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RESEARCH ARTICLE

A Study on the Barriers like Intersectionality, Postcolonial Feminism, and Healthcare Access Encountered by African Refugee Women in the Midwestern United States During the COVID-19 Pandemic

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Abstract: African refugee women resettled in the United States face multi-layered systemic barriers to healthcare access, which were significantly compounded by the social and structural disruptions of the COVID-19 pandemic. This investigation highlights the healthcare utilization experiences of Congolese and Rwandan refugee women residing in Waterloo, Iowa, utilizing intersectional and postcolonial feminist theoretical frameworks to analyze how gender, race, legal status, and linguistic identity converge to shape clinical interactions. The socio-structural dynamics of healthcare exclusion come to light through semi-structured, in-depth virtual interviews with refugee women and community advocates from the Ethnic Minorities of Burma Advocacy & Resource Center (EMBARC). Linguistic barriers extend beyond basic translation issues to include functional health literacy, rendering navigation of complex medical systems and completion of intake protocols highly problematic. The absence of competent medical interpretation often forces reliance on informal interpreters, including children, which compromises confidentiality and degrades the quality of reproductive and maternal care. Deep-seated cultural orientations concerning medical authority, somatic expressions of distress, and gendered communication norms affect clinical encounters, where participants describe experiences of being rushed, dismissed, or culturally misunderstood by Western practitioners. Financial precariousness, lack of medical insurance, and transportation deficits further restrict health-seeking behaviors. The COVID-19 pandemic exacerbated these challenges by shifting clinical services to digital platforms, limiting physical outreach, and suspending the main community integration programs. These results indicate that addressing systemic health disparities requires structural reforms, including institutionalizing professional interpretation services, expanding community-partnered advocacy, and implementing culturally responsive care models.

Keywords: Healthcare Access; African Refugee Women; Cultural Barriers; Immigrant Health; COVID-19.

1. Introduction

Refugees are one of the most structurally marginalized populations globally, having been forcibly displaced from their nations of origin due to armed conflict, systematic violence, political persecution, and human rights violations. The United Nations High Commissioner for Refugees establishes that a refugee is an individual who has crossed international borders to seek safety due to a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion [1]. Over several decades, the United States has served as a primary host nation for resettlement, admitting diverse cohorts of displaced individuals from across the globe. By the mid-2010s, annual arrivals reached substantial numbers, with 2016 witnessing the resettlement of 84,995 refugees, among whom individuals displaced from the Democratic Republic of Congo constituted the largest single national cohort [2]. Despite the formal protection and legal pathway provided by federal resettlement programs, the transition into the socio-economic and institutional fabric of the host country is characterized by profound structural inequalities. The historical and geopolitical drivers of forced migration, including postcolonial civil wars, resource extraction conflicts, and state instability in East and Central Africa, place displaced individuals in positions of acute vulnerability long before their arrival [3]. Upon arrival in the United States, these pre-migration traumas are met with post-migration stressors, including socio-economic marginalization, linguistic alienation, and difficulties navigating highly privatized and bureaucratized public service institutions.

While major metropolitan areas have traditionally served as primary hubs for immigrant integration, the geographic distribution of refugee resettlement has increasingly shifted toward mid-sized cities and rural areas in the American Midwest. The State of Iowa has developed a distinctive historical legacy of refugee reception, beginning in the late twentieth century and continuing through

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contemporary resettlement efforts. This demographic transition is heavily linked to the labor demands of localized industrial sectors, particularly meatpacking and agricultural processing facilities, which actively recruit refugee and immigrant laborers to sustain their production lines. Consequently, mid-sized Midwestern cities such as Waterloo, Iowa, have transitioned from historically homogeneous populations to host highly diverse, transnational communities. This rapid demographic diversification has occurred in areas where the municipal infrastructure and social service frameworks are often unequipped to address the complex linguistic, psychological, and physiological needs of newly arrived populations. In semi-urban and rural Midwestern environments, the concentration of medical specialists, public transit systems, and multilingual municipal services is substantially lower than in metropolitan resettlement gateways. Consequently, African refugees in these regions experience a compounding form of geographical and institutional isolation, where the resources necessary to facilitate successful adaptation are structurally constrained.

The right to health is fundamentally compromised for refugee populations in the host country, with healthcare access representing a primary domain of systemic inequality. Newly resettled refugees encounter a fragmented, highly financialized Western healthcare apparatus that stands in stark contrast to both the state-subsidized structures of their prior transit countries and the traditional, community-based healing systems of their countries of origin. Healthcare utilization within this population is severely restricted by a matrix of logistical, institutional, and interpersonal barriers, including financial indigence, lack of reliable transportation, geographic distance from clinics, and cultural incongruence in clinical encounters [4].

