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Heidi Jean Worabo

University of Missouri-St. Louis, hjfty5@mail.umsl.edu

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Assessing the Feasibility and Perceptions of Health Services for Refugees of
Resettlement Organizations

Heidi Jean Worabo

MSN, Family Nurse Practitioner, Southern Illinois University Edwardsville, 2007

BSN, Nursing, Goshen College, 2002

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of Missouri-St. Louis in partial fulfillment of the requirements for the degree
Doctor of Nursing Practice

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Advisory Committee

Kuei-Hsiang Hsueh, Ph.D.
Chairperson

Richard Yakimo, Ph.D.

Susann Farberman, D.N.P.

P. Ariel Burgess, M.S.W.

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Abstract

Background: Since 1975 the U.S. has resettled 2.6 million refugees who had to flee from their home countries. Many refugee resettlement organizations have developed different models of innovation to promote a smooth transition between previous foreign refugee camps to U.S. communities so that refugees swiftly become economically and socially self-sufficient. Providing refugees with health benefits and resources has been foremost priority upon arrival as they try to overcome health care barriers. Yet there is a lack of literature examining the impact of these health services and how they are perceived by the program recipients.

Purpose: This scholarly project aimed to evaluate the feasibility and perceptions of health services provided by a large refugee resettlement agency in the Midwest region of the U.S.

Methods: The qualitative study used four focus groups to interview a convenience sample of 39 individuals who were clients of a large refugee resettlement agency in the Midwest U.S. The transcribed interviews from each focus group were analyzed by deriving dominant themes to understand the feasibility and perceptions of the health services provided by the resettlement agency and other organizations. Their attitudes and beliefs about preventive health care services and their impression of U.S. health care were also explored to identify education needs and future program development.

Results: Results of the study revealed that their impression of U.S. health care was full of waiting and calling for appointments, emergency room delays, a lack of clear communication and difficulty navigating the insurance system. Their perceptions of health screenings were that they were familiar with these tests, but would like a copy of

the results. They were confused with TB test results and valued vaccine information sheets. Their overall attitude toward U.S. health care among the four focus groups varied. Their beliefs about preventive care focused on cleanliness and they were unlikely to access preventive health services due to cost.

Conclusion: Findings suggest additional efforts are necessary to further address health needs of the resettled refugee population. This project adds new information to make lasting health care improvements enabling refugees to thrive within their new communities.

Keywords: refugees, health care, access, health care barriers, programs, perceptions

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Introduction and Background

The United Nations High Commissioner for Refugees (UNHCR) reported in 2009 that 42 million people in the world were uprooted from and forced to flee their home. Of those, 16 million had to flee their own country and are therefore, considered refugees. While most of the refugees in the world are hosted by developing nations (80%), the United States (U.S.) is one of a few developed nations offering refugee resettlement and consistently accepts the highest number of refugees (UNHCR, 2011). Since 1975, the U.S. has resettled 2.6 million refugees with an annual range from 27,100 in 2002 to 207,116 in 1980 (Office of Refugee Resettlement, 2011). The U.S. government works with private organizations to provide refugee resettlement programs that promote a smooth transition from refugee camps to designated cities across the country. The mission of refugee resettlement programs is to help refugees and their families become economically and socially self-sufficient within the shortest amount of time possible after arrival (International Institute, 2011). To meet this mission, providing refugees and their families with health benefits and resources has been the foremost priority upon their arrival.

Health and wellness are vitally important for refugee populations in the journey toward independence and becoming productive participants in society (Crosslin & Burgess, 2011). Unlike general immigrants to the U.S., refugees did not choose to migrate and were unable to prepare and plan for their relocation. In addition, refugees have a unique set of life experiences that put them at higher risk for vulnerable health status. Refugees have been found to have a higher incidence of infectious disease, complex mental health issues related to trauma, as well as adverse effects of not having

basic health care available-- sometimes for several years--while living in refugee camps (Lifson, Thai, O'Fallon, Mills, & Hang, 2002; World Health Organization, 2011). To address these issues, health programs administered by refugee resettlement agencies are the key to ensuring optimum health status to allow for a swift transition to self-sufficiency and economic independence.

The literature indicates that some of the prominent health care access barriers specific to this population are cultural beliefs and language barriers (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Sheikh-Mohammed, MacIntyre, Wood, Leask, & Isaacs, 2006; Asgary & Segar, 2011; Uba, 1992). Various programs have been established among developed nations offering refugee resettlement to reduce barriers involving cultural beliefs and communication issues (Morris et al., 2009; Sheikh-Mohammed et al., 2006; Asgary & Segar, 2011). One example of successfully overcoming cultural and language barriers to accessing health care for refugees in Australia was by establishing a Refugee Health Access Team (Smith, 2008). By having the Team work closely with the refugee community developing trust and establishing networks with various health care service agencies, they were able to reduce cultural and language barriers (Smith, 2008). Evaluations of established programs such as this can assist similar agencies in program enhancement and development.

Palinkas et al. (2003) designed a health promotion program tailored specifically for East African refugees resettled in San Diego using their traditional idioms to increase awareness of important public health concepts such as how HIV is transmitted or mental health treatment and resources. By using these idioms, the program was able to

overcome cultural communication barriers and differences in understanding disease transmission and mental health issues.

Despite these examples, there remains a lack of in-depth literature examining and analyzing the impact of these health services and how they are perceived by the clients of refugee resettlement agencies as part of quality improvement efforts.

Purpose Statement

This scholarly project aimed to evaluate the feasibility and perceptions of health services provided by a large refugee resettlement agency in the Midwest region of the U.S. For this project, the investigator examined the health program of the agency as seen through the eyes of the program recipients--the refugees themselves. Four research objectives were proposed to achieve the study aim:

1. Examine the feasibility of health services provided by the refugee resettlement agency and collaborative agencies from the clients' perspectives;
2. Understand participants' satisfactions reflected by their impression and perceptions with their experiences with U.S. health care in general;
3. To explore attitudes and beliefs toward accessing and utilizing preventive health care services;
4. To identify health education and resource needs and preferences of resettled refugees to contribute toward program improvement efforts.

Results of this project add new information to make lasting improvements to the health of the refugee population that enables refugees to thrive within their new communities.

Review of Literature

History of U.S. Refugees

The United States has a long and significant history of immigration. Between 1860 and 1920, the percent of foreign born persons within the U.S. remained around 13-15% with most immigrants arriving from Europe. Immigration declined for the next several decades, but since 1970, the percent of foreign-born persons has increased again from 4.7% in 1970 to 11.1% in 2000 with most arriving from Asia and Latin America (Gibson & Jung, 2006). As the percent of foreign-born persons rises, health care professionals are challenged to provide quality service with attention to language and cultural factors (Fortier & Bishop, 2004). Despite several similarities between general immigrants and refugees, it is vital to acknowledge the differences between the two groups.

Refugees differ from general immigrants in that refugees have been forced to flee their home rather than choosing and planning to leave their home. The United States, along with other countries began refugee resettlement programs after World War II to help provide homes for the thousands of displaced Europeans (Office of Refugee Resettlement, 2011). The 1951 Refugee Convention defined a refugee as someone who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (United Nations High Commissioner for Refugees, 2011, "Refugees," para. 3).

Due to the unique history and set of similar experiences among refugees, health care professionals can examine and become familiar with common health care issues affecting this particular population.

Health Care Issues Affecting U.S. Refugees

Refugees resettled in the U.S. face significant challenges to accessing health care services that meet their unique health needs. The San Diego Refugee Forum reported in a 2006 survey that 56% of its members ranked health or health care as the most important issue facing refugees during their first few years in the U.S. (Morris et al., 2009).

Healthcare access barriers for refugees include language and communication barriers, cultural differences in health care utilization patterns, and differing perceptions of preventive health care services (Morris et al., 2009).

Compounding these barriers is the fact that refugees present to the U.S. with higher rates of infectious disease and undetected/untreated chronic conditions related to substandard conditions of the refugee camps and lack of available health services (Bruno & de Gourville, 1993). The incidence of tuberculosis, malaria, intestinal parasites, HIV and hepatitis B is higher among many refugee populations than the general U.S. population (Lifson et al., 2002). Other common health problems of new refugees from developing nations are anemia, dental caries, eye and vision problems, nutritional deficiencies and immunization deficits (Fowler, 1998). The Georgia Refugee Health Program found that between 1983 and 1989, 3011 (37%) refugees undergoing initial screening procedures were referred for additional services, not including those referred for tuberculosis, sexually transmitted diseases or hepatitis B services. Seventy-two percent of those screened were found to have a health condition requiring referral to a

health center and 34% had more than one condition (Bruno & de Gourville, 1993). The health status of refugees is clearly an issue of concern upon arrival to the U.S.

As most health care professionals can attest to, mental health affects aspects of physical health and can have a profound impact on productivity and self-sufficiency (Pickwell, 1989). Prevalence of mental health issues and poor quality of life substantially affects the health of the refugee population. The World Health Organization summarizes the refugees' burden as follows:

Some 5 million constitute a group presenting chronic mental disorders (prior to the war) and of seriously traumatized, who would require specialized mental health care had it been available. Another 5 million people suffer from psychosocial dysfunctioning affecting their own lives and their community. The remainder majority are faced with distress and suffering. It is important to remember that refugees' reactions are normal reactions to an abnormal situation ("Mental health of refugees, internally displaced persons and other populations affected by conflict," 2011, para. 3).

The traumatic experiences many refugees have endured during their lives along with the difficulties of the resettlement process are correlated with high rates of depression, anxiety and PTSD (Lipson, Weinstein & Gladstone, 2003). Kennedy, Seymour and Hummel (1999) reported that in their Colorado health screening program for refugees, they detected 54 significant mental health concerns among 384 refugees during the months of July to September of 1998. The most common problems detected were symptoms related to a history of torture. Then, between April and June of 1999, they initiated a self-administered questionnaire and found that 43% of 115 refugees reported

psychological symptoms (Kennedy et al., 1999). These findings illustrate the importance of attention to mental health care issues for refugees as part of the management of refugee health overall.

The literature detailing the health status of refugees leads to the question of whether refugees have access to or actually are able and/or willing to utilize available health care resources. Many indicators in fact reveal that refugees do not utilize health care services to the degree of the general U.S. population (Uba, 1992). Some associated factors include language barriers, a lack of understanding of the U.S. health care system and cultural attitudes and beliefs (Morris et al., 2009; Sheikh-Mohammed et al., 2006). Refugees also do not utilize preventive health care as often as the general U.S. population (Lipson, Weinstein & Gladstone, 2003). Preventive health care becomes increasingly important as refugees settle into their new communities and acquire lifestyle behaviors similar to that of their neighbors. Palinkas et al. (2003) found that refugees post-resettlement are susceptible to conditions such as cancer, diabetes, hypertension and coronary heart disease. As refugees enter the U.S., it is vital to understand reasons for low utilization of health care services and preventive health care services and then implement strategic and effective refugee health programs.

