Use Authorization

In presenting this thesis in partial fulfillment of the requirements for an advanced degree at Idaho State University, I agree that the Library shall make it freely available for inspection. I further state that permission to download and/or print my thesis for scholarly purposes may be granted by the Dean of the Graduate School, Dean of my academic division, or by the University Librarian. It is understood that any copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Signature _____

Date _____

THE CULTURAL AND ECONOMIC IMPACT OF AFRICAN REFUGEES' HEALTH IN THE UNITED STATES: A CASE STUDY OF ENGLISH SPEAKING REFUGEES IN BOISE, IDAHO COMMUNITY.

by

Elizabeth Ouma

A thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Science in the Department of Public Health

Idaho State University

Spring 2015

Committee Approval

To the Graduate Faculty:

The members of the committee appointed to examine the thesis of Elizabeth Ouma find it satisfactory and recommend that it be accepted.

_____

Dr. Elizabeth Fore,
Major Advisor

_____

Dr. Monica Mispireta,
Committee Member

_____

Professor Rick Tivis,
Graduate Faculty Representative

Idaho State
UNIVERSITY

Office for Research Integrity
921 South 8th Avenue, Stop 8046 • Pocatello, Idaho 83209-8046

October 31, 2014

Elizabeth Ouma
3046 N. Elisha Ave.
Meridian, ID 83646

RE: Your application dated 10/28/2014 regarding study number 4131: The Socio-cultural and economic impact of refugees' health in the United States: A case study of English-speaking African refugees in Boise, Idaho community in the United States

Dear Ms. Ouma:

Thank you for your response to requests from a prior review of your application for the new study listed above. Your study is eligible for expedited review under FDA and DHHS (OHRP) designation.

This is to confirm that your application is now fully approved. The protocol is approved through 10/31/2015.

You are granted permission to conduct your study as most recently described effective immediately. The study is subject to continuing review on or before 10/31/2015, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Tom Bailey (208-282-2179; fax 208-282-4723; email: humsubj@isu.edu) if you have any questions or require further information.

Sincerely,

Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

Acknowledgements

Many thanks to Professor John Ouma, (my father) who inspired me to go into the field of Public Health, to strive to better not only my health, but the health of those around me. He also supported me financially and encouraged me to further my education with no limitations.

To my mother, Mrs. Joyce Ouma and younger brother Hosea, who have always been there for me and taken the time to encourage me both spiritually and mentally.

To my older brother Mark and family, Shelly, Lylah and Declan Ouma who have supported me financially and constantly encouraged me to press on. Without them, I would not have been able to come this far.

Lastly, to my Professors for the academic support that they have given to me.

TABLE OF CONTENTS

Page

Lists of Tables xii

Lists of Figures xi

List of Abbreviations xiii

Abstract xv

Chapter 1: Introduction 1

Background and Significance 1

Statement of the Problem 5

Purpose of the Study 5

Study Aims 6

Conceptual Framework 6

Cultural Identity 7

Relationships and Expectations 7

Cultural Empowerment 8

Chapter 11: Literature Review 10

Introduction 10

Refugee Demographics 12

Refugees Worldwide 12

Refugees in Idaho 15

Resettlement in the U.S 16

Lifestyles 17

Health Issues 18

Post-Traumatic Stress Disorder (PTSD) 19

Tuberculosis (TB) 21

Sexually Transmitted Infections (STI's) 21
Barriers to Healthcare for Refugees 22
Healthcare Disparities 23
Patient Factors 23
Patients have different Attitudes towards their Clinicians 23
Cultural conflict or barriers may arise 23
Healthcare System Factors 24
Language Barriers 25
Insurance and other payment issues 26
Provider Challenges 27
Healthcare Process Factors 28
A. Stereotyping 28
B. Prejudice or Bias 28
Interventions to address the barriers 29
Conclusion 31
Chapter 111: Methods 32
Purpose of the study 32
Research Design 34
Study Area 34
Research Setting and Target Population 35
Conceptual Framework 36
Research Instruments 37
Pre-Testing 38
Data Collection Techniques 39
Data Analysis 40

