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Public Health Center Service Experiences and Needs among Immigrant Women in South Korea

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Purpose: To support implementation of comprehensive, person-centered healthcare, this study aimed to explore immigrant women's public health center (PHC) service experiences and needs while considering Photovoice's feasibility for this purpose. **Methods:** This qualitative study included 15 marriage-based immigrant women. Participants were recruited from churches and multicultural family support centers using purposive and snowball sampling. Data were collected through four focus group interviews and were subjected to inductive content analysis. **Results:** Five categories of experiences were identified: language barriers, hectic environment, affordable and practical primary healthcare, feeling ignored and discriminated against, and feeling frustrated. In addition, five categories of needs were identified: language assistance services, ease of access, healthcare across the lifespan, expansion of affordable healthcare, and being accepted as they are. This study provides preliminary evidence that the Photovoice approach can facilitate the interview process in a qualitative inquiry involving participants with limited ability to express their perspectives in the researchers' language. **Conclusion:** Study findings highlight the need to implement institutional policy and procedural changes within PHCs and to provide culturally competent, person-centered care for South Korea's marriage-based immigrant women and other ethnic minority populations. The findings also provide evidence-based direction for PHC service planning.

Key Words: Culturally competent care; Health services accessibility; Immigrants; Public health; Qualitative research

INTRODUCTION

In 2020, there were about 281 million international migrants globally, equating to 3.6% of the world's population. More than 40% of immigrants worldwide were born in Asia [1]. Rapid economic growth, fertility declines, and aging are increasing the demand for migrant labor to serve the industrial economy of East Asia, including Japan, Taiwan, and South Korea (hereafter, Korea) [2].

In East Asian countries, another important sociodemographic trend is the delay of marriage and the increasing proportion of women choosing to remain single. Since the mid-1980s, international marriage has become a strategy for single men in Japan, Taiwan, and Korea who are having difficulty finding brides [3-5]. Thus, marriage has become a principal reason for the immigration of women within and to Asia [2]. For instance, from 2003 to 2008 in Japan, Taiwan, and Korea, from 5% (Japan) to 32% (Taiwan) of all marriages involved marriage-based immigrants [2,3,5]. Since 2009, the proportion of international marriages in Korea has fluctuated between 7.2% and 10.5% [6]. Most of these marriages involved women from Southeast Asian countries and China [7]. Unlike most migrants, who eventually return to their home countries, marriage-based immigrant women (MIW) generally form families and live and age as members of the receiving societies.

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International marriage has important implications for fertility. Korea has experienced a low fertility rate over the last two decades. In 2019, the total fertility rate was just 0.92, the lowest among Organization for Economic Co-operation and Development countries [8]. Since 2009, the proportion of births to international marriage couples has steadily increased, accounting for 5.9% of all 2019 births [9]. Many MIW (63.8%) give birth to their first child within 2 years of their marriage, at an average age of 28.9 years [9]. These MIW, who are both culturally and socioeconomically vulnerable, have become important clients for the maternal and well-baby healthcare provided by Korea's public health centers (PHCs) [10].

In general, public health services in Korea are provided through public health institutions such as PHCs, which focus on health promotion and disease control and prevention for local residents, and public medical institutions, which focus on treatment [11]. PHCs have been established across the country to provide essential preventive and promotive health services such as epidemiological investigation, preparation for public health crises, integrated health promotion program, and chronic and infectious disease control and prevention. Immigrants are known to be at risk of receiving less preventive and promotive healthcare than non-immigrants [12].

Meanwhile, the overall increase in international immigration has resulted in a growing proportion of aging immigrants in most high-income countries [13,14]. In Korea, a recent national survey revealed that among marriage-based immigrants, 45.2% are now in their 40s or older, and 60.6% have been residents of Korea for more than 10 years [15]. For those in their 40s or younger, perceived health status among both MIW and Korean-born women is similar, but for women in their 60s and older, perceived health status is worse among MIW [15]. This demonstrates that MIW are in need of PHC service not only during their reproductive years but also across their lifespan. However, in Korea's National Health Plan 2030, the focus on MIW is generally limited to providing home visits for parent education and language support services, leaving their other health needs unaddressed [16]. MIW account for an ever-increasing proportion of the Korean population. To implement comprehensive, person-centered public health services, public health workers and policymakers will need to explore the specific, lifelong health needs of MIW.