Health Programs for Refugees in the U.S.

As part of the “Refugee Act of 1980,” states resettling refugees are required to provide a certain level of health screenings for newly arrived refugees to protect both refugees and the general public (Office of Refugee Resettlement, 2011). There is a wide range of methods for completing this requirement as determined by each state and some states strive for more comprehensive services as they observe shortcomings of basic,

minimal programs (Pickwell, 1996). Some refugee health programs are more centrally managed, such as the Minnesota Health Department Refugee Health Program; other states take more of a collaborative approach with academic institutions, such as in Colorado and still others, have a team approach to refugee health services, such as the a large refugee resettlement agency in the Midwest region.

In Minnesota, the state health department plays a significant role in managing health screenings. The Minnesota Health Department (MHD) sends out a packet, including The Refugee Health Assessment form and an immunization record form to the particular health care provider or clinic in the county where the refugee plans to resettle. Then, the provider performs the health assessment, orders the screening tests and fills out the forms in the packet with the test results and then sends it back to MHD after which the information is sent on to the federal Office of Refugee Resettlement. The Health Assessment Form includes results of the TB test, results of chest x-ray if indicated, hepatitis B blood test, stool test for parasites, test for eosinophilia and anemia, and if indicated, tests for STI's and malaria (Minnesota Department of Health, 2008). Minnesota also has a central database into which all information is entered and can therefore, produce statistical information quickly while easily accessible to all participants involved in the process ("eShare," 2011). Not all states are in the position to conduct and design such a comprehensive refugee health program. However, other states have coordinated with other institutions to do more than the minimal requirement to improve the health of the refugee population.

Kennedy, Seymour & Hummel (1999) describe a model for a refugee health screening and assessment program that was a joint venture between The Department of

Family Medicine at the University of Colorado Health Sciences Center and the Colorado Refugee Services Program. Outstanding aspects of the program were single point of access for all family members, interpreting services, comprehensive health assessments including special attention to mental health, data collection and evaluation and culturally competency training for health care providers. The authors see the benefits of this type of program to be better disease detection and follow-up care, more culturally sensitive introduction to the U.S. health care system, unique opportunities for health care workers, and long-term benefits of improving transition to life in the U.S. through improved health. They also acknowledge the need for further evaluation studies and outcome analyses of the program. Evaluation of health programs is vitally important to justify their existence and resource allocation.

As these examples illustrate, each state differs in their approach to managing refugee health programs. In one Midwestern state, private agencies are the primary organizers of refugee health services, but collaborate closely with public health departments at the state and city level, as well as with other private health agencies. One of the advantages to conducting health programs through the private refugee resettlement agency is that the refugees are familiar with the agency/staff and the screenings and vaccine programs can be centralized on the campus of the resettlement agency. This way, the collaborating health agencies travel to the resettlement agency and can serve the clients in a setting that is easily accessible and familiar for clients.

History and Structure of the Health Program at the Refugee Resettlement Agency in the Midwest Region

This scholarly project was conducted in a city within the Midwestern U.S. The Office of Refugee Resettlement with the U.S. Department of Health and Human Services reported that 1276 refugee individuals were resettled in this Midwestern state in 2010 out of the total number of refugees arriving in the U.S. (73,311). General immigration to this Midwestern city is about one half of the national average, yet the number of refugees is consistent with the national average for U.S. cities. Therefore, the foreign born population in this city is largely persons who have come as refugees rather than general immigrants (Crosslin & Burgess, 2011). The fact that the city has a strong history of refugees becoming part of the community, demonstrates the importance of working toward providing new refugees with the necessary tools for becoming productive, healthy participants of the community.

The large refugee resettlement agency in the Midwest region is a not-for-profit organization existing to provide comprehensive adjustment services to immigrants and refugees with the goal of reducing poverty of new Americans (International Institute, 2011). The agency is the largest refugee resettlement agency in its state and reports assisting 634 refugee individuals in 2009 (International Institute, 2011). As part of the comprehensive services, they coordinate several health related activities comprising the refugee health program. See Figure 1 for an illustration of health related activities of the agency and its collaborative agencies.

REFUGEE HEALTH PROGRAM LOGIC MODEL

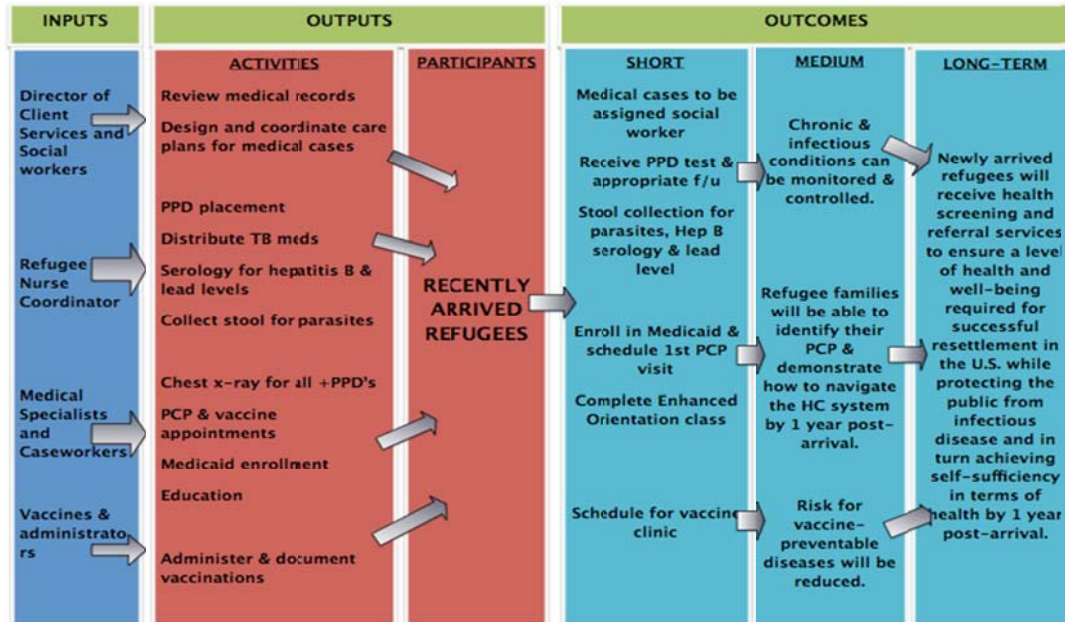


Figure 1. A logic model illustration of the refugee health care activities coordinated by the refugee resettlement division.

After the new refugees arrive, they are assigned a caseworker who usually speaks their language. The caseworker is responsible for enrolling each person in a Medicaid plan, and in coordination with the medical specialists, they choose a primary care provider (PCP) and schedule them for their health screening and vaccines. They try to have the children scheduled with a PCP within the first month of arrival and the adults, within three months. During the process of scheduling clients with a PCP, the medical specialists strive to teach clients how to schedule appointments independently in the future. If they have a health need sooner than their appointment time, the caseworker and medical specialist triage the health problem and help them decide where to seek care.

The health screenings are done by the Refugee Health Nurse from the City Health Department. The nurse travels to the agency to do tuberculin skin tests, collect stool specimens for parasites, and draw blood for hepatitis B, and lead levels (children only). For the positive tuberculin skin tests, the caseworker and the medical specialist schedule and transport them to a local facility for a chest x-ray. The Refugee Health Nurse administers tuberculosis prophylaxis medications and any other medications that the facility physician prescribes, at the agency and occasionally travels to the client's home to promote medication compliance.

The medical specialist schedules clients for the vaccine clinic held on the campus of the agency. If the client does not have any written documentation of receiving vaccines, then they are given the required vaccines as determined by the CDC Division of Global Migration and Quarantine and the Advisory Committee on Immunization Practices (ACIP). A local non-for-profit community health organization is contracted to manage the adult vaccines and a community outreach group from a large children's hospital in the area is contracted to administer the children's vaccines.

Each new group of refugees goes through "Enhanced Orientation" class which meets three days per week for three weeks within the first month of arrival. They provide a brief orientation to the U.S. health care system on one of these orientation days. The medical specialist and a group of medical students from a local medical school present general health care information and suggestions for managing common conditions encountered in the U.S.

These health care activities meet federal health screening and vaccination requirements, yet also expand to meet observed needs as the agency strives to promote

successful resettlement for their clients. However, there has not been significant formal attention to evaluating how these activities are perceived by clients and their understanding of the purposes of these activities. There is also a lack of knowledge as to whether the refugees feel they benefit from these activities and the extent to which they apply the principles of these activities to their lives. This project aimed to discover potential barriers to successfully accessing health care services in this Midwestern city as well as discovering perceived benefits of the program. What cultural factors might need to be considered in planning future program activities and how can the refugee resettlement agency and health care professionals meet refugee health needs in the most effective manner? By first listening to the refugees themselves in regards to their perceptions of health care activities they encounter upon arrival to the U.S. and their attitudes toward preventive health practices, agencies and health care organizations can make significant improvements to current programs.

Barriers to Health Care Services for Resettled Refugees

It is crucial to review the literature connected to the topic of resettled refugees in relation to health programs and preventive health care. The review reveals key studies examining barriers to accessing health care for refugees, refugee perceptions of western health care systems, such as the U.S., Canada and Australia, and reveals a lack of utilization of preventive health care services by refugees and examines some factors contributing to this observed trend. The review demonstrates a lack of information regarding refugees in the Midwest region and perceptions of specific refugee health programs.

Lack of access to health care.

The Agency for Healthcare Research and Quality (AHRQ) defines health care access as “the timely use of personal health services to achieve the best health outcomes” (AHRQ, 2005, p. 87). Despite the strengths of the U.S. health care system, there is a large percentage of individuals without timely access to health services. For example, in 2008, 16.8% of the U.S. population did not have health insurance and 10% of the U.S. population reported in 2007 that they were unable to access needed medical care, dental care or obtain prescription medications (Healthy People 2020, 2010). Health care access affects many U.S. residents and is gaining more attention as the problems increase.

A lack of access to health care services is one of the significant problems facing refugees today. Morris, et al. (2009) discovered through 40 interviews in San Diego, California, with health care practitioners, employees of refugee serving organizations and recent refugee arrivals, that the majority of refugees do not regularly access health services and that language and communication affected all stages of health care access, from calling to make an appointment to filling a prescription. Similarly in Australia, Sheikh-Mohammed et al. (2006) found factors inhibiting access to health care were language barriers, transportation deficits, unemployment, misconceptions about infectious diseases and poor access to health information. Structural barriers for refugees in urban U.S. included health care affordability, inadequate interpretation, insecurity related to shelter, food and employment (Asgary & Segar, 2011). Many of these factors affect many low-income families in the U.S., but some are more specific to refugees.