Limitations 41
Chapter IV: Qualitative Study Results 43
Identification of Documents 43
Description of Program Documents 44
Document Analysis Results 49
Major Health Challenges 49
Increase in the Prevalence of Health Problems 49
Lack of Access to Care and Medical Services 50
Culture in Relation to Refugees and Their Healthcare Providers ... 51
Language Barriers and Solutions 52
Developing Successful Health Interventions 53
Screening 53
Training of cultural competence and acceptance 53
Follow-up and ongoing monitoring 54
Successful Outcome of Interventions Access to Healthcare 54
Sustaining Interventions 56
Interviews 58
Description and Background of Participants 58
Government Assistance 59
Unfamiliarity with the U.S. Health System 63
Impact of Unemployment on Health 63
Financial Status as a Barrier to Health 64
Transportation 65
Culture and Religion 66
Chapter V: Discussion 69

Summary 69
Discussion 69
Document Analysis 69
Interviews 71
Similarities between the Document Analysis and Interviews 72
Differences between the document analysis and interviews. 73
How the results fit into the literature 74
Strengths 76
Limitations 77
Methodological limitations 77
Principal investigators limitations 78
Recommendations for future studies 79
Conclusion 80
CITATIONS 82
APPENDICES 89
A. DATA FOR PIE CHART FOR REFUGEE ADMISSIONS 89
B. DOCUMENT ANALYSIS 90
C. INTERVIEW QUESTIONNAIRE 91

List of Tables

Table 1. The top 10 countries of origin of refugees 13

Table 2. Characteristics of the Respondents 60

List of Figures

Figure 1. The PEN-3 Model 8

Figure 2. Refugee distribution by country in the United States..... 14

Figure 3. The Idaho percentage refugee count 15

Figure 4. Major themes and subthemes of health challenges of refugees 62

List of Abbreviations

AHRQ	Agency for Healthcare Research and Quality
ANA	Agency For New Americans
UNHCR	American Anthropology Association
U.S	United States
C.A.R.E	Culturally Appropriate Resources and Education
IRC	International Rescue Committee
WR	World Relief
RI	Refugees International
OHCR	Office of The High Commissioner for Human Rights
GTR	Global Trends Report
IDP's	Internally Displaced Persons
UNRWA	United Nations Relief and Works Agency
PEN	Person, the Extended family and/or the Neighborhood
PEN	Perception Enablers Nurturers
PEN	Positive Exotic Negative
IOR	Idaho Office for Refugees
BCIS	Bureau of Citizenship and Immigration Services
IOM	International Organization for Migration
RCA	Refugee Cash Assistance
WHO	World Health Organization
NGO	Non-Governmental Organization
HPRT	The Harvard Program in Refugee Trauma

PTSD	Post Traumatic Stress Disorder
TB	Tuberculosis
NIMH	National Institute of Mental Health
STI	Sexually Transmitted Infections
USDHHS	U.S. Department of Health and Human Services
HSCL-25	Hopkins Symptom Checklist-25
SSI	Social Security Income
DRC	The Democratic Republic Of Congo
MD	Medical Doctor
IRB	Institutional Review Board

Abstract

Every year the president approves many refugees into the United States from different parts of the world .The purpose of this study was to assess the barriers to healthcare that English speaking refugees in Boise, Idaho face on coming to the United States. Through this assessment, one can explore refugees' perceptions and experiences with healthcare, leading to recommendations for changes that should be made. This approach involved research based on literature and interviews with the refugees. The study was carried out between the months of October and December 2014 using qualitative methods. Data was collected by reviewing articles and conducting interviews with 17 male and female refugees. Results showed that working systems have been put in place for the provision of healthcare for refugees, but more effort is needed to ensure that the new programs being implemented are effective and the growing numbers of refugee populations receive appropriate care.

CHAPTER I- INTRODUCTION

Background and Significance

In many countries in our world today, certain individuals are forced to leave their home and country due to conflict. These people who consist of refugees, asylum seekers, returnees, stateless persons and certain groups of internally displaced persons (IDP's) are collectively referred to as 'persons of concern.' According to the 2011 United Nations High Commissioner for Refugees (UNHCR) Global trends report, 42.5 million people worldwide were 'persons of concern' to the UNHCR. Of this number, 15.2 million were refugees, 26.4 million were IDP's and the remaining 835,000 represented those seeking asylum status.

Today, the number of refugees in the United States is significant, with the U.S Department of State (U.S. DOS) reporting that- since 1975, over 3 million refugees have been welcomed into the country from all over the world (U.S DOS, 2014). These individuals have established new lives, homes and even communities throughout the U.S. A 2013 database in the U.S. Department of Health and Human Services, Office of Refugee Resettlement report depicts that: in 2012, there were a total of 58,238 refugees admitted in the United States from 85 countries all over the world. The highest number, consisting of 5,923 refugees settled in Texas, followed by California (5,173) and Michigan (3,594).