Quantitative and qualitative studies of MIW in Korea have increased sharply over the past decade [17,18]. The quantitative studies have mainly focused on social support; access to healthcare; physical, psychological, and social health; and quality of life [17]. During the same period, many qualitative studies have attempted to explore MIW's experiences of transition to motherhood and child-rearing [18]. To date, the issue of immigrants' healthcare experiences has been studied most intensively in Europe, where many studies have explored immigrants' overall experiences with healthcare services in their adopted countries [19]. However, studies of immigrants' experiences and needs with PHC services remain scarce. Thus, the purpose of this study was to explore (1) PHC service experiences, (2) PHC service needs, and (3) the feasibility of using Photovoice to understand these experiences and needs among MIW in Korea.

METHODS

1. Design and Participants

This study employed a descriptive design and qualitative methods. We used purposive and snowball sampling to recruit a total of 15 MIW (four Korean-Chinese women, four Japanese women, four Vietnamese women, and three Filipino women) from churches and multicultural family support centers, which were attended predominantly by MIW. The inclusion criteria were adult first-generation Korean-Chinese, Japanese, Vietnamese, or Filipino MIW who had experience using PHCs, were able to communicate in Korean, and used a cell phone with photo-taking functions.

This study was reviewed and approved by the research ethics committee of the first author's institution (IRB No. 1040198-160603-HR-039-05). Informed consent was obtained from all participants.

2. Data Collection and Procedures

Four focus group interviews (one per country of origin) were conducted from December 2016 to March 2017 across several locations according to the participants' preferences: in cafes (two groups), a church (one group), and a multicultural family support center (one group). Before each focus group interview, the participants were asked to use their cell phones to take photographs that represented their perceptions related to PHC services. Where possible, the photograph files were obtained from participants and printed in letter size, and the interviews were conducted while looking at the printed photographs. However, only eight participants (53.3%) brought photographs; the rest participated without photographs. Of the total of 34 photographs provided, 12 were taken by the participants themselves, and 22 were from unidentified Internet sources. In

this study, we selected three photographs as examples that vividly revealed the perspectives of the participants.

Each focus group interview was conducted in Korean and lasted about 90 minutes. The interviews started with questions such as "How was your experience using PHC services?" and "What do you expect from PHC services?" and "Please tell us more about this photograph." The participants who submitted photographs provided an interpretation of how their photographs were related to their PHC service experiences and needs. The participants were then asked specific questions such as "What difficulties were caused by cultural differences when using PHC services?" and "What cultural characteristics of yours should public health workers consider when providing services?" All interviews were conducted by the first author, who has extensive experience in nurses' cultural competence and in immigrant healthcare, using a semi-structured interview guide. All interviews were audiotaped. Two research assistants participated in the interviews and wrote field notes. Data were collected until data saturation was achieved and no new information was obtained.

3. Analytic Strategy

We used an inductive content analysis approach to analyze the qualitative data [20]. Three researchers independently read the focus group interview transcripts in-depth to gain an overall understanding of the experiences and needs expressed by the participants. Each researcher divided the text into meaning units (sentences) that were then condensed and coded. Through subsequent discussion and reflection, the three researchers interpreted the codes and compared them for similarities and differences. Finally, the researchers reached a consensus on 10 categories of experiences and needs. The trustworthiness of the data was maintained by adhering to recommended measures throughout the steps of the research process [20,21]. Credibility was assured through peer debriefings during the research team meetings. Confirmability was strengthened by having two of the focus group participants review the codes and categories to ensure that our findings were consistent with their lived experience. We used Microsoft Excel to code and thematically analyze the qualitative data.

RESULTS

1. Participant Characteristics

A total of 15 MIW were recruited for this study. Their ages ranged from 28 to 59 years (mean=43.20±9.10 years), and their time living in Korea ranged from 4.8 to 28 years (mean=13.62±6.51 years) (Table 1).