Refugees also have been found to avoid seeking health care services due to issues of mistrust mixed with a lack of cultural competency of health professionals (Asgary &

Segar, 2011; Carroll et al., 2007). Asylum seeking refugees reported major internal barriers to health care access to be mistrust of health professionals and institutions related their immigration status/documents. Mental illness, fatalism, and perceived discrimination also hindered their access to services. Literature also highlights poor cultural competency of health care providers as a barrier for refugees (Asgary & Segar, 2011; Carroll et al., 2007). For instance, Somali refugee women are hesitant to utilize western health care services in part related to their cultural and religious preference for same sex providers and interpreters (Carroll et al., 2007; Omeri, Lennings & Raymond, 2006). These studies bring not only financial and transportation issues to the forefront, which are issues affecting many low-income populations, but also reveal issues of trust between refugees and health care providers as actual barriers to accessing health care.

Another barrier to accessing health care for refugees is their cultural beliefs regarding health care (Morris et al., 2009; Omeri et al., 2006; Asgery & Segar, 2011; Lipson et al., 2003). Refugees acknowledged that their health care choices were influenced by their culture which in turn affected their concept of prevention services, independence, expectations of care and stigma around health care conditions. For instance, in some cultures there is particular stigma around mental health issues. One Afghan refugee stated, “We do not choose to use counseling services because this is foreign to us when dealing with our personal or family problems” (Omeri, et al., 2006, p. 35). Prior experiences, religion and cultural practices influence many aspects of one’s life including accessing health care.

Lack of understanding of western healthcare systems.

Several factors influence the way in which an individual accesses health care. Studies found that refugees usually wait to seek medical care until their condition is severe. They attribute this cultural practice to how they accessed care in their home country or in the refugee camp (Morris et al., 2009; Asgary & Segar, 2011). A group of Bosnian refugees in California contrasted their health care experience in pre-war Bosnia with that which they receive in the U.S. They were accustomed to the state-run health system with local clinics and physicians who visit them in their home. They developed a strong relationship with the provider and did not have to wait for appointments as they do in the U.S. (Lipson et al., 2003). A common theme Carroll et al. (2007) discovered through interviews with Somali refugee women was that they would not choose to go to a doctor unless they were sick. This cultural barrier highlights the adjustment from one health care system to another. Resettled refugees may find utilizing western health care systems that emphasize preventive care challenging. This characteristic also poses challenges to health professionals as they try to promote services that prevent disease before it starts or worsens.

The adjustment period can pose challenges to refugees and can elicit emotional strain, which can in turn affect their ability to access health care. Refugees in a Canadian study expressed disappointment with the health care system of Canada because prior to arrival, they had expectations that all their needs would be taken care of if they could only enter a country like Canada (Anderson et al., 2010). Once resettled, they found that they had to redefine their expectations in order to avoid becoming discouraged and hopeless. A qualitative study in Australia revealed refugees experience feelings of

shame, sadness, guilt, anger, fear, grief and loss (Omeri et al., 2006). They also experienced hopelessness and frustration related to isolation from family and friends, no sense of belonging, loss of identity, financial difficulties, discrimination, culturally different health care services, a lack of health information in their language and a lack of familiarity with the health care system (Omeri et al., 2006). Past health care experiences in their home country and refugee camps strongly impacts perceptions of health care services within their new community.

Lack of acceptance of preventive health care.

Research highlights the contrasting utilization rates of preventive health care services between refugees and the general U.S. population. Lipson et al. (2003) found that that the Bosnian refugee population engaged in more health risk behaviors, such as eating a lot of meat, smoking and low reports of recreational exercise. Both the Bosnian and the Former Soviet Union (FSU) refugee populations in California accessed preventive care at very low rates. Only six percent of Bosnian women had had a gynecological exam in the past several years and only eight percent of FSU women. Most of the women had not had a mammography and did not practice self-breast exams (Lipson et al., 2003).

Similarly, Jenkins, McPhee, Bird and Bonilla (1990) interviewed 215 Vietnamese refugees in the San Francisco area and found that there was a lack of knowledge regarding cancer and associated behavior, such as smoking. Even though hepatitis B was endemic among Vietnamese, 48 percent had never heard of hepatitis B. They also found low rates of women accessing preventive health care services. Thirty-two percent had never had a Papanicolaou test, 83 percent had never had a mammogram and 28 percent

had never had a breast exam (Jenkins et al., 1990). Somali refugee women also expressed little understanding of cancer screening rationale even though they were familiar with the process and rationale for immunizations and routine medical exams for their children (Carroll et al., 2007). In comparison, these groups of refugees utilized preventive health services at much lower rates than the general U.S. population. According to the Partnership for Prevention 2007 report, 80.3 percent of U.S. women age 18 and older reported being screened for cervical cancer within the previous three years and 67 percent of U.S. women aged 40 and older reported breast cancer screening within the previous two years. With these statistics in mind, one must consider what factors contribute to the disparities in preventive health care utilization between refugees and the general U.S. population.

Some studies point to the factor of living through stressful experiences over a long period of time leading to a stronger focus on the immediate, day-to-day needs and not looking toward long-term health (Anderson et al., 2010; Carroll et al., 2007). Despite these tendencies among refugees, Carroll et al. (2007) found that Somali refugee women consider keeping themselves and their children healthy a vital part of their lives. The participants described key elements of promoting health for themselves and their family to be good sanitation, adequate nutrition and exercise, traditional remedies and rituals, the role of religion and access to health care and medications. So despite some knowledge and familiarity regarding preventive health care services, refugees still access preventive health care at low rates. There is still a lack of information regarding their perception of specific health programs and screenings. There is also a lack of information whether the

current refugee groups in the Midwest are aware of preventive health care services and what their attitudes, views and beliefs are regarding preventive health care.

The literature includes reports of health programs and descriptions of the process of program development, but there is a lack of evaluation and outcome measurement studies to reveal program impact (Palinkas et al., 2003). Researchers in Australia (Hancock, Cooper & Bahn, 2009) have recently produced a formal refugee health program evaluation study, but there is still a gap in knowledge as to the impact of many refugee health programs across the U.S. Further, the literature lacks qualitative data regarding resettled refugees' perceptions of health programs. This scholarly project aimed to contribute new information to the body of knowledge on this topic as well as initiate a foundation for future outcome-based studies for program evaluations.

Theoretical Framework

This study used the Neuman Systems Model to help conceptualize the project purpose and data with an emphasis on Neuman's holistic approach to primary, secondary and tertiary prevention (Neuman & Fawcett, 2011, p. 13). The Neuman Systems Model has been widely used in research concerning how lines of defense/resistance such as prevention interventions and health activities coordinated by government funded agencies may help protect the individuals from health threats including infectious and preventable diseases. The aim of this study was to gain a better understanding of the feasibility of the health activities already in place and coordinated by the large Midwest refugee resettlement agency, yet also generate knowledge as to ways of improving health and wellness of the refugee population through a phenomenological approach (Patton, 2002, p. 104).

The Neuman Systems Model puts the client(s) in the center of a series of rings, which represent barriers to stressors or “lines of defense” (Neuman & Fawcett, 2011, p. 25). The various prevention interventions can help to strengthen the flexible line of defense as to enable the client(s) to react to the stressors in a positive, productive way leading to stable health. For this project, the refugee community is viewed as the “client” and the refugee resettlement agency health activities and preventive health care services are the interventions aimed at strengthening the flexible line of defense against the numerous stressors directly and indirectly affecting this population (Neuman & Fawcett, 2011, p. 25). The literature has identified several barriers to optimum health for resettled refugees and therefore, this project aimed to gather data that can guide future preventive health efforts that will empower this population to avoid stressors or reduce negative effects of stressors.

Project and Study Design

This qualitative study aimed to gather rich narrative data on impressions, perceptions and satisfactions of resettled refugees with health care and health screenings administered and/or managed by a large refugee resettlement agency in a Midwest city. The investigator also explored their attitudes and beliefs about preventive health care and their perceived needs regarding health education and promotion.

Data collection was done through four focus groups by the principal investigator (PI). Focus groups are advantageous in eliciting overall perceptions and feelings toward a service or program in a nonthreatening, permissive environment (Krueger & Casey, 2000). Another benefit of having focus groups as a data collection method is the opportunity to observe a large amount of interaction among participants as they discuss a

topic (Morgan, 1997). With the group members interacting and building upon each other's statements, the researcher gained the perspectives and attitudes of a group of people versus an individual's single experience and attitude toward health services. By having four different focus groups, the investigator was able to compare and contrast the groups' perceptions and see the range of views on the topic.

Setting and Resources

The setting for the focus group interviews was a conference room with a circular table and chairs at the refugee resettlement agency. The setting was chosen because the agency is a place where participants feel comfortable and have familiarity, while the conference room ensured a quiet and private atmosphere (Krueger & Casey, 2000). The newly arrived refugees spend considerable time at the agency. They go through three weeks of classes upon arrival held at the agency and return for guidance and resources on a regular basis throughout their first several months in the U.S.

In addition, this setting provided many necessary resources to facilitate the implementation of the project. The Director of Client Services at the refugee resettlement agency volunteered her time to communicate with four of the agency caseworkers asking them to each invite at least ten of their clients to the focus group sessions. The Director of Client Services also reserved the conference room space at the agency and designated dates and times of the four focus group sessions that were most convenient for everyone involved.

Staff Recruitment and Training

In preparation for data collection, four caseworkers at the refugee resettlement agency were chosen as recruiters to identify and refer potentially eligible individuals to

participate in the project using the Recruitment Guide developed by the PI (see Appendix A). The four caseworkers were chosen because they worked at the agency, developed good relationships with refugees since their arrival to the U.S., and spoke their primary language.

In addition, four interpreters were recruited and hired by the PI from a professional language service provider. The interpreters undergo professional training and those asked to interpret for the study had medical interpreting training which allowed for accurate communication of health care terminology and standards. The PI trained the interpreters prior to each focus group session on the process of the focus groups, reviewed the purpose of the study and read through the forms together, including the Informed Consent form, the Demographic Information form and the Discussion Guide form. A research assistant was recruited as the focus group assistant moderator because he had recent experience working with refugees in Eastern Africa. The research assistant read through the study proposal and met with the PI prior to the first focus group session to plan for technical details and operations of the focus group sessions.

Sampling

Inclusion criteria for this project were 18 years-old and older and resettled refugees by the agency within the past five years. A total of 39 out of 40 eligible individuals who were recruited participated in four focus groups (Krueger & Casey, 2000; Morgan, 1997). Focus group experts recommend that focus group size is between six and eight participants per group. This size allows for a diverse set of perceptions and experiences, but also small enough that each group member has a chance to speak on all the issues (Krueger & Casey; Morgan). For this study, ten participants were originally

recruited for each of the four focus groups with the notion that all ten may not actually attend.