Not only have refugees settled throughout the U.S but they have also migrated from a wide range of countries. The U.S Department of State reports that out of the 3 million refugees admitted since 1975, approximately 280, 000 were from Africa with more than 100,000 of these individuals from Somali and almost 50,000 from Ethiopia

(2013). Other large numbers of African refugees in the United States (U.S.) are from: The Republic of Congo, Burundi, Eritrea, Somalia, Sierra Leone, Sudan, Liberia and Rwanda. (U.S DOS, 2013; RA 2013; UNHCR 2010). The top three non- African countries that refugees flee from include Afghanistan, which happens to be the highest, followed by Iraq and China (UNHCR, 2010).

Although direct immigration to the U.S is common for most immigrants, this does not hold true for the refugee population (UNHCR, 2013). Many escaped from their country of origin to one or multiple nearby countries, before being discovered and resettled in other countries - by refugee organizations such as the International Rescue Committee (IRC), Agency for new Americans (ANA), World Relief (WR) and Refugees International (RI).

The Office of the United Nations High Commissioner for Refugees (UNHCR), established on December 14th, 1950 is the main agency responsible for protecting and resolving refugee problems worldwide (UNHCR's Guiding Principles, 2008-2012). One way of protecting and resolving refugee problems, would be through public health programs for refugees and internally displaced persons (IDP's). The law from the 1951 Convention backs this statement, claiming that refugees should enjoy access to health services equivalent to that of their host population, while everyone has the right under international law to the highest standards of physical and mental health (UNHCR's Guiding Principles, 2008-2012).

Refugees and local people from poor adjacent host countries that refugees fled to are said to be accustomed to subsistence levels of existence in terms of the basic needs as well as basic health care (UNHCR, 2010). This implies that when they settle

down in developed countries and are faced with the advanced healthcare system, such as that in the U.S, some challenges are anticipated. These challenges not only affect them as refugees, but their healthcare providers as well.

Within the healthcare system all over the U.S, factors linked to refugees have led to health disparities. These factors include communication barriers related to language and culture which make it hard for them to comprehend their medical condition, or can lead to the risk of adverse medication reactions (Institute of Medicine, 2003).

As previously indicated, refugees have settled throughout the U.S. This would include Idaho. The history of refugee resettlement in Idaho began in 1975 when Governor John Evans, established the Indochinese Refugee Assistance Program - in response to the need for all states to participate in refugee resettlement. Resettlement initially focused on refugees from Vietnam, Cambodia and Laos, but later broadened to include Eastern European refugees who fled from the Soviet eras oppressive regimes (IOR, 2013). Resettlement has continued to develop in the present. According to the Idaho Office for Refugees (IOR), in 2012 alone, 686 refugees and special immigrants settled Idaho, having arrived from 20 different countries (IOR, 2013). The majority of the refugees in Idaho are located in the capital city of Boise (Advances in Nursing Science, 2010). As a large and diverse population of refugees, this population requires programs to address barriers to healthcare specific to their refugee status with attention paid to addressing human rights issues.

In order to address the needs of refugees in Boise, studies and projects have been implemented locally such as the C.A.R.E (Culturally Appropriate Resources and

Education) clinic. This project was developed by different health care providers within the St Alphonsus Health System in 2009 to cater to mostly pregnant refugee women and their babies. The clinic offers services such as pregnancy tests, prenatal exams, well baby checks, immunizations, educational classes, health advisors and assistance in applying for Medicaid and financial assistance (SAHS, 2014). The clinic has reported positive results, such as increased access to care, education and social services for refugees, a reduction in the level of anxiety before participating in the available programs and fewer missed appointments amongst this population (Widener, Lipscomb & Hobbs J et al., 2010). However this study focused primarily on perinatal and pediatric needs, leaving out the male refugee population as well as the women who are not expecting.

Figuring out the cultural and economic impact of refugee healthcare in Boise, Idaho, is important as it will establish the methods that have been used in the past by various programs including the C.A.R.E clinic to address refugee health. These programs successes, challenges and weaknesses will be evaluated and assessed to identify unmet health needs among the growing population of refugees. As mentioned the refugee population within Boise is increasing at a very fast rate, and in order for people to be more aware and sensitive of the needs of this population, studies such as the one currently proposed can provide feedback to improve refugee health programs. The results can be presented not only to the refugee community but also to professional health care workers and the community, so that information about the health needs of refugees and solutions to their barriers can be communicated to a widespread audience.

