experiences that left participants feeling rushed, dismissed, or uncared for. One participant said that although front office staff were friendly, the clinic app “didn’t help,” and off-campus navigation remained confusing. Another participant said that the female doctor was “very nice and respectful,” yet the front office made her feel “shooed away” when she had too many questions. This suggests that patient

experience at UCR was not consistent across the care process. A student could enter the clinic and encounter kindness in one moment, only to feel unsupported in the next. Such inconsistency matters because patient trust is not built through one isolated positive interaction; it depends on continuity, clarity, and a sense that all parts of the system are working together for the patient's well-being.

Participants repeatedly described this split feeling. One Egyptian participant said the front desk workers were friendly, but once she got into the patient room, "the doctor doesn't smile," and the tone felt entirely different. She said that walking out of the clinic felt more stressful than walking in. Another participant said the front office answered her insurance questions clearly one time, especially about specialist copays, but that same overall system failed her when she later needed help using the app or managing referral logistics. Another student said most providers she had seen were "relatively kind and trusting," but still recalled instances where providers did not show up to appointments on time or at all, and where they refused to address more than one concern without forcing another appointment. These stories demonstrate that friendliness alone did not erase deeper dissatisfaction with the overall care experience.

Language Barriers

The findings also show that language barriers were more nuanced than simply whether a participant spoke English or not. Several women stated directly that they had "no issues" with language barriers or "no difficulty communicating," which is important because it prevents the analysis from overstating language as a universal obstacle. However, for other participants, language functioned less as a formal translation problem and more as an issue of being misunderstood, rushed, or not given enough patience to explain symptoms in a second language. One participant described being "frustrated over the language barrier, the accent, the way they

phrase," and recalled people being told, "I can't understand you. Follow the instructions," adding that this "puts people with language barrier at risk." Another participant explained that because English was her second language, she had difficulty explaining her health issue and felt that staff did not take her seriously. These responses suggest that the real language problem was not only vocabulary; it was the lack of communicative flexibility, empathy, and effort from staff when patients needed more time or clearer explanations. In this sense, the barrier was relational as much as linguistic.

Participants' stories make this clearer. One woman said she had heard from others that people were not treated as well because of language barriers and were not understood. In her own care, she felt that when she tried to explain her symptoms, providers blamed her condition on being overweight and sexually active rather than listening carefully to what she was trying to say. Another participant said that the front office would not answer all her questions because there were many people behind her in line, which intensified her sense of being brushed aside rather than supported. Even participants who did not identify language as a formal issue still described interactions where staff tone or impatience made it harder to ask for help. This suggests that for immigrant women, communication problems may appear not only through limited English proficiency, but also through the speed, tone, and willingness of staff to listen to someone who may already feel uncertain about how to phrase her concerns.

Validation

The interviews further reveal that being listened to and taken seriously was central to how participants evaluated care. Several women did not frame their experiences primarily as overt racism, but they repeatedly described feeling dismissed, minimized, or treated as though their concerns were not important. One participant said, "They don't take you seriously, negligence,"

and explained that during an early visit her symptoms were not fully addressed until the problem worsened. Another participant described trying to explain her condition and felt that providers blamed it on her weight and sexual activity rather than listening carefully to her actual concerns. A different participant felt that staff "just wanted to be done," while another believed that some providers had been "dismissive" and refused to discuss additional concerns without requiring another appointment first.

These repeated experiences point to an important finding: for many participants, the most painful part of the encounter was not only the medical issue itself, but the feeling that their voices did not matter enough to shape the care they received. The stories in the interviews make this especially vivid. One participant went to student health with worsening skin problems and left feeling that she had to rely on a cream her aunt gave her because the clinic did not act decisively enough the first time. She later said that she hoped providers would "listen, not just tell you it is normal or stress." Another participant said that when she tried to talk about additional issues during an appointment, a provider would not acknowledge them unless she scheduled another visit, making her feel compartmentalized rather than cared for as a whole person. Another participant felt confused and unsupported when staff asked her to decide whether or not to take a needed shot, even though she did not feel well-positioned to make that choice without better guidance. In these stories, not being taken seriously was not merely emotional; it shaped the quality, timing, and usefulness of care itself.