These structural impediments do not operate in isolation but are deeply tied to socio-economic positioning, educational access, and institutional discrimination [5]. This makes the health landscape exceptionally difficult to navigate for refugee women, who must manage their own health needs alongside domestic labor, childcare, and community integration responsibilities. Evidence suggests that refugee women experience disproportionate burdens of maternal morbidity, untreated psychological distress, and barriers to reproductive healthcare, often exacerbated by gender-based discrimination and historical exposures to sexual violence in conflict settings [6]. The emergence of the SARS-CoV-2 pandemic in 2020 served to expose and widen the existing health disparities within highly vulnerable populations. Displaced and marginalized communities faced elevated biological and socio-economic risks due to crowded housing conditions, high representation in essential front-line labor sectors such as meatpacking, and restricted access to protective resources and timely medical diagnostics [7]. The institutional responses to the pandemic, while necessary from a public health perspective, introduced new structural barriers that severely disrupted the thin network of support available to refugee families [8].

During this period, healthcare systems underwent rapid, radical reorganizations, including the widespread suspension of in-person consultations, a sudden transition to telemedicine platforms, and the restriction of physical access to clinical spaces. For African refugee women, who already faced significant barriers to healthcare access, these structural changes introduced new challenges. The shift to digital health portals assumed a level of technological literacy, high-speed internet access, and English proficiency that many newly arrived refugees did not possess. The suspension of community outreach programs, home visits, and localized support services severed the vital human linkages that previously facilitated healthcare navigation, thereby deepening the isolation of these women in a period of global crisis.

To capture the complex, multi-layered nature of the healthcare barriers experienced by African refugee women, this study is grounded in the theoretical framework of intersectionality. Developed within Black feminist thought by scholars such as Kimberlé Crenshaw, intersectionality posits that social categories such as gender, race, class, legal status, and language do not operate as independent, additive variables of identity [9]. Within health equity research, an intersectional lens moves beyond individualistic explanations of health disparities, directing analytical attention toward the power structures that produce health inequalities. For African refugee women, their social location is defined by the convergence of being female, Black, of refugee status, socio-economically marginalized, and linguistically non-dominant in an English-centric society. Their clinical experiences cannot be understood solely through the lens of gender, nor can they be captured by generic models of immigrant health. Rather, their position at the intersection of these axes of power exposes them to unique forms of clinical bias, institutional neglect, and systemic exclusion that are qualitatively different from those experienced by other marginalized groups. This research also utilizes postcolonial feminist theory to critically analyze the power dynamics inherent in the resettlement context and the medical encounter. Postcolonial feminism critiques mainstream, Western-centric feminist discourses for constructing a homogenized, universal category of the "Third World Woman" characterized as universally powerless, uneducated, and traditional [10]. Instead, postcolonial feminism insists on historical specificity, recognizing the agency of subaltern women while critically examining how legacy structures of colonial power, Western cultural hegemony, and institutional racism persist in contemporary social structures. When applied to the healthcare experiences of African refugee women, a postcolonial feminist approach interrogates the epistemic violence that can occur within the Western medical model. Western medicine often operates under colonial assumptions of scientific supremacy, pathologizing or dismissing indigenous, non-Western epistemologies of health, disease, and bodily autonomy. Refugee women are frequently positioned as passive recipients of care, whose cultural beliefs, traditional healing practices, and modes of communication are viewed as deficits to be corrected rather than legitimate systems of knowledge. This study aims to disrupt these paternalistic medical narratives, highlight their active agency, and challenge the institutional structures that silence their lived experiences by centering the subjectivities and voices of Congolese and Rwandan refugee women.

2. Material and Methods

2.1. Research Design and Epistemology

This study utilizes a qualitative, interpretive research design to investigate the complex barriers to healthcare access encountered by African refugee women during the COVID-19 pandemic. Qualitative methodology is highly suited for this inquiry, as it prioritizes the subjective, lived experiences of participants, allowing for an in-depth exploration of the social processes, cultural meanings, and structural conditions that shape individual lives [11]. Given the focus on intersectional and postcolonial feminist perspectives, the study adopts an interpretive phenomenological approach, seeking to grasp how these women make sense of their health, illness, and clinical interactions within the specific context of Midwestern resettlement and a global public health emergency.