The four target groups were persons originally from Iraq, Eritrea, Bhutan and Somalia. These groups were chosen because of the higher numbers of refugees in these groups who are currently arriving to this particular city. These groups also are more likely to all speak the same primary language compared to some of the other groups arriving to this city. This decision helped with the logistics of the focus group discussion members able to understand each other.

Data Collection and Procedures

After obtaining approval from the Institutional Review Board (IRB) of the University, the refugee resettlement agency was given a copy of the IRB Approval Letter. Thereafter, the agency's verbal permission for the study was granted. The focus groups were scheduled on four separate days over the span of two weeks.

Each focus group session followed the same procedure. Bottled water and writing utensils were provided at each seat at the table. Index cards with numbers one through ten were placed at each seat at the table so that each participant was referred to by a number rather than their name. The research assistant checked the audio-recording equipment (two microphones, a Mac laptop with the Garage Band application, an I-phone with a Voice Memo application) to ensure proper functioning.

After the participants arrived, the PI and the research assistant started each focus group session with self-introduction and describing the purpose of the study. The PI stressed that their participation was voluntary and they could choose to leave at any time. The Informed Consent form was read by the PI and verbally translated into the

participants' primary language by the interpreter. After explaining the usual course of focus groups, the need for audio-recording and the steps that would be taken to protect personal and identifying information, the PI asked that those who would like to participate sign the Informed Consent form (see Appendix D) and those who do not wish to participate be excused. At this time, the research assistant made copies of the signed Informed Consent forms to give to each participant for their record.

During the discussion sessions, the research assistant managed the audio-recording equipment (two microphones were recording simultaneously in case one malfunctioned--they included a Mac laptop with the Garage Band application and an I-phone with a Voice Memo application). The focus groups followed the Discussion Guide (see Appendix C). The PI began the discussion by asking each participant to share something they are proud of. The purpose of this activity was to engage all members of the group and to "break the ice" so that each participant realized that their input was valued (Morgan, 1997; Rivera-Goba et al., 2011). At this time, the PI began with the general question of, "how do you describe your experience with the health care of the U.S.?" The PI asked follow-up questions and probes to elicit more detail, to clarify, and to enrich the discussion. The discussion questions were arranged to address the four objectives of the study. They included their experience with the health care of the U.S., their perception of screening activities administered at the refugee resettlement agency, their attitude toward preventive health care and health topics of interest.

To obtain information for program improvement with an emphasis on Neuman's System Model of prevention efforts to strengthen "lines of defense," the investigator

asked for suggestions for changes to the health activities offered by the agency and what type of health programs, resources and health education topics would be helpful for them.

Each focus group concluded with asking each participant to share what topic of discussion stood out to them as the most prominent topic or most important topic that was discussed. This question helped the investigator in determining which parts of the discussion were most important in their eyes so their input could assist in categorization of data analysis (Morgan, 1997, p. 62). Aside from the discussion content, the PI and research assistant observed body language and facial expressions as the participants interacted and shared perceptions. Each focus group was scheduled to last approximately two hours. The PI provided a \$10 gift card for each participant to compensate for their time devoted to the project. The PI and the research assistant each wrote their own reflections of the discussions soon after completing each discussion session.

Data Analysis

The PI transcribed the data verbatim from the audio-recordings. Three other readers reviewed the transcripts including the chairperson of the project, the research assistant and a committee member with expert experience in qualitative research. The PI and the expert committee member individually read through the transcripts and reflections several times to identify broad categories and themes through exploring key phrases and quotes. To promote validity of the results, the PI and the expert committee member read through the transcripts aloud together, which aided in further discussion and analysis of the identified themes (Patton, 2002, p. 463).

The holistic approach of the Neuman Systems Model helped the PI to examine the data from all angles that contributed to their experiences and perspectives including the

physiological, psychological, socio-cultural, spiritual, and developmental aspects of their lived experiences regarding health care (Neuman & Fawcett, 2011, p. 237). However, the genuine perspectives and viewpoints of the participants were upheld as predominant in the analysis. The themes were verified by referring back to the raw data to be sure of the accuracy of the theme by the PI and the chairperson.

Results

Demographics of Participants

There were 39 participants involved in the focus group discussions. Each group was comprised of ten participants except the Eritrean group had nine participants. The PI noted data saturation by the fourth group and decided more groups were not necessary for this pilot study. Table 1 presents the profile of the sample's demographic characteristics.

Each focus group was distinct in its composition. The Iraq group consisted of persons who had been in the U.S. for a longer period of time (1.5 years average); whereas the Somali group all recently arrived in the U.S. (1.8 months average). The participants in the Iraq group were all high school graduates and beyond; whereas a majority of the participants from Bhutan reported no education (60%) and only one of the participants had a high school education. The groups from Somalia and Eritrea were on average younger (27.4, 28.4 years respectively) and the participants in the group from Bhutan were older in age (average 47.3 years). The male gender was dominant in all groups except the Somali group only had two male participants. Most of the participants were unemployed. No one was employed within the Somali group; which can be explained by the fact that most of the participants had arrived within the past few months to the U.S. Few of the participants reported being literate in English, but the Iraq group had the

highest number of participants literate in English (n=5). The most common religion identified among the participants was Islam. The characteristics of the participants helped to shed light on potential factors influencing their responses and perspectives.

Table 1. Demographic information of participants (n=39).

		G 1: Iraqi (10)	G 2: Eritrean (9)	G 3: Bhutanese (10)	G 4: Somalian (10)
Continuous Variables		<i>Mean/Range</i>	<i>Mean/Range</i>	<i>Mean/Range</i>	<i>Mean/Range</i>
Age (years)		37.8 (25-54)	28.4 (21-44)	47.3 (26-66)	27.4 (19-50)
Time in U.S. (months)		18 (1-33)	8.2 (0.75-22)	4 (2-10)	1.8 (1-6)
Number of children		1.7 (0-4)	0.9 (0-4)	3.6 (1-8)	1.1 (0-8)
Categorical Variables		<i>Percentage</i>	<i>Percentage</i>	<i>Percentage</i>	<i>Percentage</i>
Gender	Male	70%	88.9%	60%	20%
	Female	30%	11.1%	40%	80%
Marital Status	Married	70%	55.6%	100%	10%
	Single or Other	30%	44.4%		90%
Place of Birth	Major	80% (Iraq)	77.8% (Eritrea)	100% (Bhutan)	100% (Somalia)
	Other	10% (Kuwait); 10% (Sudan)	22.2% (Ethiopia)		
Education Level	None			60%	20%
	< High School		55.6% (7-11th grade)	30% (4-6th grade)	10% (4th grade); 30% (9-11th grade)
	High School	60%	44.4%	10%	40%
	> High school	40%			
Employment Status	Yes	10%	11.1%	20%	0%
Literacy	English	50%	33.3%	10%	10%
	Arabic	100%	22.2%		50%
	Other		100% (Tigrinya); 55.6% (Amharic)	40% (None); 60% (Nepali); 10% (Hindi)	90% (Somali)
Religion	Christianity	10%	55.6% (Orthodox Christian); 11.1% (Catholic)	10%	

Country of Residence prior to U.S. Resettlement	Islam	90%	33.3%		100%
	Other			60% (Hindu) 30% (Buddhist)	
	Ethiopia		55.6%		10%
	Kenya				40%
	Nepal			100%	
	Syria	40%			
	Yemen				50%
	Other	20% (Jordan); 20% (Turkey); 10% (Iraq); 10% (Kuwait)	11.1% (Djibouti); 11.1% (Israel); 11.1% (Egypt) 11.1% (Romania)		

Focus Group Discussion Results

Table 2 lists the major study findings and the corresponding themes and sub-themes. The findings are presented using four category headings to reflect the main focus for each of the four project objectives. The four category headings are: Impression of U.S. Health Care, Perceptions of Health Screening Services, Perceptions of Health Screening Services, and Perceived Needs for Health Education and Resources.

Table 2: Four major categories with corresponding themes and sub-themes.

Impression of U.S. Health Care	
Theme 1 Sub-themes	The Challenge of Adjusting to the U.S. Health Care System *”Waiting and Calling” *”The Emergency Delay”
Theme 2	Navigating the Insurance System and Brief Medicaid
Theme 3	Lack of Clear Communication

Impression of U.S. Health Care	
Theme 4 Sub-themes	Overall Attitude Toward U.S. Health Care Varied Among Groups *”They see you as a financial element” *”If there is no money, you will die” *”They treated me like family”
Perceptions of Health Screening Services	
Theme 1	Familiarity with Health Screenings
Theme 2	“They Do Not Tell You the Results.”
Theme 3	The Importance of Vaccine Information
Theme 4	Tuberculosis Test Confusion
Perceptions of Preventive Health Care	
Theme 1	Activities to Prevent Illness Focus on Cleanliness
Theme 2	Wellness Exams and Procedures are Great, but Not Worth the Cost
Theme 3	Lack of Understanding of Cancer Screenings and the Cost Barrier
Perceived Needs for Health Education & Resources	
Resources	*Health Education Lectures with Supplemental Health Literature in their Primary Language *Community Health Resources
Health Topics of Interest	Hypertension, Diabetes, Chronic Headaches, Kidney Disease, Infectious Diseases, Heart Disease, Autoimmune Diseases, Asthma, & Cancer

Category I. Impression of U.S. Healthcare

Category I reflects the main focus of Objective 1: To understand impressions, perceptions and satisfactions of resettled refugees in a Midwest city regarding their experiences with U.S. health care in general. This category emerged and sustained itself based on discussions of the first question: “How do you describe you experience with the

health care of the U.S.?” This question generated a large amount of responses with several participants sharing personal struggles and stories of their experiences with health care since they arrived in the U.S. The participants particularly from Iraq displayed strong emotions related to their experiences with health care. This category was represented by the following themes.

Theme 1. The challenge of adjusting to the U.S. health care system.

Theme 1a. “*Waiting and calling.*” The first response from the first focus group (Iraqi group) came to be a resounding theme among all groups--

I think it is waiting and calling. Call next week...sometimes late. Everything is a waiting list and they ask you to come back again and the interpreting is not there. Some place I have problem. I have a fracture in my left foot. Yesterday I missed my appointment because this place--the doctor's office--they cannot provide an interpreter and I cannot pay for an interpreter.

The participants explained that it is difficult to adjust to the system of calling the health center to make an appointment and then having to wait several weeks or even months to see the health care provider.