Table 1. General Characteristics of Study Participants (*N*=15)

Characteristics	Categories	n (%) or M±SD	Range
Age (year)		43.20±9.10	28~59
Ethnicity	Korean-Chinese	4 (26.7)	
	Japanese	4 (26.7)	
	Vietnamese	4 (26.7)	
	Filipino	3 (20.0)	
Education attainment	Junior high school	2 (13.3)	
	High school	5 (33.3)	
	College	8 (53.3)	
Duration of stay (year)		13.62±6.51	4.8~28
Number of children		2.20±1.32	1~5
Number of times using public health centers		12.08±7.85	4~30
Types of services used at public health centers†	Vaccination	15 (100.0)	
	Maternal and child health	4 (26.7)	
	Oral health	4 (26.7)	
	Physical exam	4 (26.7)	
	Health education	3 (20.0)	
	Physician services	3 (20.0)	
	Nutrition management	2 (13.3)	
	Chronic disease management	2 (13.3)	
	Other	1 (6.7)	

† Multiple responses.

2. Participant Experiences Using PHC Services

Five categories of PHC service experiences were identified: language barriers, hectic environment, affordable and practical primary healthcare, feeling ignored and discriminated against, and feeling frustrated (Figure 1).

1) Language barriers

In the early stage of moving to Korea, the participants had received help from their family members or from other immigrants who were fluent in Korean when using PHC services. This was due to lack of interpretation services and limited multilingual written materials. Language barriers continued to make it difficult for the participants to use PHC services even after many years, not only at the beginning. Because of these language barriers, the participants often doubted whether they were receiving adequate services.

> I can't speak Korean [like native Koreans]. So if I go to the PHC alone, I [worry about if] I wrote something wrong on the paperwork. There would be a disadvantage to the baby. Even if I talk to the staff, I can't understand them well, so I start to lose my confidence. (Group 3, Participant B)

2) Hectic environment

The participants also had negative experiences while using PHC services because they felt that the PHCs had a busy and hectic environment. One participant recalled that being at a PHC was like standing at a busy, congested traffic intersection. The participants also experienced confusion caused by lack of information on PHC services. In many cases, information on various services was not properly advertised for the MIW.

> It's the same feeling as when people gather in all four places at the moment the signal changes at a scrambled intersection. It felt like people were running around trying to get service first and talking frantically. (Group 2, Participant B)
>
> My niece went to the PHC to get vaccinated, and took the vaccination record she received in China. Because vaccinations in Korea and China are different, it is impossible to distinguish the dose and type … Eventually, she went to China to get her vaccination. (Group 1, Participant D)

3) Affordable and practical primary healthcare

The participants thought that PHC services offered the advantage of accessing a variety of types of affordable primary healthcare, such as nutrition programs, smoking cessation programs, dementia counseling, Eastern medicine treatment, and physical therapy, for free or at low prices. The participants were satisfied with the practical and tailored health information that they received. They said that the information provided was tailored to the level of understanding of immigrants and could be applied in everyday life.

> It's good because they check the food the baby needs and whether the baby is healthy and not lacking in nutrition. It was also nice to be able to use such a service for free or at a low price. (Group 3, Partici-