Statement of the problem

With the growing number of refugees in the United States – who are displaced from their countries of origin due to persecutions of various types, mainly, politics and tribalism, many health issues arise due to socio-cultural and economic factors. Being away from one's country of origin can result in challenges to acculturating to a new set of cultural values and systems of care, especially those that undermine their health statuses. Such problems summarized by Widener et al., (2010) include:

- Obstacles to care such as transportation difficulties, lack of understanding in the importance of keeping appointments, lack of insurance, lack of education in terms of knowing how to apply for assistance programs and language barriers.
- Fear and anxiety due to unfamiliarity of medical practices, such as screenings or preference of female providers versus male providers for women.
- Limited provider knowledge of culturally diverse populations.

Widener and colleagues (2010) indicate that despite relocating refugees to the U.S. to seek refuge from the various harsh conditions that they were subjected to like war and rape, unmet health needs related to both individuals and system barriers continue to exist.

Purpose of the study

The purpose of this study is to explore the experiences of African refugees in accessing healthcare. By identifying various avoidable obstacles and circumstances that African refugees face, the results of this project can inform efforts to reduce negative

health effects that affect refugees. With the right approach to this sensitive topic amongst refugees, one should be able to create a large impact on improving the health of the refugee population as a whole, ensuring that everyone's rights are not undermined and that all refugees have equal and/or better access to healthcare.

Study Aims

The goal of this study is to identify the socio-cultural and economic barriers and challenges to accessing health care faced by English speaking refugees in Boise, Idaho, and to use the experiences of those refugees to assess the appropriateness of recommendations for improving refugee health.

1. To identify the major socio-cultural and economic factors influencing health among refugees through the refugees' perspectives.
2. To explore refugees' perceptions of effectiveness of various health programs and services in both improving health and protecting their human rights.
3. To determine the most effective as well as the missing factors in programs that have already been implemented in regards to refugee health care.

Conceptual Framework

Due to the fact that this research will present information which can be used to develop culturally competent programs to prevent larger problems from developing amongst this population: it will be based on aspects of the PEN-3 Model and its domains and subcategories of the domains. This model addresses issues such as the poor education, poverty, communication barriers and lack of skills, amongst many others, by situating culture at the center of determinants of health behavior in health

promotion and disease prevention interventions (Airhihenbuwa, 1995: Airhihenbuwa, 1999).

The Pen-3 Model is a health education planning model that was developed in 1992 by Airhihenbuwa, for health education and disease prevention programs in African countries. As emphasis on cultural relevance and community based interventions has increased, including those targeting refugees, this model has begun to be applied in health promotion efforts all over the U.S (Fitzgibbon & Beech, 2009; Kannan, et al). It consists of three domains and each domain had three categories that form the acronym PEN.

Cultural Identity

This is the first domain of the model which focuses on the level of health education program. As an ecological model of health, the level of intervention can be at the micro or macro level. The main aim of this domain is to identify the point of entry or entries for the educational program among each Person, the Extended family and/or the Neighborhood (Airhihenbuwa, 1999).

Relationships and Expectations

This is the second dimension and it addresses the Educational Diagnosis of Health Behavior. These are the interpersonal, intrapersonal, or social factors related to health behavior. The acronyms present are P-Perception, where one's personal beliefs or practices may hinder or promote one's health actions. E- Enablers where these could be the things that may create or enhance barriers in terms of health beliefs of practices and lastly N-nurturers who are the reinforcing factors of individuals (Airhihenbuwa, 1999).

Cultural Empowerment

The third dimension assesses the cultural appropriateness of health beliefs. The acronyms for this are: P-Positive, practices that positively influence health. E- Exotic, which includes practices that have no effect on one's health and lastly N-Negative, which includes health practices that may cause harm to one (Airhihenbuwa, 1999).