2.2. Study Setting

The empirical research was conducted in Waterloo, Iowa, a mid-sized industrial city in the Midwestern United States with a population of approximately 70,000 residents. Historically characterized by a largely homogeneous demographic profile, Waterloo has undergone significant demographic shifts over the past two decades, driven by the expansion of agricultural manufacturing and meatpacking industries. These economic sectors have served as key employers for resettled refugee populations from various East, Central, and North African nations, including the Democratic Republic of Congo, Rwanda, Burundi, Somalia, Ethiopia, and Sudan. Consequently, Waterloo presents a critical geographical site to study the challenges of healthcare integration in mid-sized, non-metropolitan municipalities that lack the robust social service infrastructures found in major urban refugee gateways.

2.3. Sampling and Participant Recruitment

Given the historically marginalized and hard-to-reach nature of refugee populations, particularly during a global pandemic, the study employed a purposive, non-probability sampling strategy to identify and recruit participants. Purposive sampling is highly effective when researchers seek to engage specific cohorts who possess direct, experiential knowledge of the phenomenon under investigation [12].

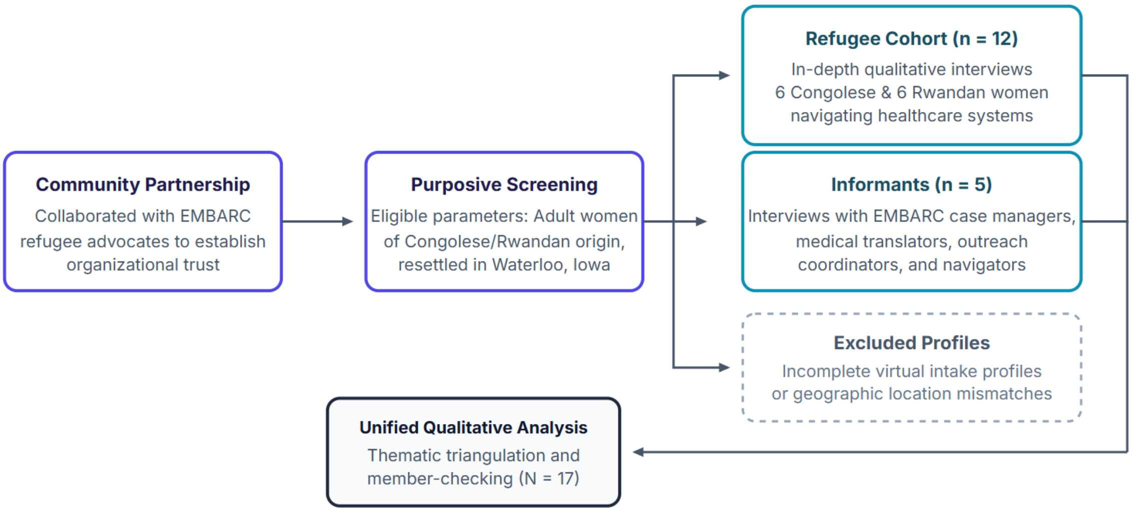

Figure 1. Qualitative Recruitment and Participant Pathway

To facilitate trust and ensure culturally safe engagement, the principal investigator established a collaborative partnership with the Ethnic Minorities of Burma Advocacy & Resource Center (EMBARC). Founded and led by refugees, EMBARC operates as a critical community-based social service organization in Iowa, providing essential resettlement support, linguistic translation, and health navigation services to diverse immigrant and refugee communities. The established trust between EMBARC staff and the local African refugee population served as a vital bridge, mitigating the suspicion and historical exploitation often associated with academic research in marginalized communities.

To expand on statistical and narrative breadth, the study cohort was significantly expanded to include a total of seventeen participants (N = 17). This sample was composed of:

- Twelve African refugee women (six originating from the Democratic Republic of Congo and six from Rwanda) resettled in the Waterloo area.
- Five main informant staff members from EMBARC who specialize in medical translation, health navigation, and refugee family advocacy.

Through this expanded cohort, thematic saturation was successfully achieved, ensuring a representative and rigorous dataset that accounts for varying lengths of residency and post-migration experiences.

2.4. Data Collection

Data collection was carried out through semi-structured, in-depth qualitative interviews conducted by the principal investigator. Due to the stringent social distancing mandates, university travel restrictions, and institutional review board regulations in place during the height of the COVID-19 pandemic, all interviews were conducted virtually via the Zoom videoconferencing platform. While virtual interviewing introduced certain challenges regarding digital access and the establishment of interpersonal rapport, it also offered a safe and accessible means of communication that protected the health of both the participants and the research team. To capture a holistic perspective of the healthcare landscape, the researcher utilized two distinct semi-structured interview protocols tailored for each cohort group. The interviews with the refugee women focused on personal narratives of navigating the Iowa healthcare system, experiences with pregnancy, childbirth, and general medical care, perceptions of clinical interactions, and the specific impact of COVID-19 on family health-seeking behaviors. The interviews with the five EMBARC community advocates and service staff provided systemic insights, highlighting the institutional, bureaucratic, and structural barriers observed across the broader refugee community, as well as the organizational strategies deployed to address these challenges. The interviews, lasting between 45 and 60 minutes, were conducted in English or with the assistance of professional community interpreters when requested, ensuring that participants could express their experiences fully and comfortably. The semi-structured interview guide was designed to be open-ended, allowing participants to lead the narrative and introduce themes of significance to them, in alignment with feminist research principles.