Cultural and Gender Mismatch in Care

Related to this, the theme of cultural and gendered mismatch appeared in subtle but important ways. Some participants stated that they had not encountered cultural miscommunication and believed UCR generally respected diversity. Yet others described a more complicated reality in

which formal respect for diversity did not always translate into culturally responsive care. One participant felt that “male providers don’t get females” and that cultural differences shaped how women’s needs were interpreted. Another contrasted the more welcoming behavior of front desk workers with the colder tone of providers inside the patient room, saying that the doctor “doesn’t smile” and that nothing in the interaction made her feel comfortable or safe. Her suggestion that “the doctor can smile” and create a “safe zone” may sound simple, but analytically it reveals something deeper: immigrant women were not only evaluating clinical competence, they were evaluating whether the care environment felt emotionally safe, culturally sensitive, and respectful of their vulnerability as patients.

The stories shared in the interviews show how small behaviors carried large emotional weight. One participant said that a lab worker tried to ask about her background as an icebreaker while drawing blood, but the conversation quickly turned invalidating when she was told, “A grown woman like you should not be afraid of needles,” and then, “but you are in your 20s,” even after she explained that this fear runs in her family. What may have seemed minor to the staff member felt dismissive and embarrassing to the patient. Another participant said she was not allowed to have her friend come in with her to calm her down, which worsened her distress. These moments matter because they show that participants judged care not only by medical outcomes but by whether providers recognized fear, discomfort, and cultural vulnerability as real parts of the patient experience.

Racism

Importantly, the interviews do not show a uniform pattern of explicit racism. Several participants said “no” when asked directly whether they had experienced racism or discrimination, and some believed that people were generally treated the same. However, the absence of overt racism did

not mean the absence of inequity. A number of participants were unsure whether what they experienced was racism or simply a broader pattern of indifference, stress, overload, or institutional negligence. One participant said she did not know whether the behavior was racist or whether "they do that with everyone." Another participant said providers were "very respectful" and that negative behavior felt more like people who "hate their life," rather than something personal. This is a significant qualitative finding because it suggests that inequity may be experienced less as open discrimination and more as accumulated dismissiveness, poor communication, emotional coldness, and bureaucratic burden. For students navigating care, the effect can still be harmful even when intent is unclear.

The participant stories strongly support this interpretation. One student said she did not think the front-desk worker was necessarily discriminatory, but she still felt "pushed away" and left frustrated because no one made space for her questions. Another said she was unsure whether negligent treatment was rooted in bias or whether stress and overload caused staff to treat everyone poorly. Another explicitly said that people were respectful overall, but she still believed some workers were acting from burnout or unhappiness, which affected patient interactions in ways that did not feel personal yet still felt harmful. This ambiguity is important because it shows how participants themselves often struggled to name the source of the problem, even while clearly describing its effects on their trust and comfort.

Systemic Barriers

The clearest and most repeated pattern in the data concerns systemic barriers, especially referrals, insurance, off-campus coordination, and digital navigation. Participants described a "big lack of communication," confusion about specialist referrals, difficulty understanding what insurance would cover, and an overall feeling that they had to figure out the process alone. One

participant said UCR failed to send a referral even though she had been told it would be handled, which led to unexpected charges and confusion about in-network versus out-of-network care. Another participant described needing MRI-related follow-up and said the app was not helpful for getting the referral completed. A different participant who went to the emergency room became afraid of seeking further care because she did not understand why charges were not covered and felt too intimidated to call the insurance company herself.