For all the focus groups, they were accustomed to health care on a walk-in basis which made it difficult to adjust to the system of making and waiting for appointments. One participant from Somalia said,

The first thing that I have had experience with the health care in the U.S. is that when I wake up in the morning, I feel a lot of pain, but to go to the doctor, I have to wait two months for the appointment, so I was wondering about this issue. In Africa, if I have a pain, I go immediately to the doctor or clinic. But when we

come here, we have to set up an appointment. It is difficult. I was wondering about this.

It is difficult to understand this type of system and all groups reported struggling with having to call and make appointments and then having to wait to have their health problems addressed. The participants from Iraq, whom on average had been in the U.S. the longest, shared the most stories illustrating this theme.

My son had a nasal surgery and was supposed to follow-up in September, but every time I called to make an appointment, the receptionist or nurse would ask if he was still taking the medication and they told me he needs to finish the medication and then call back. So he finished the medication then I called back. Then they said, 'go get another medication and finish that one before an appointment.' It has been taking all this time just to make an appointment and they keep saying the same thing. I have been trying to make an appointment [for the past 6 months] and I could never get past the receptionist. They do not pass me to the doctor.

The participant was clearly upset that her son's health problem was not being adequately addressed and one of the primary factors was the difficulty with making appointments and actually getting time with the doctor. Even the group from Eritrea who presented a much brighter impression of the health care of the U.S., validated this theme.

I have a question that I didn't understand before. When we come to the United States, we have Medicaid for eight months. So, when you want to see a doctor, they give you an appointment after two to three months. When you finally get to

that appointment, they give you another appointment. Then the eight months are gone without even using the card. Why are they doing that?

Aside from waiting for appointments, participants also struggled with waiting for emergency care.

Theme 1b. “*The emergency delay.*” One participant from Somalia stated, “I came from Yemen, but before that it was Africa. And the difficult thing about the health care here is that I went to the emergency room one time. I arrived at 5:00 pm and I met the doctor at 1:00 am. I was waiting seven hours for the doctor.” The Iraqi group also shared similar experiences.

In general it’s clean and sanitized--everything is perfect. But when you got to the emergency and you really need to get treatment immediately, they make you wait and wait and wait. It’s not like you can wait for it. There is one time I went there and I had to take my kids. I had to stay there until 4:00am just to get the treatment. As a suggestion, if you could make it bigger or more facility or more people to help you. That is one of the main problems that I faced--the emergency delay.

Despite frustration with having to wait for emergency care, the participants demonstrated their reliance on the ER. When presented with the question “where do you go or who do you call if you are facing a health problem?” they said they would call 911 or have someone drive them to the emergency room. When the question was rephrased, “where do you go if the problem is less urgent?” their responses revealed a note of uncertainty and confusion regarding how to access and finance routine health care.

Theme 2. Navigating the insurance system and the brief Medicaid. Most participants were aware that they were provided with Medicaid for eight months beginning the day they arrived in the U.S. However, many participants were completely unaware of what to do once the Medicaid expired. One participant from Eritrea asked,

If you have an insurance, that is fine and easy for everyone. But if you do not have insurance, then that is the problem--then what do you do? If you have a serious health condition, you can call 911--with or without insurance. But if you do not have insurance and your situation is not serious, what do you do?

Many of the participants were hungry for information on health resources which was demonstrated by the fact that the discussion turned into more of an educational session at times rather than data collection. The PI and sometimes the interpreters told the participants about how private insurance provided by employers still carries significant out-of-pocket cost. The groups also discussed the federally-qualified health center option for the uninsured and various financial discounts provided by some health institutions for those without insurance. The participants who had arrived more recently were more likely to struggle with navigating the system. One participant pointed out the importance of networking in the community or lack thereof. His statement highlights the need for an advocate who can assist with navigating the health care system.

First, I am single and living alone, so sometimes you get sick. Especially the new arrivals--the other people are in the mainstream of the United States so they can go everywhere, but we are not like those people who have stayed here seven or eight years. We are new arrivals; I am single and living alone in an apartment. So when I get sick it is difficult to know where to go. Now even I am not feeling

well, so I have an appointment on the 23rd of this month, so up to that date, I am getting worse and worse. I am not like the other people who have stayed here seven or eight years. I have no relatives here. Some do not have friends to contact. That issue is difficult for me as a refugee.

The participants certainly demonstrated a desire for health resource guidance and highlighted the importance of sharing information within the refugee community.

The topic of Medicaid surfaced frequently throughout the discussions. Some of the feelings about Medicaid included disappointment with the brief period of coverage, the restrictions on medication and provider coverage, and some groups expressed receiving less quality care due to having Medicaid. A participant from Iraq stated,

If you have a Medicaid, then you are on the end of the list. They make you wait, wait, wait. And really wasting your time. They give us doctors who are under-qualified because we are Medicaid recipients. They never treat you and figure out what is wrong with you. They just give you medication to just keep you quiet and waste your time and do not figure out the problem.

Another participant explained restrictions of Medicaid coverage,

If I have a prescription for a medication, for example ibuprofen for 200 tablets, they give me 100 and say 'oh we don't have all 200.' That is just ibuprofen-- forget about the real expensive medicine. I went back to the doctor and explained that they only gave me 100 or less and he said to go back to the pharmacy and I get thrown back and forth.

A participant from Somalia shared a similar situation.

The other thing that is difficult with the health issue is the Medicaid. So when we go to the pharmacy, they say that Medicaid does not cover this medicine, so we have to go back to the doctor. At that time, my mom is suffering. She wants to get the high blood pressure medicine at that time, but she has to wait.

The participants acknowledged the value of Medicaid, but point out its limitations.

Theme 3. Lack of clear communication. The lack of clear communication between participants and health care personnel was associated with feelings of frustration, missed appointments, and untreated health problems. They reported dissatisfaction with or lack of available interpreting services and highlighted the need to learn English so that they could “express themselves freely to the doctor.” The fact that the participants were so eager to share their health problems with the PI through the hired interpreter, spoke to how much they wanted medical help while an interpreter was available. As soon as the PI met the group from Bhutan, a participant showed her the rash on his hands and asked what to do. Several others wanted advice and guidance for their specific health problems.

The group from Bhutan in particular stressed that not knowing English was by far the most prominent barrier to quality health care which affected all steps of accessing care.

I have a problem--I cannot speak English--and I had an appointment on April 18th and someone was coming to pick me up from my house for the appointment, but when he called I could not reply because I do not know English, so I missed the appointment. There is no one in my family who speaks English, so I want to make an appointment, but have not been able to.

This participant missed her appointment because she could not speak to the transportation driver who was to take her to the appointment.

An Iraqi participant recounted how he missed his appointment because the doctor's office asked that he pay for an interpreter, but he was unable to pay. Some participants felt that the interpreting service over the phone was unsatisfactory.

I went to the emergency for high blood pressure and high sugar. I stayed there for eight hours before they called my name. Then you go to the room and all the nurses and doctors are there and they want me to talk to the interpreter over the phone. I cannot lift my arm and they want me to hold the phone and talk to the interpreter. They cannot afford an interpreter. That is one of the worst hospitals to try to get treatment.

The issue of interpretation can be a vital part of providing successful treatment.

The group from Bhutan brought up another aspect of the language barrier that they see as a hindrance to adequate health care.

We feel that the doctor treated us well. They talk to us. But we do not understand each other properly. We would like to ask something else, but having an interpreter does not allow us to express ourselves. If we know the language, it would be better because we can express ourselves to the doctor. We are sad because of this problem.

With this group there was another layer of the language barrier that went beyond just translation--it went to the fact of having another person in between the patient and the provider.

Theme 4. Overall attitude toward U.S. health care varied among groups.

Theme 4a. “*They see you as a financial element.*” The stark contrast among the focus groups in terms of their attitude toward U.S. health care seemed to be related to how they experienced health care in their previous places of residence. The first group, the Iraqi group, expressed several concerns and frustrations with the health care of the U.S. One of the prominent themes from this group was feeling like the cost of American health care was too high compared to their homeland, and yet the quality of care was no better.

Where we came from, all the services are operated by the government so everything is free. The ambulance and firefighters and hospital and emergency are owned by the government so it is a free service. When we came here, everything has to be paid. If it is \$100 it is reasonable--we can pay, but \$500 or \$600 is just something we cannot pay.

The cost issues made them feel like no one cared. “They see you as a financial element and not as a human being like they really want to treat you and make sure you are fine.”

When the PI asked how their experience of waiting in the emergency room is different than what they experienced previously, an Iraqi participant said,

One time back home when I was really sick, I had to go to the emergency. In our emergency, it is really an emergency--all the doctors are going to come see you and make sure you are fine. Not like here. I was shocked when I went to emergency here.

Another participant then added, “I see on the TV like American shows where the doctors all come to you and treat you, but that is not real. You sit there and wait and sleep and

maybe God is going to help you.” The Iraqi group’s attitude toward U.S. health care revealed feelings of disappointment, frustration and mistrust. They felt the high cost of health care and modern technology did not equal better care. They felt like the focus on payment for services overshadowed any compassion for them from health care personnel.

The group from Somalia validated many of the feelings of the Iraqi group, such as being frustrated that the treatments they had been prescribed so far were not helping their problems and they were disappointed with the limitations of Medicaid. They struggled with adjusting to the system of making appointments rather than health care on a walk-in basis as they were accustomed.

Theme 4b. “*If there is no money, you die.*” However, the group from Bhutan told a contrasting story of the care in their previous country. They said that if a person is unable to pay, they could not receive treatment.

First they will make a list of the check-ups or treatments that the person needs to undergo--they will make a bill--and show it to the person, and then the person has to pay. If there is no money, you will die.

The Bhutanese group viewed the U.S. health care system as advanced and far better than what they had experienced previously.

I believe that the treatment given here is systematic and advanced. They don’t give medicine without the proper diagnosis, so I feel safe to take the medicine. In our country, you used to get the same medicine for all diagnoses. For headache, stomachache, or any kind of pain, you would get the same tablet from the hospitals. But here you get a specific medicine for a specific problem. The system of treatment is far better here.

Theme 4c. “*They treated me like family.*” The group from Eritrea had a very positive outlook on the health care of the U.S.

I was in Egypt as a refugee. My wife was sick and I went to the hospital and it took time--the process was long to see the doctor. When I compare America to Egypt, it is different. America is a good country. The treatment is good. You have access to see the doctor. I am glad to be here.

Another participant shared,

When I lived in another country, I was in a wheelchair, but when I came to the U.S., I was treated well and now I do not need a wheelchair. They are good people who treat me--they treat me like family. The health care really helps for refugees. Especially the card [Medicaid], it helps me financially. I am very happy to come here. I am not telling you this to make you happy--I am telling facts.

Several others in the group reiterated that when they go to the hospital or health center, they experience good customer service and they feel as though they are treated like family.