2.5. Data Analysis

All interviews were digitally recorded with the explicit consent of the participants and subsequently transcribed verbatim. To ensure analytical rigor and systematic depth, the transcriptions were analyzed utilizing Braun and Clarke's six-step thematic analysis framework. This iterative process began with the researcher immersing themselves in the transcript data to achieve deep familiarity, followed by the generation of initial, systematic codes that captured key semantic and latent meanings. These codes were then clustered into broader, candidate themes that reflected recurring patterns across the dataset.

The thematic structure was iteratively refined and reviewed against the entire dataset to ensure coherence, validity, and representativeness. Rather than utilizing specialized qualitative analysis software, the coding and thematic mapping were organized systematically using Microsoft Excel, which allowed for a transparent, close-to-the-data analytical process.

To maintain the trustworthiness of the qualitative findings, the study employed several strategies, including triangulation of data sources (comparing the narratives of the refugee women with the perspectives of the service providers), member-checking with community advocates to verify the interpretive accuracy of the themes, and maintaining an audit trail that documented every phase of the analytical decision-making process.

2.6. Ethical Considerations

The conduct of research involving refugee populations demands heightened ethical vigilance, given their legal, socio-economic, and historical vulnerabilities. This study involves human subjects and was formally reviewed and approved by the Institutional Review Board (IRB) of the University of Northern Iowa under Protocol Approval Number #2020-0114.

At the initiation of each virtual interview, the principal investigator read a comprehensive, culturally accessible consent form detailing the study's purpose, the voluntary nature of participation, the right to withdraw at any point without consequence, and the measures implemented to protect confidentiality. Verbal informed consent was obtained and recorded before beginning each interview. All identifying information was stripped from the transcripts, and pseudonyms are used throughout the manuscript to protect participant anonymity.

Consistent with postcolonial feminist research practices, the principal investigator engaged in continuous reflexivity throughout the research process. Recognizing one's positionality as an academic researcher navigating institutional privilege while seeking to represent the voices of marginalized subaltern women is essential to prevent the reproduction of extractive, colonial knowledge dynamics. The researcher maintained a reflexive journal to critically examine how their personal background, professional training, and assumptions influenced the research design, participant interactions, and qualitative interpretations.

3. Results

3.1. Socio-Demographic Characteristics of the Expanded Cohort

The empirical evidence analyzed in this investigation draws from the qualitative narratives of twelve resettled African refugee women and five key informant staff members from the Ethnic Minorities of Burma Advocacy & Resource Center (EMBARC) in Waterloo, Iowa. To ground the qualitative themes, the demographic profile of the primary refugee respondents is detailed in the table below. The refugee participants ranged in age from 20 to 52 years and had resided in the United States for periods ranging from four to twenty-one years, representing diverse stages of post-migration resettlement.

Table 1. Socio-Demographic Characteristics of the Expanded Refugee Participant Cohort

Participant Pseudonym	Country of Origin	Age Range	Year of Resettlement	Primary Languages Spoken	Household Size (Dependents)	Employment Sector
Participant A	Dem. Rep. of Congo	40–49	2005	Swahili, Kibembe, French	6	Food Services
Participant B	Dem. Rep. of Congo	30–39	2008	Swahili, Lingala	4	Agricultural Processing
Participant C	Dem. Rep. of Congo	30–39	2008	Swahili, French	5	Unemployed / Homemaker
Participant D	Rwanda	20–29	2012	Kinyarwanda, English	2	Manufacturing Assembly
Participant E	Rwanda	40–49	2014	Kinyarwanda, Swahili, French	7	Meatpacking Sector
Participant F	Dem. Rep. of Congo	20–29	2015	Swahili, Kifuliiru	3	Commercial Cleaning
Participant G	Rwanda	20–29	2016	Kinyarwanda, French	3	Unemployed / Homemaker
Participant H	Rwanda	30–39	2016	Kinyarwanda, Swahili	5	Meatpacking Sector
Participant I	Dem. Rep. of Congo	40–49	2017	Swahili, French	6	Agricultural Processing
Participant J	Dem. Rep. of Congo	30–39	2018	Swahili, Lingala, French	4	Retail Services
Participant K	Rwanda	50–59	2019	Kinyarwanda	2	Unemployed / Homemaker
Participant L	Rwanda	20–29	2020	Kinyarwanda, English	1	Hospitality Services