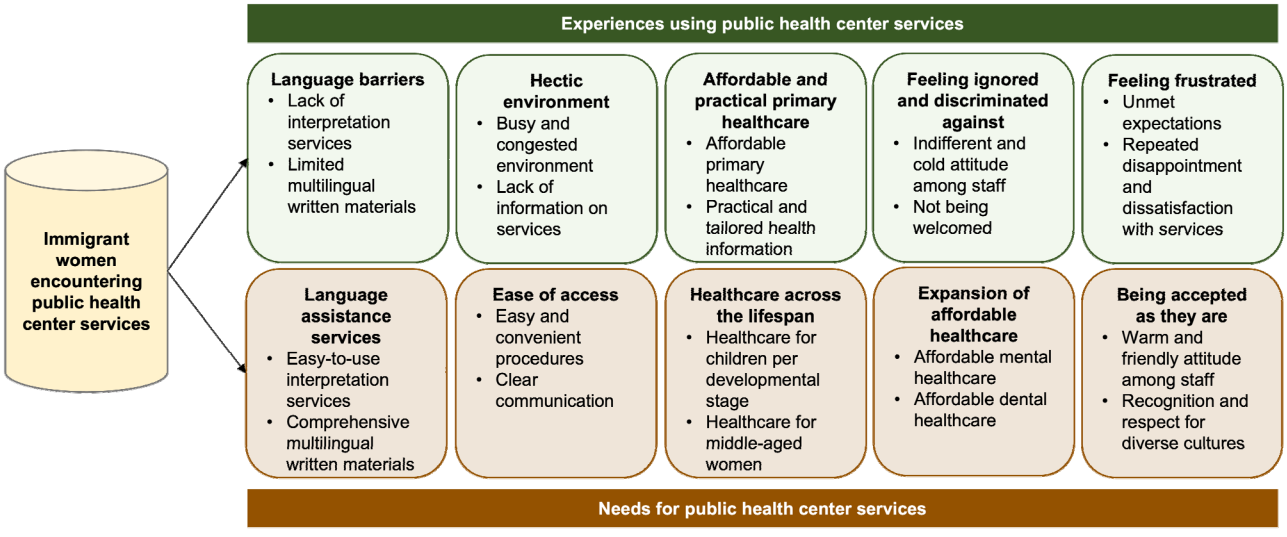

Figure 1. Public health center service experiences and needs of immigrant women.

pant B)

They taught us what we should eat every day at home... Once, I went with my mother to receive training on diabetic diet management. Older people do not understand well even if it is explained to them. However, the teacher made separate models for breakfast, lunch, and dinner and explained them in a kind and detailed manner. (Group 1, Participant D)

4) Feeling ignored and discriminated against

The participants perceived that they were being ignored or discriminated against because they were thought to be foreigners who used low-cost PHC services. They were uncomfortable with the indifferent and cold attitude of the administrative staff at the PHCs' registration desks. The participants felt that the public health workers did not welcome them initially and that it was difficult to approach the workers.

When I went [to the PHC], the reservation staff drew an impression about what I came for. It's difficult to talk to them. "How did you get here? What are you going to do?" the staff asked bluntly. [Sighs] I feel like I'm here for nothing… and the doctor only talks perfunctorily. (Group 2, Participant B)

The staff at the registration desk don't laugh. There is no smile on their face, they don't respond, and they don't give directions on where to go. (Group 4, Participant A)

5) Feeling frustrated

One barrier to accessing PHC services was revealed through Photovoice. Participants said that although they visited PHCs with certain expectations, they often returned with unmet expectations and felt disappointed and dissatisfied. One participant expressed her experience with a photograph of an empty house and cart (Figure 2-A).

I went to the PHC because of my child, but every time I went, I didn't get anything like this, and I felt frustrated… like an empty house... It's the same feeling when I shop and buy nothing. (Group 2, Participant A)

Because there are a lot of people and it is complicated, work is busy. They rush the treatment and call the next person right away. I want to ask more, but I can't. After returning home, I feel somewhat frustrated and dissatisfied. (Group 3, Participant A)

3. Participants' Needs for PHC Services

Five categories of PHC service needs were identified: language assistance services, ease of access, healthcare across the lifespan, expansion of affordable healthcare, and being accepted as they are (Figure 1).

1) Language assistance services

The participants argued that for PHCs to deliver accurate information, the availability of an easy-to-use interpretation service and comprehensive multilingual written materials was essential. They felt this way because they and their accompanying family members experienced limitations in communicating with public health workers.

[Even] if my husband listens to the explanation on my behalf and checks it [on the form], I don't know what explanation I heard or where I checked it. At that time, I thought it would be good to have someone who interprets it in Vietnamese in detail next to me. (Group 3, Participant A)

Due to the nature of the Japanese people, we like to know everything [about our health]. Without information, we are insecure... We need [written] information in Japanese [not just oral explanations]. (Group 2, Participant B)

2) Ease of access

The participants wanted easy and convenient procedures, such as extended service times. The participants also said that clear communication of information at all levels was crucial. They wanted public health workers to speak slowly and clearly when talking to them and to make sure they understood the information correctly. Furthermore, they thought that clear communication between PHCs and the immigrant community was essential for effective care. The participants suggested that multicultural family support centers could provide information about the PHC services and explain how to access them.