The perceptions of U.S. health care for refugees varied among the focus groups. Most of their impression was linked to how they contrasted U.S. health care with that of the places in which they lived before.

Category II. Perceptions of Health Screening Services at the Refugee Resettlement Agency

Category 2 reflects Objective 2: To examine feasibility of health services provided by the refugee resettlement agency and collaborative agencies from the clients’

perspectives. This category “Perceptions of Health Screening Services at the Refugee Resettlement Agency” was represented by the following themes

Theme 1. Familiarity with health screenings. Most participants expressed understanding and acceptance of health screenings and were pleased that most of the tests were done at the refugee resettlement agency. An Iraqi participant noted “Here in the [refugee resettlement agency], it is way better than going to the emergency room or the hospital.” Most were familiar with the process of screening for infectious diseases. An Eritrean participant said, “What I have experienced before, this is the same thing here at [the refugee resettlement agency]. Whenever you enter some country it is good to check whether you are sick.” A Somali participant commented, “Yes, it was easy to understand. I feel it is good to know yourself so that you can prevent the virus from spreading to others.” There was some confusion as to what exactly the screenings tested for, but overall, everyone was familiar with this process and thought it was important to know that they were healthy.

Theme 2. “They do not tell you the results.” All groups expressed strong desire to be given a copy of their screening test results, including the blood work and stool specimen results. They point out that other doctors they go to are not aware of the tests that were done and what the results were. They also want to have a record for themselves. “Everyone would love to know what is wrong with them and what the result shows, whether it is a blood test or x-ray or stool specimen. We would all love to have it, but nobody gives.” The group from Bhutan agrees, “We would like the results in written format so when we visit the doctor we will know our health record. We can ask our children to read it at home for us.” All groups concluded that they would appreciate

written screening test results for their own record, as well as for future health care providers.

Theme 3. The importance of vaccine information. Most understood the importance of vaccines, but some were concerned about possible side effects of repeated vaccinations.

When we were in the refugee camp in Yemen, we took a lot of shots for the kids. But when we come here, they said you have to take another shot here. They said if you don't have a shot record, you have to have the shots again, so we do not have the shot record. The shots that you are giving us now, is there side effect or problem with getting the shots again?

There were mixed opinions of whether they were told what the vaccines are for. One participant from Eritrea expressed his appreciation of receiving the CDC Vaccine Information Sheet in his own language. "I even got a little Amharic language paper from you. I am happy if it is possible to have for everyone--either Amharic or Tigrinya. The letter is not only for why you are getting the shot--it is telling the whole history." Others said they were only motivated to get the vaccines because they knew it was required for their green card application process.

Theme 4. Tuberculosis (TB) test confusion. Most groups were confused by the tuberculin skin test (TST) that they received at the refugee resettlement agency. Many reported a "positive result" but then a negative chest x-ray and no symptoms, but were instructed to take TB medication. It was concerning to them to be taking medication when they were not sick. They did not feel like they understood the rationale for taking

medication for a sub-clinical infection (latent tuberculosis) and expressed concern about medication side effects.

I am confused with the TB test. The first time, they give you the test here at the [refugee resettlement agency], then it is swollen, so they send you to x-ray. The first time, they say you are positive. Then after that, the x-ray, they say ‘negative.’ So I am confused. They say you have TB so you have to use medicine for 9 months. The first test is positive and the second test is negative, but then they give you medicine.

The PI spent some time discussing this issue and explaining the difference between latent and active TB. They felt like some of their uncertainty was cleared through the discussion.

Category 3. Perceptions of Preventive Health Care

Category 3 reflects the main focus of Objective 3: To explore perceptions and attitudes toward accessing and utilizing preventive health care services, and was presented by the following themes.

Theme 1. Activities to prevent illness with a focus on cleanliness. Cleanliness and eating fresh food were seen as key to preventing illness. One participant from Eritrea said, “Cleaning is the best thing. Prevention is better than cure.” The group from Bhutan had similar ideas of health prevention. “Take care to keep the house clean. Sanitize.” Another said, “We take care of our children. We do not let them play in the dirty places. We make sure they wash their hands before food or after playing.” One group saw disease prevention as connected with their religious convictions--”we don’t smoke, we

don't drink and we eat healthy food." Another person said, "to have faith" promoted health.

Some expressed the importance of exercise and acknowledged that their lifestyle in America lacks exercise as compared to their life in Africa, which caused them concern for their health. "In Africa we eat almost everything because we are walking everywhere--running and have exercise, but not here." They realize the difference in behavior affects their health and identified the need for exercise and nutritious food.

Theme 2. Wellness exams and procedures are great, but not worth the cost.

The cost of visiting the health center was a strong deterrent for wellness exams. When the PI asked the group from Bhutan whether they would go to the doctor to be checked even if they were not sick, everyone laughed. "We feel it is silly to go to the doctor without being sick. It is a waste of money." However, they noted that if it were free to get a check-up, they would definitely like to be checked. "We will know the condition of our body. We will know about our health problems so it is good to get such check-ups." One Eritrean participant said he would go to the check-ups even if he had to pay.

Even if I have to pay, I go to check for myself because in Ethiopia or Eritrea, we do exercise--our eating is good and our bodies are fine and we take care of ourselves. But here, the food is not really good, so I have to go and get check-up even if I pay for it.

He acknowledges the dangers of a sedentary lifestyle in combination with nutritionally deprived food and how that motivates him to attend wellness check-ups.

Despite the majority of participants perceiving well checks as a positive and important activity, one Somali participant felt differently.

I am not satisfied for that. If you are not sick, you do this routine for check-up, but I am not satisfied for that. I trust in God only. Only if I am sick I go to the doctor. Sometimes, they say that if the kid does not have a physical, they will not accept them in the school. If they are not sick, why are they doing that one?

Theme 3. Lack of understanding of cancer screenings and the cost barrier.

Most lacked understanding and details of cancer screening procedures. Only a few mentioned undergoing procedures, such as mammograms. One Iraqi participant reported undergoing a mammogram and that was when the refugee resettlement agency coordinated with a local hospital to conduct the mammograms. Others concluded that they would be happy to undergo these procedures, but the issue is funding and knowing how to access the resources. “The difficult part is knowing the resources. Where do I go to get a mammogram? Or coverage of insurance? Or if I need other tests? We need to get the resources for these tests.” Another participant shared,

If you have insurance card, you can do whatever they are asking of you--cancer or mammograms--you can do it, but if you do not have any insurance, it is difficult to pay for it. Even if I am sick I don't even want to go to get check-up. Only if it is serious, then I will go. But otherwise, I do not go to check-up.

The view of preventive care among these groups is that it is a luxury. They would appreciate the services, but the services are not worth the cost, so they cite very little utilization of preventive health services. They realize the importance of taking care of

themselves and their families and even use their fear of having to make doctor's appointments as motivation for trying to stay well.

I have a phobia of going to the doctor--with making appointments or with going to the emergency. I make sure my kids are fine and my husband says please make sure I am okay so I don't have to go to the doctor.

Category IV. Perceived Needs of Health Education and Resources

Category IV reflects the main focus of Objective 4: To better understand health education and resource needs and preferences of resettled refugees to contribute toward program improvement efforts. Regarding resources, all groups were very grateful for the discussion and the topic of health care elicited strong, emotional responses--especially from those who were older and had been in the U.S. longer.

As far health topics of interest, everyone expressed interest in obtaining more information about the health care system and health care resources. For example, one participant from Bhutan said, "I have an eye problem. I started the language classes, but I have a problem with my eyes. I would like to see the doctor for my eye problem." The importance of learning English cannot be overstated. This person was attending English classes, but learning was even more difficult with vision impairment. The Bhutanese and Eritrean focus groups spent considerable time addressing health resource needs and offering guidance on where to go for specific health problems. The need for health resources was clearly evident by the direction of the focus group sessions.

The need for primary care providers was also evident. One of the Iraqi participants confronted the PI individually after the conclusion of the discussion session

and asked where the PI practiced and whether she could bring her whole family to see the PI as their primary care provider.

The participants wanted to learn ways to manage diseases and prevent them-- especially diabetes and high blood pressure. Chronic headaches was a condition common to all groups. Other health topics they wanted to learn more about were kidney disease, heart disease, infectious diseases, asthma, cancer and autoimmune diseases. They would like to have health educational lectures held at the refugee resettlement agency with supplemental written information in their primary language.

Discussion

The aim of this project was to better understand the perceptions of recently resettled refugees in a Midwestern city regarding their views and attitudes toward health care in the U.S., including their experience with routine health screenings and their feelings about preventive health care. The data gathered through the four focus groups provides a glimpse into how they see health care; thereby including the program recipients in problem solving and program improvement efforts. The high response rate and eagerness with which the participants shared their perspectives speaks to the importance of the subject of health care within the refugee community. This study finding is similar to the 2006 San Diego Refugee Forum survey which revealed that 56% of its members ranked health or health care as the most important issue facing newly arrived refugees to the U.S. (Morris et al., 2009). Each focus group began with discussing their overall impression of the health care of the U.S. The groups shared similar perspectives, such as the difficulty with making and waiting for appointments and the brief Medicaid coverage, but also varied in their overall attitudes toward U.S. health care.

The Iraqi group demonstrated strong emotional feelings regarding health care services they experienced in the U.S. A couple of characteristics of this group that sets them apart from the other three, are that they are more highly educated and they had been in the U.S. for a longer amount of time. Being in the U.S. longer, they were able to recount many more encounters with health care services than those participants that had more recently arrived, so they had more chance to see negative aspects of the health care system. Their higher education status likely influenced their perspective and helped them be more confident in their critique of the system.

They painted a very bright picture of the health care they had received in their previous places of residence and were disappointed with the U.S. health care. The fact that they were accustomed to socialized medicine where the government covered the expense of health care likely contributed to their frustration with the high cost of health care in the U.S. and the confusing insurance system. Lipson et al. (2003) discovered similar feelings from a group of Bosnian refugees in California. They were accustomed to the state-run health system with local clinics and physicians who visit them in their home. They developed a strong relationship with the provider and did not have to wait for appointments. A factor to consider is whether the Iraqi refugees were used to living in an established community where they knew their neighbors and their health care providers were living and practicing within their regional community. Closer relationships with health providers may have made them feel like the providers cared about them as an individual rather than demanding payment to be seen. This study reveals that refugees' previous experience with health care strongly affects their view of U.S. health care.

The Somali group consisted of mostly recent arrivals, so they did not have as many health care experiences to share. Most of the participants were young in age, with the exception of two of the participants. One of the older participants expressed his struggle with navigating the health care system on his own, without any family or friends. His situation illustrates the danger of loneliness and isolation that has been documented among some refugee populations. Omeri et al. (2006) found resettled refugees in Australia experienced hopelessness and frustration related to isolation from family and friends, no sense of belonging, and loss of identity. These situations are strong barriers to accessing health care and can lead to poor health outcomes.