Across these accounts, the barrier was not necessarily the complete absence of healthcare resources. Instead, the barrier was that resources were fragmented, poorly explained, and difficult to navigate without prior knowledge, confidence, or outside help. The stories attached to these barriers were some of the strongest in the interviews. One participant explained that she was told she needed to submit her referral both to the specialist and to the insurance company, but she only sent it to the specialist and ended up being treated as out-of-network and charged. She described this as a "big lack of communication" and emphasized that people are often not told important details, including coverage for services like abortion pills. Another participant said she needed approval to cover the rest of an emergency room visit and ended up confused about whether a CT scan was covered. She was told to call Blue Cross, but because she was afraid and unsure, she never did, and instead just paid part of the bill herself. Another participant said she got a list of resources and websites, but no meaningful help on how to actually use them. Yet another said that when her roommate tried calling referral and radiology offices, no one answered. These stories reveal a system that often gives information without guidance, documents without navigation, and referrals without follow-through.

Digital and Administrative Care

This problem of navigation appeared again in participants' descriptions of the digital and administrative burden involved in using services. One participant suggested that UCR should post on Instagram explaining how to navigate the app and how to find providers, especially for off-campus resources. Another described CAPS information as spread across multiple sites with "vague instructions," making mental health care especially difficult to access. Another said UCR gives resources but not ways to navigate those resources, reducing the system to an "Okay, figure it out" approach. These comments are analytically important because they show that access is not just a matter of whether information exists. Information that is scattered, overly technical, or dependent on self-advocacy can still function as a barrier. In other words, the clinic may be supplying resources in theory while leaving students unsupported in practice.

Participants gave multiple concrete examples of this burden. One student said the app was the main problem, not the staff themselves, and felt that students needed clearer education on how to use it, how to locate providers, and how to understand off-campus care. Another said the digital information for CAPS was spread out across too many different websites, which made the process exhausting and discouraging. Another participant said that the system provided the resources but not the navigation, as though once the website or handout was given, the responsibility was entirely on the student. Even a participant who had mostly positive experiences recommended more detailed online resources so students could get answers without being pushed away at the front desk. These stories show that when information is fragmented, digital systems become another layer of labor that immigrant women must carry themselves.

Mental Health Care

Mental health care emerged as a particularly vulnerable area. Although several participants said physical care at UCR was relatively manageable, mental health services were repeatedly

described as more flawed, fragmented, or inaccessible. One participant stated that UCR Health was “relatively great” for most physical problems, “however, for mental health problems, it felt much more flawed,” citing late or missed appointments, referrals to non-contracted facilities, unclear copays, and confusing digital instructions. Another participant was even more direct, saying “CAPS don’t care like that,” and described a “bigger disconnect when it comes to immigrants.” Another reported being told that mental health is only urgent if someone is suicidal, and said she hoped for “more accessibility to mental health.” This suggests that the mental health system may be perceived as more reactive than supportive, and more likely to leave students feeling abandoned unless their distress reaches a crisis threshold.

The participants’ stories show how serious that perception can become. One participant described repeatedly encountering vague, scattered online information while trying to navigate CAPS, making the process feel inaccessible before care even started. Another connected that system-level gap to immigrant students more broadly, saying the system and “lack of care in the system” are the issue and that staff “don’t understand student needs.” Another participant’s statement that mental health is seen as urgent only when a person is suicidal suggests that care may be framed too narrowly around crisis rather than early support, prevention, or sustained emotional care. Together, these stories point to mental health as an area where students may feel especially invisible or unsupported.

Emotional and Behavioral Consequences

The emotional and behavioral consequences of these experiences were substantial, even when participants said the barriers had not formally affected their physical or mental health. Several women described frustration, fear, avoidance, and loss of trust. One participant said she was “willingly would not go there” because the clinic did not feel comfortable or “homelike.”