Table 2. Profiles of EMBARC Informants and Family Advocates

Informant ID	Professional Role within EMBARC	Years of Advocacy Experience	Language Proficiencies	Primary Areas of Health Navigation Support
Advocate 1	Senior Health Navigator	8	Swahili, Kibembe, English	Maternal healthcare access, Medicaid enrollment navigation
Advocate 2	Medical Interpreter & Translator	6	Kinyarwanda, French, English	Specialized clinical translation, pediatric clinic outreach
Advocate 3	Refugee Family Case Manager	5	Swahili, Lingala, English	Emergency department mediation, mental health referral routing
Advocate 4	Community Outreach Coordinator	7	Swahili, Kinyarwanda, Kirundi	Vaccine education distribution, mobile clinic coordination
Advocate 5	Linguistic Access Specialist	4	Kinyarwanda, French, English	Clinical intake forms conversion, provider education

3.2. Systemic, Institutional, and Cultural Barriers

The qualitative thematic analysis revealed a dense matrix of structural, institutional, and interpersonal barriers that impede healthcare access for African refugee women. These challenges are not isolated phenomena but represent overlapping axes of socio-structural exclusion. The primary categories of these barriers, along with clinical examples and descriptive parameters, are detailed in the subsequent table.

Table 3. Intersectional Matrix of Healthcare Barriers and Clinical Consequences

Intersectional Axis of Identity	Structural Barrier Pattern	Clinical Consequence	Representative Empirical Observation
Gender × Linguistic Identity	Absolute shortage of female medical interpreters for sensitive clinical examinations.	Postponement of gynecological evaluations; complete omission of cervical and breast cancer screenings.	Refugee women avoiding reproductive health visits due to extreme discomfort speaking through male family members.
Race × Legal Status	Institutional bias and administrative gatekeeping regarding Medicaid eligibility.	Delays in prenatal care initiation; exclusion from specialized pharmaceutical therapies.	Pregnant women facing delays in coverage authorization, leading to emergency department births.
Class × Spatial Geography	Absence of localized clinics combined with minimal public transit infrastructure.	High rates of missed preventative appointments; complete reliance on emergency services.	Single-car households prioritizing factory shifts, leaving women without transit for daytime clinics.
Linguistic Identity × Epistemology	Absence of translation terms for complex psychological and mental health states.	Misdiagnosis of emotional trauma; somatization of psychiatric distress.	Expressing severe postpartum psychological trauma as physical abdominal pain due to a lack of translational concepts.

3.2.1. Linguistic Disenfranchisement and Health Literacy

The primary obstacle identified by both the refugee women and the community advocates was the profound barrier of language, which operates far beyond simple conversational English limitations. Linguistic disenfranchisement encompasses a systemic deficit in functional health literacy, which prevents patients from navigating administrative paperwork, comprehending pharmaceutical dosages, or consenting to complex medical interventions. Key informants from EMBARC highlighted that Western medical systems assume a baseline level of structural literacy that many newly arrived refugees do not possess.