An alternative perspective within the Somali group was a female participant who was much older than the others and was a mother of eight children. She was outspoken regarding her disapproval of the health care she had received so far in that her pain had not been adequately addressed. She also did not believe that regular wellness check-ups--even for children--were necessary. She shared that it was difficult to adjust to a new system of calling for medical appointments because her previous experience of health care on a walk-in basis. Morris et al. (2009) and Asgary & Segar (2011) found similar practices among resettled refugee populations in that there is tendency to wait to seek medical care until their condition is severe. Carroll et al. (2007) discovered through interviews with Somali refugee women that they would not choose to go to a doctor unless they were sick. This study's findings within the Somali group are different than these previous studies in that only one out of the ten participants was against wellness check-ups. The other nine participants who readily voiced their favor toward wellness check-ups were much younger, unmarried and had obtained higher levels of education.

Being younger and more educated likely contributes to accepting new health care practices and adjusting to or accepting change.

Much of the literature review consisted of barriers to accessing health care for resettled refugees and their disappointment or frustrations with the U.S. health care system (Anderson et al. 2010; Sheikh-Mohammed et al., 2006; Morris, et al., 2009). However, this study found two out of the four focus groups felt that the health care in the U.S. is much better than where they came from and expressed gratitude for the way they were treated. The Eritrean group felt like they were treated like family and that they experienced good customer service.

America does not mean God, but when I am thinking about America--I am in America right now--when you don't have any family members and you are seriously sick--you don't have money or family members--it doesn't mean you have to die because help is everywhere--when you go to the hospital, they will help you.

The Bhutanese group also detailed how much more sophisticated the U.S. health care is and how much more they trust U.S. health care providers and medicines than those they had encountered in Nepal.

The strongest barrier to adequate health care for the Bhutanese group was the language barrier. This is likely related to the fact that their literacy rate in their primary language of Nepali was low to begin with (40% reported no literacy skills in any language). The participants from Bhutan were older than the other groups, which makes it even more difficult to learn a new language. Even so, the group pointed out that they really prefer to learn English over using an interpreter because the interpreter is actually a

barrier to them feeling that they can express themselves freely to the doctor. They are the only group who brought up this issue of not being able to tell everything to the doctor because the factor of going through an interpreter. This is a topic for further inquiry into whether this feeling stems from a cultural or religious aspect. Most of the participants identified themselves as Hindu with less percent reporting Buddhism as their religious affiliation.

The language factor was a barrier for all groups which mirrors the reports of other studies. Language and cultural factors have been identified as contributing factors to lower rates of health care utilization, both in general and preventive health care. (Uba, 1992; Morris et al., 2009; Sheikh-Mohammed et al., 2006; Lipson, Weinstein & Gladstone, 2003). Similarly, one of the participants from Iraq shared that she has a “phobia” of making appointments, so she and her husband try to stay healthy on their own so they do not have to utilize health services. This study found that recently resettled refugees struggle to keep health care appointments because of the lack of interpretation services. They also expressed dissatisfaction with phone interpretation service. Previous studies found similar perspectives. Morris, et al. (2009) found that the majority of refugees do not regularly access health services in large part due to language and communication which affected all stages of health care access, from calling to make an appointment to filling a prescription.

Other literature has identified a lack of cultural competency as one of the factors related to poor health outcomes for refugees (Asgary & Segar, 2011; Carroll et al., 2007). This study did not specifically cover this area, but some of the comments from the Iraqi group revealed strong feelings of frustration and even mistrust. Some commented on

health care professionals taking too much of their blood. In other cultures, blood may symbolize more than what traditional American culture believes. A participant from Iraq said, "I'm so skinny, why they taking all that blood? Always when you go to the hospital, they take extra blood for themselves. Why?" Someone then commented, "Most likely it is a student. They are just trying to study you." These comments infer a sense of mistrust among this group toward health professionals. This type of attitude points to either cultural or language barriers, but could also be related to health care personnel's lack of cultural competency. One of the Somali participants made the comment, "All are satisfied, but one thing we are not satisfied, is the blood robbing! Too much blood robbing!" This comment was followed by laughter of the group. But, they all agreed that too much blood was taken without knowing the reason or obtaining the results to show the next health care provider. In some situations, it is difficult to determine whether there was miscommunication (interpretation deficit) between the patient and provider/staff or whether it was a cultural misunderstanding or difference. Either way, it is vital to understand each other's perspectives and feelings regarding health care services in order to decrease mistrust and failed health interventions.

This study found little utilization of preventive health services common among all groups and a lack of understanding of cancer screening procedures and recommendations. This finding is similar to other literature. Lipson et al. (2003) found that most Bosnian and Former Soviet Union refugee women had not had a mammogram and did not practice self-breast exams and only six percent of Bosnian women had had a gynecological exam in the past several years and only eight percent of FSU women. Carroll et al. (2007) reported similar findings among Somali women in that they expressed little

understanding of cancer screenings; however, they were familiar with vaccines and well-child check-ups for children. The participants in this study also expressed understanding of vaccinations and familiarity with wellness check-ups for children, but little understanding of the importance of cancer screenings.

There is lack of literature looking at perceptions of the health screenings for newly arrived refugees to the U.S. The findings of this study reveal that resettled refugees have been through the process of infectious disease screenings before and understand infectious disease prevention strategies, such as keeping children's hands clean and eating only fresh food. The participants' responses to illness prevention focused much more on their experience living in refugee camps or developing nations and the hazards of infectious disease rather than wellness activities of preventing chronic conditions more common in developed countries, such as diabetes and hypertension. However, when asked what they would like to learn more about in terms of health topics, their responses revealed a keen awareness of the dangers of lack of exercise and excess intake of less nutritious food. They verbalized this concern and also stressed that they would like to learn how to manage and prevent diabetes, hypertension and cancer. This shows how they are still accustomed to their previous living arrangements, but beginning to look ahead and figure out how to avoid the unhealthy behaviors common in their new home.

In terms of the Neuman System's Model, the findings of this study confirm that the resettled refugees' perceived health care needs and health care activities coordinated by the Midwest large refugee resettlement agency are critical "lines of defense" and can be strengthened by incorporating new health promoting interventions. After

implementing program changes based on these results, the PI expects that the negative impressions or feelings toward U.S. health care will be lessened, which in turn will affect their overall perception of the health care they receive.

Limitations

There were some limitations to this study. The sample was not randomized and the participants were recruited as a convenience sample. Therefore, the results cannot be generalized to the larger refugee population. Each of the focus groups were people identifying themselves originally from a particular country (Iraq, Eritrea, Bhutan, and Somalia); however, this small sample of nine or ten from each country, cannot characterize the people of that country as a whole. For instance, the fact that most of the participants in this study were unemployed does not mean that most resettled refugees are unemployed. Likely those without the constraints of a job were more available to participate in the focus groups sessions and thus easier to recruit.

Another limitation or at least a significant challenge to accuracy of the data is the language barrier and the need for an interpreter. The PI noticed that in all four groups, the interpreter had a hard time translating all that was said because of the group atmosphere. Often times, many people spoke at the same time and were going back and forth in their primary language, so the interpreter did not have time to interpret everything that was said to the PI. Frequently, she/he gave the PI a summary of what was said, rather than word-for-word interpretation. A more time and cost-consuming way to increase accuracy of translation would have been to have the audio-recordings transcribed by a person who spoke the group's primary language and then have it back-

translated. This more intense method of transcription was not feasible for this small, student-funded study.

Another aspect of the methodology to consider is that the PI was not only the focus group moderator, but also was familiar with some of the participants because she administers the adult vaccination program at the refugee resettlement agency. Therefore, the responses of the participants may have been influenced by their previous relationship with the PI. The participants' own relationships with each other are also a factor to consider in how they responded within the discussion groups.

Another consideration is that the focus groups were held at the refugee resettlement agency, which is the agency that the participants have a strong connection with and depend upon for connecting them with many vital resources, especially upon arrival. This type of relationship could have inhibited the participants from expressing their views, attitudes and opinions openly and fearlessly. On the other hand, their familiarity with the organization may have helped them feel more comfortable and relaxed promoting honest and open responses.

Implications for Practice

The findings of this study have broad and significant implications for practice. The feedback and responses from the participants pave the way for program enhancement and future program development to meet needs of resettled refugees in an effective and client-centered manner. The study findings reach several groups, including program development staff for refugee resettlement agencies, health care institutions, church outreach programs, and universities (schools of nursing, medicine, public health and

social work). Even though this study consisted of a small sample size, the results can be a starting point for positive change that can benefit the health of many individuals.

The findings that refugees struggle with making and waiting for appointments related to their previous experience of health care on a walk-in basis, has several implications for health care services. This finding puts forth the proposal of how to expand primary care practices available for the refugee population and even offering care on a walk-in basis. Many health care institutions are adapting their practices to meet the needs of patients by expanding their evening hours and offering visits on a walk-in basis. This demand is evident by the fast rise in convenient care clinics and urgent care centers in recent years (Braden, 2010). Introducing refugees to the concept of urgent care centers and convenient care clinics would also be beneficial to addressing the health care access barrier of long waits for appointments. In this study, the participants only mentioned seeking care at the emergency room or at a primary care office. By showing the refugee community these alternative options, their frustration with the long appointment and emergency waits can be reduced. The financial implication of reserving the emergency room for what other centers are unable to handle due to illness severity, could potentially save significant costs to the health system.

This study also implies that health care professionals and employees of health care institutions need to improve their cultural competency and interpretation services. The findings certainly revealed a lack of clear communication between refugees and health care personnel that sometimes leads to mistrust and health care service avoidance. These findings encourage health care institutions and health-related schools to stress the importance of learning how to interact with people from diverse cultures. This goal can

be achieved through cultural competency training sessions for employees of health care institutions or through student clinical experiences involving diverse populations. For instance, schools of nursing students can spend their public health clinical time organizing and then presenting health resource information to new groups of refugees detailing local health care options. They can provide written information to supplement the lectures that are written in the group's primary language. This way, both the students and the refugee clients benefit and learn (Sullivan, 2009).

The findings of this study also reveal the need for increased use of interpretation services by health care institutions, as well as the continued need for English classes. Interpretation services should continue to be improved so that all persons involved in caring for a non-English speaking person--from the medical transport driver to the appointment receptionist--have access to interpretation services.

To address the issue of navigating the insurance system, resettlement agencies can enhance health care education for newly arrived refugees with a focus on what to do once their Medicaid expires. It would be helpful to provide written material in the client's primary language on the available health care resources in the area and who they can call or go to for additional assistance if needed.