When we go to the PHC, we have to fill out paperwork. But I don't know why there are so many things to check. In China, if you go to get vaccinated, you only need to check a few things to see if you have a fever or if you are allergic to drugs. (Group 1, Participant C)

If the multicultural family support centers are informed of the services provided by the PHCs, the multicultural family support centers can send a text message to immigrant women so that interested people can participate. (Group 1, Participant A)

3) Healthcare across the lifespan

The participants wanted various healthcare to be provided for their children according to developmental stage, from infancy to adolescence. Desired services included counseling on child growth and development and psychological counseling for adolescents. In addition, as MIW approached midlife, they faced different health challenges. The participants said that they needed healthcare for middle-aged women to properly manage their changing health issues. In addition, they wanted to receive physical therapy and an exercise program suitable for middle-aged women at low cost.

> As our children grow, we need a variety of information and healthcare services. If a child has atopic dermatitis, they can be treated... [Information should be provided on] necessary vitamins, food, glasses, dental treatment, etc. [for children]. (Group 4, Participant B)
>
> Now that we are in our 50s, we are at an age where our health is not getting better. It would be nice if there was an education program on yoga or exercise that is good for back or shoulder pain that can be learned in the evening or on weekends. (Group 2, Participant D)
>
> I have urinary incontinence because I am old… Menopause is also coming... I think it would be good if an expert could educate us on how to manage those conditions. (Group 1, Participant C)

4) Expansion of affordable healthcare

The participants expressed the need for affordable mental healthcare. They thought that psychological counseling was a health service that everyone from adolescents to adults needed, and they hoped that it would someday be available at low cost in PHCs. The participants also wanted affordable dental care in addition to basic checkups, because the burden of dental care costs was high.

> These days, everyone is under a lot of mental stress and pressure. I think I can get rid of everything with psychotherapy... So I want to go and get it. I wanted to receive treatment, but I didn't know where to go [weeping]. (Group 1, Participant C)
>
> Going to the dentist for treatment is too expensive. The PHC only provides basic checkups, but it would be nice if they would also provide specialized treatment that is costly elsewhere. (Group 4, Participant A)

5) Being accepted as they are

The participants' needs for PHC services were further captured through Photovoice. The participants wanted public health workers to have a warm and friendly attitude toward immigrants. One participant expressed the friendliness, kindness, and meticulous consideration desired from public health workers through a photograph of a cup of hot coffee decorated with a heart (Figure 2-B). The participants wanted PHC services to be accompanied by recognition and respect for diverse cultures. The participants said that when their unique cultural characteristics were not accepted, they felt a wall between themselves and Koreans and would hide their true selves. One participant expressed the desire for cultural acceptance through a photograph where flowers of various colors were harmonious in their beauty (Figure 2-C).

> There are countries as diverse as these different colors of flowers. These colors are all different, but they all exist beautifully, so please acknowledge their



A. An empty house and cart



B. A Cup of hot coffee decorated with a heart



C. Flower of various colors with harmonious beauty

Figure 2. Photovoice of participants' public health center service experiences and needs.

differences and pay attention. (Group 2, Participant A)

When I enter the PHC, it is an unfamiliar environment, so I am afraid and have a passive attitude. I feel bad when the public health workers gossip, saying "Why is that person wearing such thick clothes?" Since we lived in a cold region, it is customary to wear a lot of clothes... We don't want them to see us as strange people. (Group 1, Participant D)

DISCUSSION

This study sheds light on MIW's experiences and needs related to PHC services in Korea and provides qualitative evidence to support future PHC service planning. It also provides preliminary evidence of the feasibility of Photovoice for enhancing communication. Through the perspectives of MIW, we identified priority areas that need to be tackled in a timely manner to reduce the health disparities between aging immigrants and non-immigrants and achieve better health for immigrants. Some categories reported in this study, such as hectic environment and affordable services, show that MIW and non-immigrants have similar experiences and needs for PHC services. Yet there were also unique challenges and needs among MIW, such as language barriers, feeling ignored and discriminated against, language assistance services, and being accepted as they are.