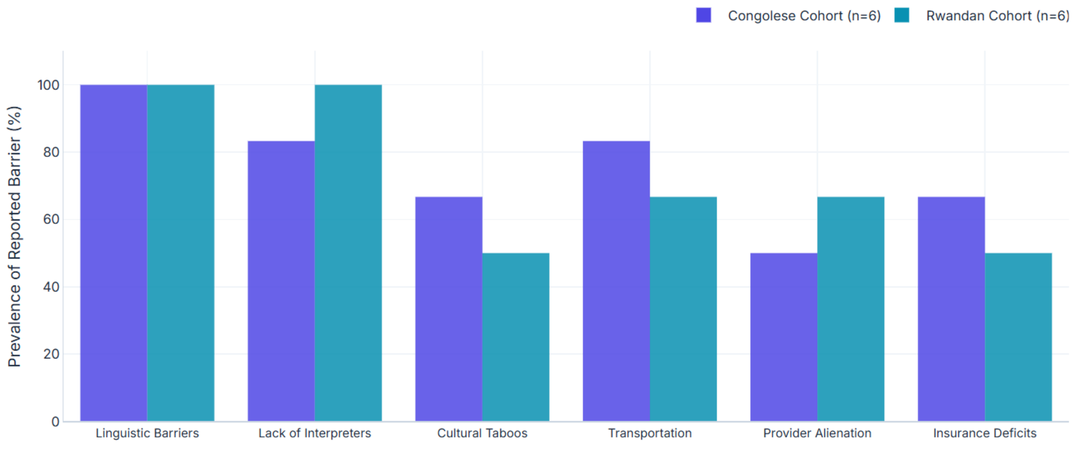

Figure 2. Reported Prevalence of Primary Healthcare Barriers by National Cohort

Participants noted that specific clinical concepts, particularly within mental health and reproductive care, do not have direct lexical equivalents in Swahili, Kinyarwanda, or French. This semantic gap results in significant clinical miscommunication, where women find themselves unable to articulate somatic expressions of psychological distress, such as anxiety or postpartum depression [13]. This semantic misalignment often leads to clinical misdiagnosis or the complete omission of crucial diagnostic assessments.

3.2.2. The Critical Shortage of Certified Medical Translation Services

Compounding the fundamental language barrier is the chronic systemic failure of healthcare facilities to provide certified, culturally competent medical interpreters. The data indicates that clinics frequently bypass professional interpretation services, opting instead for informal workarounds. This de-professionalization of language services forces refugee families to rely on bilingual relatives, including minor children, to translate during highly sensitive medical appointments.

The use of child interpreters introduces severe ethical complications, particularly in clinical encounters addressing reproductive oncology, maternal health, or sexual violence. Refugee women expressed deep discomfort discussing bodily functions, contraceptive choices, or traumatic physical symptoms in front of their children due to cultural taboos. This reliance on informal interpreters violates patient confidentiality, degrades the quality of clinical information shared, and compromises clinical safety by introducing significant medical translation errors.

3.2.3. Epistemic Incongruence and Rigid Authority Hierarchies

Cultural differences regarding medical authority, bodily autonomy, and modes of healing heavily shape the clinical experiences of Congolese and Rwandan women [14]. In many East and Central African contexts, Western-trained physicians are viewed as absolute authority figures whose clinical decisions must not be questioned. This hierarchical perception of medical authority prevents refugee women from asking clarifying questions about their treatment plans, seeking second opinions, or reporting adverse side effects of prescribed pharmaceuticals.

Additionally, strong cultural norms surrounding reproductive health and female modesty often deter women from seeking timely gynecological care, particularly when assigned to male practitioners. In the absence of culturally responsive clinicians who acknowledge these taboos, refugee women frequently postpone seeking care until their physical symptoms reach an acute stage, relying instead on traditional home remedies and community support networks.

3.2.4. Spatial, Financial, and Logistical Immobility

The material conditions of resettlement in mid-sized Midwestern cities like Waterloo, Iowa, present severe logistical hurdles that restrict health-seeking behaviors [15]. Unlike major metropolitan areas with robust public transportation, Waterloo lacks comprehensive transit networks, making a private vehicle a necessity for accessing medical facilities. Refugee households frequently rely on a single, shared family vehicle that is primarily dedicated to transporting male breadwinners to industrial meatpacking facilities, leaving women and children geographically isolated.

This spatial mismatch is exacerbated by acute financial precarity and a lack of medical insurance. Many refugee families lose their initial federally funded Medicaid coverage shortly after resettlement, navigating a complex transition to employer-sponsored insurance plans that are often unaffordable or difficult to comprehend. The fear of catastrophic medical debt, coupled with the lack of reliable transit, results in high rates of missed clinical appointments and a reliance on emergency departments for non-emergent health needs.

3.2.5. Interpersonal Dismissal and Systemic Alienation

The subjective experiences of the participants within Midwestern clinical spaces were frequently characterized by feelings of alienation, systemic neglect, and interpersonal dismissal. Refugee women reported that Western practitioners appeared rushed, detached, and impatient during physical consultations. This clinical alienation is deeply tied to the commercialized structure of the United States healthcare industry, which mandates high patient volumes and short consultation windows.

For refugee patients who require additional time for language translation, cultural framing, and trust-building, these brief clinical encounters are highly counterproductive. Participants felt that clinicians did not dedicate sufficient time to listen to their bodily narratives or validate their concerns, leading to an overriding perception of being culturally undervalued and clinically dismissed.

4. Discussion

An intersectional analysis of these empirical findings reveals that the healthcare disparities experienced by African refugee women are not merely the result of individual linguistic deficits or cultural differences. Instead, these barriers are produced by the convergence of multiple, overlapping structures of oppression, including systemic racism, gender-based discrimination, class-based exclusion, and legal marginalization [9]. The social location of these women as Black, female, linguistically non-dominant, and socio-economically marginalized refugees places them in a position of unique institutional vulnerability.