Another implication from this study is that clients should be receiving paper copies of their health screening test results. Especially for people with limited English skills, it is important to provide written copies of test results for future health care providers so that tests are not duplicated or repeated unnecessarily. In addition, this will save health care costs. Each new client could be provided with a health care folder where they could put all their health care records. Then whenever they encounter health services, they can

present their record to the health care providers. This way, all their vaccine records, vaccine information sheets, health screening results, TB medication information, chest x-ray results and any other exams or procedures they may undergo will be easily accessed by all health care service providers. This can fulfill their preference to know their results and avoid further blood draws, which was a voiced concern. It is also important for the vaccine clinic to provide vaccine information sheets in each primary language that they encounter. By giving patients their medical records, the patients are empowered and able to take ownership of their own health.

Another suggestion for the health screening process is to provide a written statement about what it means when a TB skin test is positive, but the chest x-ray is negative. The concise statement should explain latent TB and the purpose of taking medication and the importance of medication compliance to decrease TB resistance. The statement should be translated in the major languages of refugees arriving currently so that they can read and understand.

The findings concerning preventive health care reveal the importance of insurance companies covering preventive care without out-of-pocket cost. The participants of this study were not likely to utilize preventive care services unless it was provided without significant cost. The findings also imply that refugees may be more likely to undergo procedures, such as mammograms, if the resettlement agency collaborates with health care organizations to conduct the screenings. The study revealed a positive sense of trust with the resettlement agency and participants appreciated when services were held at the agency.

Primary care providers are usually the key to informing patients of which cancer screenings they should undergo and which preventive procedures are important for that particular individual. The findings of this study imply that the refugees do not have a strong relationship with a primary care provider (PCP); this was demonstrated by the fact that everyone said they would go to the ER if they had a health problem. No one mentioned calling their PCP for help or guidance of where to seek care for a health problem. Because the refugees revealed a strong sense of trust with the resettlement agency, it would be beneficial for the agency and primary care providers in the area to develop stronger collaboration and communication. Further research into the connection between refugee resettlement agencies and primary care practices should be pursued.

The study findings also provide valuable information as to health education needs of recently resettled refugees. Most of the participants preferred that health information be shared in a lecture-style atmosphere at the resettlement agency with supplemental information in their primary language. Their interest in diabetes, hypertension and cancer reveals that resettled refugees are open to new information and desire to learn how to stay healthy in their new home community.

The findings of this study pave the way for future research into health care for resettled refugees. It is also the starting point for program improvement and program innovation.

Plans for Dissemination

The results of this study will be shared with the staff of the refugee resettlement agency. The results are direct feedback regarding their efforts at meeting health needs of their clients and will be valuable to program evaluation. The PI also plans to share the

results with her place of employment as a nurse practitioner. She works for a community-based organization whose mission is to provide innovative primary and basic health care to disadvantaged populations. The results of this study provide valuable information on the needs of this population which can help guide future health care practices, as well as be used in grant applications.

The PI also plans to pursue publication of the study in an inter-professional health care journal so that other refugee resettlement agencies, health care institutions and universities can benefit from this addition to the body of knowledge regarding resettled refugees and health care. The PI would also like to share the findings by presenting at health care conferences or conferences focusing on the refugee population in developed countries.

The results of this project have potential for impacting policy as well. The PI can provide expert testimony to amplify the voices of resettled refugees through contacting state representatives to promote broad-based change to meet the health needs of this population.

Influence on Doctoral of Nursing Practice

The DNP Scholarly Project has proved to be a comprehensive way for this student to synthesize and use the knowledge and understanding attained from the DNP courses and put it into practice. The student gained research skills to perform a thorough literature review and analysis, which helped determine the direction of the project proposal. After discovering knowledge gaps in the literature and seeing substantial health needs during clinical work with the refugee population as a nurse practitioner, the student was able to design this pilot study to examine perceptions of resettled refugees.

The student has learned that it is crucial to involve stakeholders in program development and evaluation. One of the primary stakeholders is the recipients of the program services. Therefore, the student aimed to give voice to the refugee population in this Midwestern city so that further improvements could be made for them and for future new arrivals to this city and beyond. The courses and the Scholarly Project have contributed to the student continuously “brainstorming” the best methods for delivering effective health care for those in need and given her the tools for gathering data in a scientific way and then designing implementation strategies so that knowledge can be put into practice in order to attain desired outcomes. The core reason for attaining the DNP degree is to gain the skills needed to make research-based, cost-effective clinical changes to fill gaps in the health care system and improve the lives of those being served. The student hopes that this scholarly project will have lasting effects for positive impact.

Conclusion

This project aimed to provide a glimpse of what it is like for an individual or family to undergo the refugee experience of being forced from home into a foreign community and then begin to navigate the health care system to figure out how to meet the health needs of oneself or one’s family. By first understanding this experience and the perspectives of refugees themselves, health professionals and resettlement agencies can move health programs forward to ensure that everyone has a chance at a fresh start with economic and social prospects benefiting both themselves and their new community.

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Appendix A

Recruitment Guide

You are invited to join a group discussion to share experiences that can make health care and services better. The group will meet at the refugee resettlement agency in room ___(#)_____ on ___(day)_____ at _(time)_____ with light refreshments served.

The group discussions are part of a Scholarship Project conducted by Heidi Worabo, a doctoral nursing student from the University of Missouri-St. Louis. Approximately 24-32 individuals will be invited to participate in the project. The purpose of the project is to reveal perceptions and attitudes regarding health screening activities and preventive health care practices.

Your participation in the group discussions is voluntary and would be much appreciated. You will receive a \$10 gift card in appreciation of your time and participation.

Appendix B

Demographic Information Form

1. Age:
2. Gender:
3. Marital status:
4. Number of children:
5. Highest level of education attained:
6. Employment status:
7. Place of birth:
8. Most recent place of residence prior to coming to the U.S.:
9. Arrival date to the United States:
10. Languages spoken:
11. Languages with reading and writing skills:
12. Religious affiliation:

Appendix C

Focus Group Discussion Guide

1. Introduction by principal investigator--
 - a. Career background
 - b. Purpose of the study
 - c. Usual course of focus group discussions-what to expect--audio recording explanation
 - d. Those who would like to participate can stay and begin reading and signing the Informed Consent form. Those who would not like to participate can be excused.
2. "Break the Ice" Group Member Introductions
 - a. Remind participants that they should not verbalize their name
 - b. Go around the circle and share something that they are proud of.
 - c. PI can begin--will share about family life
3. How do you describe your experience with the health care of the U.S.?
 - a. What has been your experience like as you encounter health services?
 - b. Tell me more about what are pleasurable or not so pleasurable experiences you had.
 - c. How were your questions/concerns answered and addressed?
4. How would you describe your experience with the health screening activities that you have experienced here in the U.S.? Would you consider each of the tests, such as the TB test, the stool test, the blood draws as important or not? Why?
 - a. What was the process like for you?
 - b. How well were the process and rationale for these tests explained to you?

- c. How easy or difficult was it for you to understand why you need to go through these tests?
 - d. How would you describe your feelings about the vaccine program?
 - e. How similar or different were these processes to what you experienced in your previous residence?
 - f. What is your understanding about why you undergo these health screenings?
 - g. Is there anything you would like to be changed regarding these screening tests?
5. If you are sick or have a health concern, what do you do?
- a. Who do you go to for help with health problems?
 - b. How would you describe your experience with the process of accessing health care?
6. Most people want to stay healthy so that they can take care of their families and go to work.
- a. What do you and your family members do to stay strong and healthy? How do you do that?
 - b. What are the activities or services that you consider important to you to remain healthy?
7. How do you feel about going to the health center/primary care provider for routine physicals even when you do not feel bad? Tell me more and why?
- a. How about having your children checked routinely?
 - b. When else is it important to go to a check-up? Why?
8. Preventing disease or illness can save one from a lot of pain and suffering. Are there any medical exams or procedures that you see are important at preventing disease?

- a. What are they?
- b. Why or why not?
- c. Would you recommend screenings for your friends and family members?

Why?

- 9. Are there certain health topics that you would like more information on?
 - a. What health issues are of most concern to you and your family/friends?
- 10. What is the best way for you to learn new information? Tell me more.
- 11. Each participant will be asked to share what they think have been the most important elements of the discussion today. Tell me more.



Appendix D

College of Nursing

8001 Natural Bridge Road
St. Louis, Missouri 63121-4499
Phone: 314-516-6066
Fax: 314-516-7519
E-mail: nursing@umsl.edu

Informed Consent for Participation in Research Activities

Resettled Refugees' Perceptions of Preventive Health Care and Health Screening Activities

Participant _____
315832-1

HSC Approval Number:

Principal Investigator __Heidi Worabo_____
1321__

PI's Phone Number 314-497-

1. You are invited to participate in a research study conducted by Heidi Worabo. The purpose of this research is to gain understanding of refugees' perceptions of the health services they undergo during routine screening procedures and their understanding, attitudes and beliefs concerning preventive health care services they have experienced while in the United States.

2. a) Your participation will involve a discussion group consisting of 6 to 8 people. An interpreter who speaks your language will lead the discussion, which lasts approximately 60-90 minutes.

With your permission, the discussion leader will ask several questions related to your experiences, beliefs and attitudes toward health care services in the United States. Your answers will help improve health programs and services in the future.

Your participation is anonymous and the discussion will be recorded on the audio-tape to make sure that the investigator obtains accurate information about what everyone says. No name will be mentioned during the discussion. Only numbers will be used to differentiate who is speaking. These tapes will be destroyed after the study has been completed. You will also be asked to fill out a form asking for some current characteristics of yourself, but without names or identifiers. Filling out this form will take approximately 5-10 minutes.

Approximately 32 people may be involved in participating in these group discussions.

b) The amount of time involved in your participation will be 60-90 minutes. The researcher, Heidi Worabo, will provide you with a \$10 gift card to compensate you for your time.

3. There are no known risks involved in your participation. If there are any questions that might cause you some psychological or emotional discomfort, you are welcome to skip and not answer them. Your identity will not be revealed and your confidentiality will be maintained in all reports of this project.
4. There are no direct benefits for you participating in this study. However, your participation will contribute to the knowledge about health experiences of those coming to the U.S. as refugees. You will have the chance to inform health care providers what you think and how you feel about the health care services that you use. You will also get an opportunity to ask any questions that you would like to ask. This information will be used to design health programs that meet your needs. This way, health providers will become aware of your point of view as you access health care services.
5. Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw.
6. By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer and/or in a locked office.
7. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Heidi Worabo at 314-497-1321 or Kuei-Hsiang Hsueh at 314-516-6066. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 314-516-5897.

I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I consent to my participation in the research described above.

Participant's Signature Date		Participant's Printed Name

		Heidi Worabo
Signature of Investigator/Designee Date		Investigator/Designee Printed Name