Another said she now avoids going there and would rather "bear with the pain." One participant described frustration so strong that she felt "pushed away," while another became afraid to seek care because of possible billing problems. These reactions show that the impact of barriers cannot be measured only by immediate health outcomes. A patient may say the barrier did not directly change her health, but if it causes fear, avoidance, delay, or mistrust, then it is already affecting health behavior and future access. In some cases, the consequences were also physical. One participant described severe bruising after a blood draw, saying that 25–30% of her arm was bruised, that the worker changed the tube aggressively, and that blood even fell on the floor. She said she could not move her arm normally for a week, drove with one hand, and experienced significant pain. Another participant said that because she did not get enough help finding dental care or understanding referrals, she ended up going to Mexico for a dentist visit, where she was told she should have been receiving regular dental care and had developed a cavity. These stories show that frustration and avoidance can eventually become health consequences, not just emotional reactions.

Individual Kindness and Systemic Failure

One especially powerful finding is that participants often distinguished between individual kindness and systemic failure. Many of them did not condemn every provider or every encounter. In fact, some praised nurses, front-desk staff, or specific doctors. Yet even those same participants still described a broken process around referrals, insurance questions, mental health access, or follow-up. This distinction is important because it prevents the analysis from becoming too simplistic. The problem was not always that individual staff lacked compassion. Rather, the larger care environment often required students to advocate constantly for themselves, manage confusing paperwork, chase referrals, interpret insurance rules, and return

multiple times before receiving clear answers. Thus, the qualitative data suggest that dissatisfaction stemmed not only from interpersonal behavior but from structural disorganization and the unequal burden it places on students who are already vulnerable.

Participant stories made this distinction very clear. One Syrian participant repeatedly praised the nurses, staff, and doctors and was happy that the clinic had "improved" and even "had new machines," yet still questioned why she had once been sent off campus for a chest X-ray when it seemed like those resources existed at UCR. Another participant said the doctor and nurse explained things well when directly asked, but the front office was not supportive and pushed her away from getting her questions answered. Another participant emphasized that most providers were kind and trusting, but the management and referral process were where problems appeared most strongly. These narratives show that the structural weaknesses of the system were often more persistent than the attitudes of any single individual staff member.

Participants' Recommendations

Participants' recommendations were remarkably consistent and reveal what a more equitable model of care might look like. They asked for clearer online information, better explanations of coverage and referrals, more accessible walk-ins, more patient support for navigating specialists and insurance, and more humane communication from front office staff and providers. One participant suggested student health advisors who could help students navigate clinic systems. Another wished for a Blue Cross insurance person on campus who could answer what is covered so students would not be "afraid to go." Another wanted clearer and more detailed online resources, while another emphasized that UCR should help students understand off-campus services instead of just handing them a list.

Together, these suggestions show that participants were not asking for luxury or exceptional treatment. They were asking for guidance, respect, and communication that make healthcare usable. Their stories strengthen these recommendations. One participant specifically said UCR should post information on Instagram explaining how to use the app and navigate provider searches, which reflects a student-centered understanding of how communication could actually reach the campus community. Another wanted "health student advisors" because students may be more approachable and easier to trust when learning how to navigate care. Another hoped for staff who would help with contacting referral offices and walking students through the process rather than leaving them alone with specialist lists. Another participant simply wanted doctors to smile more, let patients feel safe, and reduce the emotional stress of the encounter. These recommendations may seem basic, but precisely because multiple participants independently named such similar needs, they point to clear areas where UCR could improve access and patient trust.

Table 3. Participant Recommendations for Improvement

Issue Identified	**Suggested Improvement**
Referral confusion	Provide referral guidance and staff support for follow-up care
Insurance uncertainty	Offer an on-campus insurance advisor or navigator
Poor app navigation	Create online tutorials and Instagram guides for healthcare navigation
Front-desk overload	Increase staffing and improve communication training
Mental health accessibility	Simplify CAPS access and improve early-stage support
Lack of emotional safety	Encourage patient-centered communication and culturally responsive care
Limited support systems	Create student health advisors or peer navigators

Overall, the interviews suggest that immigrant women students at UCR do not experience patient care in one fixed way; instead, their care experiences move between gratitude and frustration, respect and dismissal, access and confusion. The strongest finding is that patient care quality was shaped less by dramatic acts of overt discrimination and more by everyday failures of listening, explanation, coordination, and emotional safety. In that sense, the interviews strongly support the capstone's broader argument that barriers to care are not only linguistic or cultural in a narrow sense, but also systemic and relational. These women's experiences show that healthcare becomes inequitable when patients must do excessive interpretive and administrative labor just to receive basic, respectful care. The data therefore point toward a practical conclusion: improving healthcare for immigrant women at UCR requires more than offering appointments. It requires building a system in which students feel informed, believed, guided, and safe throughout the entire care process.