The structural landscape of healthcare in the Midwestern United States is fundamentally designed for English-speaking, middle-class citizens who possess private transportation and a high baseline of health literacy. When refugee women attempt to interact with this highly bureaucratized system, their multiple identities intersect to compound their exclusion. For instance, their gender dictates specific maternal and reproductive needs, yet their linguistic status prevents them from accessing professional interpretation for these intimate clinical encounters, while their class position limits their ability to pay for private medical services. This systemic neglect reinforces the need to move away from simplistic, single-axis health interventions and instead develop comprehensive policies that address these intersecting vulnerabilities simultaneously.

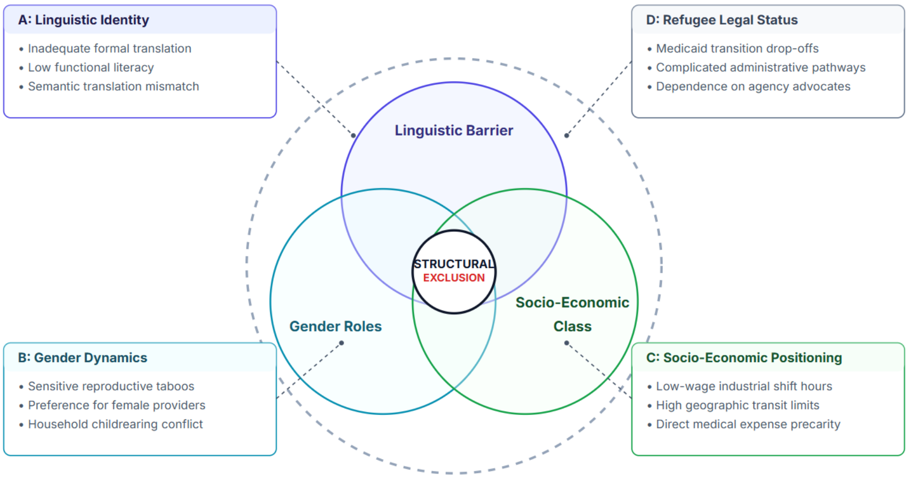

Figure 3. Compounding Clinical Barriers

Applying a postcolonial feminist perspective to the qualitative data exposes the legacy of colonial power dynamics and epistemic violence inherent in Western clinical encounters [10, 18]. Western practitioners, operating under assumptions of scientific supremacy, frequently dismiss the cultural frameworks and traditional healing systems of Congolese and Rwandan women as primitive or unscientific. This epistemic dismissal effectively silences subaltern women, stripping them of their agency and reducing them to passive, compliant recipients of Western medical interventions. The clinical encounters described by participants characterized by being rushed, dismissed, or ignored reflect a broader paternalistic structure that views the refugee patient as a cultural deficit to be managed rather than a partner in care. To dismantle these oppressive dynamics, health systems must transition from colonial models of cultural assimilation to models of epistemic humility, where the traditional knowledge, bodily narratives, and agency of refugee women are actively centered and respected.

Table 4. Digital Divide and Telemedicine Barriers during Pandemic Reorganization

Technical/Structural Dimension	Operational Barrier in Telemedicine Platforms	Impact on Patient Engagement	Mitigating Action by EMBARC Advocates
Infrastructural Deficits	Household reliance on low-bandwidth cellular data rather than high-speed fiber internet.	High connection dropouts; video consultation failure forcing low-quality audio-only sessions.	Establishing localized socially distanced internet kiosks at community centers.
Software Accessibility	Patient portals, scheduling platforms, and verification interfaces offered exclusively in English.	Total inability to register for virtual appointments or view diagnostic test results independently.	Developing pictorial step-by-step navigation guides translated into Swahili and Kinyarwanda.
Hardware Limitations	Lack of access to webcams, tablets, or computers within multi-generational refugee households.	Exclusion from telehealth consults; inability to upload photos of localized physical trauma.	Distributing refurbished electronic tablets on a temporary loan basis to pregnant refugee women.
Clinical Interpretation Integration	Telehealth systems lacking structural capability to patch in a three-way, off-site professional interpreter.	Consultations conducted without language services; clinicians resorting to basic hand gestures.	Advocates physically joining the patient's home space to facilitate translation on separate devices.

The onset of the COVID-19 pandemic served as a structural catalyst that exposed and widened the existing cracks within the refugee healthcare safety net [7]. The rapid reorganizations implemented by clinical systems, such as the transition to virtual telemedicine platforms, assumed a level of digital literacy, technological infrastructure, and stable high-speed internet access that was largely absent in marginalized refugee households [16]. This rapid digitization of healthcare effectively locked out refugee women who lacked English proficiency and technological familiarity, thereby deepening their clinical isolation.