1. PHC Service Experiences and Needs

In most cases, the MIW's experiences reflected needed improvements in PHC services. First, language barriers remain a persistent challenge for MIW when attempting to access PHC services in Korea. Insufficient proficiency in Korean limited the ability of MIW to comprehend public health workers' instructions, leading to distrust of or dissatisfaction with the care received. Like marriage-based Thai immigrants in Norway [22], when MIW in Korea used PHC services, their Korean husbands or family members often served as interpreters; however, the family members were frequently not able to interpret effectively. Furthermore, even MIW who had lived in Korea for more than a decade had difficulty understanding what Korean public health workers were saying. Although the importance of language assistance services for immigrants has often been emphasized [22-26], and Korea's PHC services have taken steps in this regard, additional improvements are needed. It is essential not only to provide interpretation services and informative materials in multiple languages, but also to train public health workers in how to communicate effectively with immigrants.

Cross et al. [27] defined cultural competence as "a series of appropriate actions, attitudes and policies for systems, organisations or professionals to work effectively in transcultural situations." In other words, for public health workers to provide appropriate services tailored to the cultural and linguistic needs of immigrant clients from various countries, their organizations and systems—such as principles and commitments, leadership, human resources, and physical environment and resources—should support diversity [28]. The U.S. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care provide a sample blueprint for healthcare organizations seeking to offer services that are respectful and responsive to individuals' cultural health beliefs and practices and preferred languages [29].

Second, MIW perceived PHCs as having a hectic environment. When they visited the centers, they were uncomfortable with the busy and congested environment. The participants wanted ease of access to PHC services, but the environment could negatively affect the feelings and behaviors of public health workers and MIW alike. Therefore, not only should the procedures for using PHC services be made easier and more convenient, but a more user-friendly environment should be established within PHCs. Due to lack of information on Korean PHC services, MIW felt confused when attempting to access healthcare and could not fully utilize the PHC services available to them. They wanted clearer communication so that they could obtain needed information about PHC services. To better meet MIW's communication needs, one strategy would be to provide PHC service information within the language and culture courses commonly taken by immigrants [26]. Another strategy would be public health workers conducting outreach through immigrant networks, such as local nongovernmental organization community groups and multicultural family support centers, to improve MIW's knowledge of the PHC services.

Third, MIW reported various types of affordable and practical primary healthcare as being facilitators for using PHC services. However, as their children grew up and they themselves grew older, the participants felt they needed access to healthcare services across the lifespan. They showed strong interest in health promotion and expressed concerns about chronic diseases. In addition, the participating MIW expressed strong needs for psychological counseling and dental care.

First-generation immigrants are known to be at increased risk of mental illness, especially depression [30]. A recent study reported that MIW in Korea were more than

twice as likely to experience depression as Korean-born women [31]. Korea has universal health coverage, and immigrants who reside in Korea for more than 6 months are entitled to Korean National Health Insurance [32]. However, like immigrants in Canada [33], MIW experienced barriers to accessing mainstream mental healthcare. In Korea, opportunities to obtain psychotherapy from a psychiatrist are limited, and counseling by a psychologist is not yet covered by Korean National Health Insurance [34]. Furthermore, the free mental healthcare provided by community-based mental health centers in both Korea and Canada have presented language and cultural obstacles for MIW [33,35].

With respect to dental care, MIW in Korea are known to have a significantly higher number of untreated dental caries than Korean-born women [36]. Because Korean National Health Insurance covers a limited number of basic dental services, MIW have difficulty accessing affordable dental care. Studies in the United States and Canada have also reported unmet needs for dental care among immigrants related to low income and lack of dental insurance [37,38]. Korean public health personnel should strive to link MIW with existing resources and to develop public policies for providing MIW with affordable and sustainable mental health and dental services.

A fourth need for improvement in Korea's PHC services that was uncovered by this study comes from MIW's reports of feeling ignored or discriminated against and frustrated in their encounters with public health workers. Previous studies have reported that healthcare providers frequently view immigrants as "others" and as being different from "them" [19]. Interestingly, just as immigrant women in Switzerland perceived discrimination by administrative staff at a registration desk [26], MIW in this study perceived an indifferent and cold attitude among Korean administrative staff. Consequently, this study's findings support previous arguments that cultural competence training should be provided to all healthcare personnel who serve immigrants [26,39].