The participant stories make this conclusion especially compelling. Some women described efficient, respectful, and even grateful experiences, while others shared stories of being brushed aside, blamed, confused about coverage, left alone to navigate referrals, made to feel unsafe during procedures, or discouraged from returning at all. One participant's advice to other immigrant women was to "stay aware and continue to advocate for yourself," while another said, "Do your research. unfortunately. Don't only stick with only what they tell you." Those final reflections are powerful because they suggest that students have learned to survive the healthcare system by becoming hyper-vigilant and self-protective. That, in itself, is evidence of a system that still places too much burden on the patient.

Discussion

This study included six UCR student participants, which provided meaningful insight into patient care experiences but also reflects the difficulty of recruiting a larger sample for this topic. One possible factor contributing to limited participation is the broader climate of fear and uncertainty surrounding immigration enforcement during this period. In January 2026, UCR itself acknowledged that recent reports of immigration enforcement activity had caused worry among students, faculty, and staff, and the City of Riverside was also logging community reports related to alleged immigration enforcement activity later that month. Given that this study focused on immigrant women, these conditions may have contributed to hesitancy to participate, particularly in research involving healthcare experiences, trust, and institutional systems.

Although six participants may appear to be a small sample and not allow for broad generalization, this is appropriate for a qualitative study, where the aim is to gain in-depth understanding rather than achieve statistical representation. Each interview yielded detailed narratives and personal accounts of participants' care experiences at the UCR Student Health Clinics. These rich data enabled a deeper exploration of meanings, concerns, and recurring patterns within their experiences. Therefore, the value of this study lies in the depth and quality of the data rather than the size of the sample.

From these interviews, findings suggest that the central problem at UCR Student Health is not simply whether services are available, but whether those services remain understandable, coordinated, and supportive throughout the full care process. Participants' experiences show that access to care cannot be measured only by the ability to make an appointment or walk into the clinic. In several cases, students were technically able to enter the system, but once they needed follow-up, referrals, insurance clarification, mental health support, or more detailed

communication, the system became harder to navigate. UCR's health services may be meeting the minimum standard of offering care, while still falling short in delivering care that feels continuous, patient-centered, and equitable.

A major implication of these results is that healthcare quality should be understood as a process rather than a single encounter. Some participants described individual staff members as kind, efficient, or respectful, yet still left with confusion, frustration, or distrust because another part of the system failed them. This matters because one positive interaction cannot fully protect a patient from the harm caused by poor coordination, inconsistent communication, or unclear next steps. In practice, this suggests that UCR should not focus improvement efforts only on bedside manner or only on administrative systems. Instead, the university should treat patient care as a connected experience in which front-desk interactions, provider communication, referrals, billing guidance, and follow-up all shape whether students feel supported. If one part of that chain breaks down, the overall quality of care is reduced.

The results also show that participants were not primarily asking for extraordinary services. What they wanted was basic clarity, responsiveness, and guidance. That is an important finding because it suggests that many of the barriers identified may be fixable through structural improvements rather than expensive overhauls alone. For example, when students reported confusion about referrals, insurance approval, specialist networks, or app-based systems, the issue was often not the total absence of resources, but the lack of support in using them. This points to a need for navigation-based interventions. UCR could improve the patient experience by creating clearer referral pathways, assigning staff or student health navigators to help with specialist coordination, and offering step-by-step explanations of coverage and follow-up

responsibilities. These changes would reduce the amount of administrative labor students currently have to do on their own.