The pandemic-induced economic disruptions heavily impacted the industrial sectors where many refugee families are concentrated, leading to job losses, loss of employer-sponsored health insurance, and acute financial strain. The suspension of face-to-face community outreach, home visitation programs, and localized integration efforts severed the vital human connections that previously facilitated health system navigation. These findings highlight that emergency public health responses, when implemented without an intersectional equity lens, can exacerbate the marginalization of vulnerable populations.

Amidst the structural failures of the formal healthcare apparatus, refugee-led community-based organizations have emerged as indispensable mediators of health equity [17]. The results indicate that EMBARC played a critical role in mitigating the systemic barriers faced by African refugee women during the COVID-19 pandemic. EMBARC bridged the immense gap between Western clinical institutions and the refugee community by providing bilingual health navigation, coordinating safe transit, distributing linguistically accessible health education materials, and establishing trusted community networks.

Table 5. Collaborative Interventions of Community-Led Methods and Institutional Reforms

Observed Structural Barrier	Immediate CBO (EMBARC) Mediation Strategy	Recommended Institutional Healthcare Reform	Long-Term Health Equity Outcome
Chronic shortage of professional interpreters	Ad-hoc coordination of community advocates to accompany patients to clinical visits.	Institutional mandates requiring certified medical translation services for all non-English speaking patients.	Complete elimination of the practice of utilizing minor children as clinical interpreters.
Linguistic and functional health literacy gaps	In-person demonstration of medicine labels and scheduling procedures.	Universal implementation of simplified, translated patient instructions and multilingual intake portals.	Decreased rates of medication administration errors and lower missed appointment rates.
Geographical isolation and transit deficits	Organizing community ride-shares and volunteer transit networks for medical visits.	Decentralization of care through mobile health clinics and community-based health hubs.	Enhanced utilization of preventative clinical services and early maternal wellness screenings.
Epistemic clash and cultural alienation	Preparing patients for clinical encounters; explaining clinical norms to both parties.	Implementation of comprehensive provider training centered on epistemic humility and cultural competency.	Development of trust-based, respectful clinical interactions between refugees and Western providers.

This mediating role was particularly crucial during the pandemic, when formal public health channels failed to deliver timely, culturally appropriate information regarding virus transmission and vaccine safety. The efficacy of EMBARC's interventions suggests that sustainable improvements in refugee health outcomes cannot be achieved through clinical reforms alone. Rather, health systems must invest in and partner with trusted, refugee-led community organizations, recognizing them as essential partners in the design, delivery, and implementation of culturally responsive care.

5. Conclusion

This qualitative inquiry has explored the multi-layered systemic barriers to healthcare access encountered by African refugee women from the Democratic Republic of Congo and Rwanda resettled in Waterloo, Iowa, particularly within the disruptive context of the COVID-19 pandemic. The study has revealed how gender, race, class, language, and legal status converge to produce unique configurations of institutional exclusion and clinical alienation by utilizing intersectional and postcolonial feminist trends. The empirical findings indicate that linguistic disenfranchisement, the absence of certified professional interpreters, epistemic incongruence, logistical fractures, and commercialized clinical environments systematically undermine the right to health for this marginalized population. The structural shocks of the COVID-19 pandemic, specifically the rapid transition to telemedicine and the contraction of physical outreach programs, served to amplify these pre-existing inequities.

To address these systemic disparities and cultivate health equity, structural reforms are urgently required. Healthcare institutions must move beyond voluntary translation services and institutionalize certified, professional medical interpretation as a nonnegotiable standard of clinical care. Clinical training programs must adopt curricula grounded in epistemic humility, postcolonial feminist perspectives, and cultural responsiveness, training practitioners to recognize and dismantle implicit biases and paternalistic communication patterns. Public health agencies and healthcare systems must formally integrate and financially support refugee-led community organizations like EMBARC, leveraging their trusted community status to co-design and implement culturally tailored health interventions.

Compliance with ethical standards

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Conflict of interest statement

All authors of this manuscript disclose no potential conflicts of interest or competing interests with the publication of this work, or with any institution, organization, or product mentioned within the text. No financial, professional, or personal relationships exist that could inappropriately influence or bias the outcomes of this study. The authors also declare no conflicts of interest involving products or services that compete with those mentioned in the manuscript.

Statement of ethical approval

This study involves research on human subjects. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee. Formal ethical approval for this investigation was granted by the Institutional Review Board of the University of Northern Iowa under Protocol Approval Number #2020-0114.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study

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