In addition, MIW in this study expressed that they wanted to be accepted as they are. In Figure 2-B (hot coffee with a heart) and Figure 2-C (flowers of various colors) reflected MIW's intense desire to be truly accepted and welcomed in their new homeland. In a study of women who had been subjected to genital mutilation before immigrating and were now living in and using maternity services in Australia, the researchers emphasized that when healthcare professionals reflected the women's cultural values, and when the women actively participated in the service process, the quality of care improved [40]. In the current study, one MIW said that she wore a figurative mask to hide her unique cultural attributes in order to pretend that she had adapted to Korean society. The statements of several of the participating MIW indicated that it was difficult for them to establish therapeutic relationships with public health workers, as they did not dare to reveal their true feelings if they felt that the workers did not respect their culture.

This study's results make it clear that public health workers' provision of culturally competent care to immigrants at the individual level is important but insufficient. As noted earlier, organizational and system-level cultural competence is essential to facilitate delivery of optimal PHC services to immigrants. Consequently, implementation of institutional policy and procedural changes is called for, including new equity and antidiscrimination policies, language assistance services, cultural competence training for individual public health workers, and culturally tailored services aimed at improving care for diverse community residents [28, 41]. Furthermore, according to a study on the experiences of public health workers in Korea who provide care to immigrants [39], they also reported difficulties in communicating and building trusting relationships with immigrants and were aware of their lack of preparation for culturally competent care and of the vulnerability of immigrant clients. The results of our study will contribute to providing information for healthcare providers and users and reducing their mutual gaps.

2. Advantages of the Photovoice Interview Method

A known advantage of the Photovoice interview method is that it can vividly reveal the perspectives of vulnerable populations [42]. In this study, Photovoice helped participants express their thoughts more openly through symbolic photographic images and provided us with greater insight into their experiences and needs. For example, one participant revealed her PHC service experience through a photograph of an empty house and cart. Using this photograph as a medium, we were able to more fully grasp her experiences of disappointment. This study shows that a qualitative nursing inquiry involving participants who have limited ability to express their perspectives in the researchers' language can use the Photovoice approach to facilitate the interview process.

3. Limitations

We acknowledge several limitations to this study. First, although the study was conducted with MIW from four

countries, the number of participants from each country was small, and thus data saturation may not have been achieved. Second, because all interviews were conducted in Korean only and participants' Korean language proficiency was limited, we could not always explore participants' meanings in depth. Instead we used Photovoice to more vividly grasp immigrants' experiences and needs from their own perspectives. However, even though we asked participants both orally and through text messages to take photographs with their cell phones, only some participants did so.

In addition, when conducting focus groups, it is desirable to have enough people to generate diverse ideas. Although the optimum number of participants for a focus group may vary, 4 to 12 people are suggested [43]. One group in this study had only three participants, which may have limited data generation based on the synergy of group interaction. Lastly, there were large variations in participants' length of stay in Korea and the number of times they had used PHC services. Some participants, such as MIW with relatively short lengths of stay or fewer visits to PHCs, may have hesitated to participate fully and their perceptions may not be sufficiently captured.

Despite these limitations, we believe this study is meaningful because it explored MIW's experiences with and needs for PHC services, which is a service domain far less studied than clinical healthcare services. Furthermore, this study provides a deeper understanding of MIW's perceptions, such as feelings of discrimination and frustration and the desire to be accepted as they are, which are difficult to capture through quantitative research. Because this study was limited to PHC service experiences and needs, future studies will be needed to explore immigrants' perspectives on treatment at medical institutions and on receipt of preventive and promotive services that have large disparities in use between immigrants and non-immigrants.

CONCLUSION

This study highlights the need to implement institutional policy and procedural changes in addition to providing culturally competent care at the individual level in order to improve PHC services for Korea's MIW and other minority populations. Priority areas of change for Korea's PHC services include offering language assistance services, improving procedures for ease of access to PHC services, providing PHC services across the lifespan, expanding affordable healthcare, establishing policies for equity and against discrimination, and requiring cultural competence training for public health workers. These study findings thus provide evidence-based direction for future PHC service planning by public health administrators and policymakers.

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