Another important takeaway is that communication barriers in this study were broader than formal language proficiency. Although some participants said they did not face a direct language barrier, their stories still reflected communication problems through tone, impatience, rushed explanations, and a lack of flexibility when students needed more time to describe symptoms or ask questions. This suggests that communication in healthcare should not be reduced to whether interpretation services are available. A patient may speak English and still struggle if the interaction is too fast, dismissive, or emotionally cold. For immigrant women, this can carry extra weight because uncertainty, accent differences, and cultural discomfort may already make medical encounters more stressful. What should change, then, is not only language access, but communication style. Staff and providers would likely benefit from training in culturally responsive, trauma-informed, and patient-centered communication that emphasizes listening, clarification, and emotional safety rather than speed alone.

The findings further suggest that emotional safety is a serious part of healthcare quality, not a minor interpersonal detail. Participants repeatedly evaluated care based on whether they felt heard, believed, respected, and comfortable asking for help. Small behaviors such as smiling, answering questions patiently, allowing space for fear, or avoiding dismissive remarks had a large effect on how safe the clinic felt. This is especially important because some participants did not describe dramatic discrimination, yet still experienced care as alienating or dehumanizing. That pattern shows that inequity can operate through everyday emotional conditions rather than only through explicit bias. For this reason, improving care for immigrant women at UCR requires more than diversity language at the institutional level. It requires providers and staff to

recognize that fear, uncertainty, and vulnerability are real parts of the patient experience and should be responded to with care rather than impatience.

The results also highlight mental health as an area requiring immediate attention. Compared with physical care, mental health services were described as more fragmented, more confusing, and less accessible unless distress reached a crisis level. This is concerning because students should not have to become suicidal or visibly overwhelmed before being treated as urgent enough to help. A system that responds only at the point of crisis is not preventive and may especially fail immigrant students who are already hesitant to seek mental health care because of stigma, uncertainty, or distrust. UCR should therefore consider simplifying CAPS navigation, reducing dependence on scattered online instructions, improving communication around referrals and copays, and making early-stage support easier to access. Mental health services need to feel available before a student reaches a breaking point, not only afterward.

An additional implication of these findings is that institutional ambiguity itself can become a form of inequity. Several participants were unsure whether what they experienced was racism, burnout, indifference, or simple overload. Even when intent was unclear, the outcome was the same: students felt dismissed, unsupported, and less likely to return for care. This matters because institutions often focus on whether harm was intentional, while patients experience harm through its effects. From a public health perspective, the more important question is not whether every negative encounter can be labeled discriminatory, but whether the system consistently produces avoidable stress, confusion, and mistrust for a vulnerable student population. If it does, then institutional reform is justified regardless of whether each experience fits a narrow definition of discrimination.

As shown in the findings many of the problems participants described appear to reflect system strain rather than only isolated individual failures. Because students often report inconsistency across visits, confusion in referrals, rushed communication, and a lack of follow-through, it may be helpful for the facility to consider hiring more staff and improving internal organization so employees are better supported in doing their jobs well. When clinics are understaffed or poorly coordinated, even staff members who want to help may not have enough time, energy, or structure to provide patients with the attention and guidance they need. In that sense, strengthening staffing levels and creating more organized systems could benefit both workers and students at the same time. It could reduce pressure on employees, improve consistency in patient care, and make it easier for staff to stay present, responsive, and helpful throughout the full care process, especially since so many of the barriers in these interviews seem tied to broader system problems rather than to one person alone.

Overall, these findings suggest that improving care for immigrant women at UCR requires a shift from a service-delivery model to a patient-navigation and trust-building model. The university already appears capable of providing routine care in many cases, but the results show that routine access is not enough when students feel left alone to interpret billing, chase referrals, manage off-campus care, or endure emotionally unsafe interactions. What should change is the distribution of responsibility. Currently, a disproportionate amount of the burden falls on the patient. A more equitable model would shift this responsibility toward the healthcare system by making care easier to understand, better coordinated, and more patient-centered and humane in its delivery. In that sense, the most important lesson from these interviews is that access without guidance, and treatment without trust, are not sufficient forms of care. UCR can

improve not only by expanding services, but by making those services genuinely usable, supportive, and responsive from beginning to end.

Conclusion

This capstone contributes to the broader literature on healthcare equity by centering the experiences of immigrant women in Riverside and showing that barriers to care are not limited to isolated incidents, but are often built into the way care is organized, explained, and emotionally experienced. Across the interviews, participants described difficulty navigating referrals, understanding insurance and billing, accessing mental health support, and feeling respected during clinical encounters. Taken together, these findings show that access to services alone is not enough; care must also be understandable, coordinated, culturally responsive, and grounded in trust in order to be truly equitable. The project also highlights how everyday experiences such as rushed communication, uncertainty about next steps, and dismissive interactions can discourage patients from returning for care, even when clinics and services technically exist. Ultimately, this study argues that a more equitable healthcare environment is possible when institutions listen closely to the people most affected by these barriers and design services around their actual needs. Equity means making healthcare not only available, but genuinely usable, respectful, and supportive from beginning to end.

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Appendix A: Semi-Structured Interview Guide

- Demographic Information: First we would like to know a little bit more about you?
    - Can you share with me a little about yourself, such as what ethnicity you are and how long you have lived in America?
- Access to Healthcare:
    - Tell us about your experience or experiences getting care UCR Student Health
        - Probes:How frequently do you visit the UCR Student Health clinic?
        - What challenges, if any, have you encountered when trying to access healthcare services in the region at UCR?
        - Do you believe there are health services that are difficult to access or not provided through UCR health clinics?
- Language Barriers:
    - How has your communication been with providers and others at the clinic when getting
        - Probes: Have you had difficulty understanding or communicating with health care staff in UCR health clinics?
        - Are you satisfied with receiving assistance in language, such as interpreters and translated documents, in UCR health clinics?
        - In what ways might language differences impact your overall health care experience and treatment?
- Cultural and Social Barriers:
    - Have you encountered any differences in cultures or miscommunications in attempting to receive care at UCR health clinics? Please elaborate
        - Probe-Do you feel that healthcare providers at UCR understand and respect your cultural background, beliefs, and values?
    - What are your thoughts about the healthcare system overall in terms of respect for diversity of cultures and making everyone feel welcome?
- Racism/Discrimination:
    - Have you ever witnessed or experienced racism or discriminatory treatment at UCR health clinics?
    - Do such experiences leave you feeling prepared to receive care and trust health care providers?

    - Have you ever found yourself in a position where you were treated unfairly or not equally in health care facilities?
        - Probe-Do you feel comfortable sharing more about your experiences?

- Systemic Barriers:

    - Do you believe there are significant issues, such as being able to obtain insurance, regulations, or interventions from health care professionals, that complicate immigrant women's ability to access care at UCR?
        - Probe-If they say yes : How have these system issues affected your experience at UCR health clinics?

- Support Systems:

    - Have you found any support or resources (e.g., advocacy groups, cultural centers) that helped you navigate healthcare services at UCR?
    - Do you feel that UCR provides adequate support for immigrant women in accessing healthcare?
    - What types of assistance or service would you prefer to enhance your health care experience at UCR?

- Suggestions for Improvement:

    - What might be changed or improved to make UCR health clinics more accessible and more welcoming to immigrant women?
        - Probe - provide specific ideas/examples for each of language, cultural, or systemic barriers?

- Impact of Barriers:

    - How have the barriers you mentioned impacted your physical and mental health?
    - In your opinion, how do these barriers affect the overall health outcomes of immigrant women at UCR?

- Closing Reflection:

    - Is there anything else you would like to share about your experiences accessing healthcare services as an immigrant woman at UCR?
    - Do you have any advice for other immigrant women facing similar challenges with healthcare access?