Airhihenbuwa, represented the interaction of these three domains as follows:

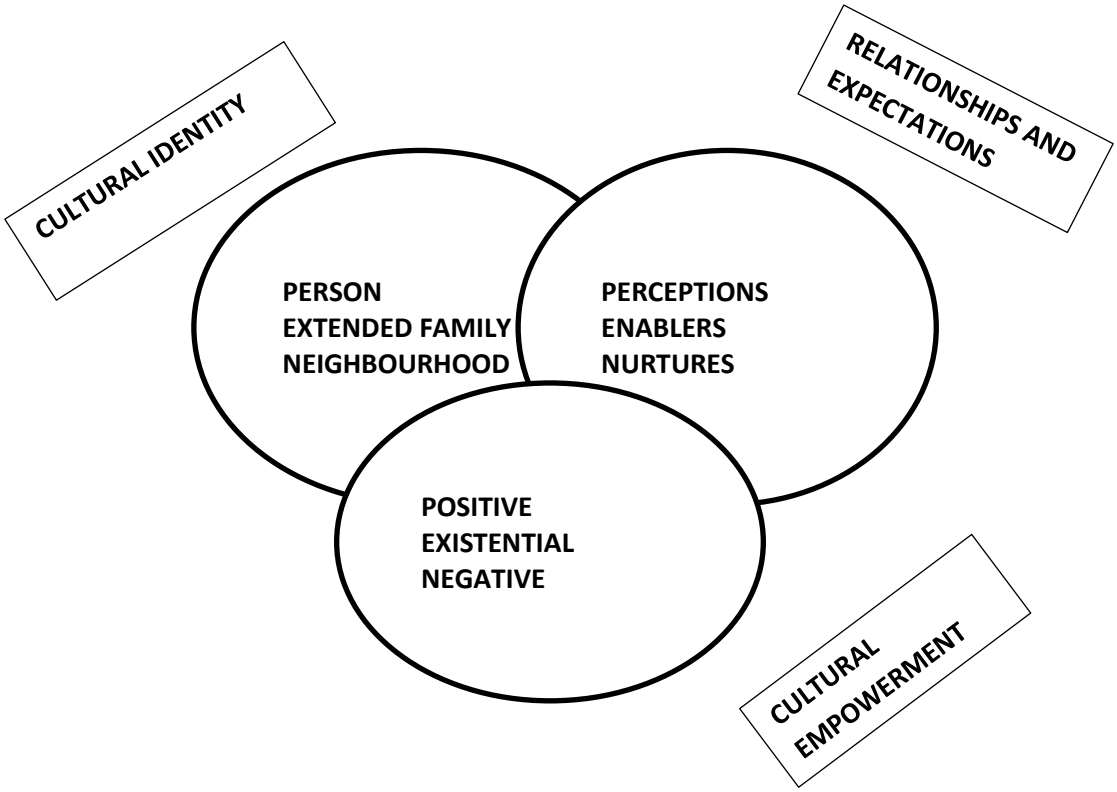

Figure 1: The PEN-3 Model. This Figure illustrates composition of the PEN-3 Model.

These three dimensions of this model are suitable for this study as it contains a detailed consideration of the issues that would help us identify cultural factors that affect health and plan effective programs that address those factors. Application of the

model will result in detailed recommendations for culturally specific approaches, to meet the health needs of African refugees.

CHAPTER II-LITERATURE REVIEW

Introduction

This literature review describes the refugees who are immigrating to the U.S. and examines factors impacting the health of refugees. Topics of discussion include: demographics, lifestyles, and health issues, barriers to healthcare, ethical issues and finally possible interventions and/or solutions.

At the beginning of 2013, 10.4 million men, women and children were of concern to the Office of the United Nations High Commissioner for Refugees (UNHCR). "Persons of concern" is a term used by this organization; referring collectively to refugees, asylum seekers, returnees, stateless persons and certain groups of internally displaced persons (IDP's).These individuals could be awaiting three possible solutions: repatriation, local integration and/or resettlement. They may receive assistance from this organization, based on humanitarian or other special grounds (UNHCR, 2013)

The UNHCR is an organization that was established in 1951 to help individuals displaced after World War II to return home. Since then, they have so far managed to assist millions of refugees and they remain the core constituency of the program (UNHCR, 2013). Another agency which is region specific is the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). This agency has assisted a further 4.8 million registered Palestinian refugees in 60 camps in the Middle East since 1949 (UNHCR, 2013).

A further classification of refugees is necessary due to the specific needs of each category. Other than refugees, there are asylum seekers, Internally Displaced Persons

(IDP's and returnees. The following classifications outline the differences among the groups.

According to the definition proposed in the 1951 Convention, a refugee is an individual who "has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries." (UNHCR, 2013)

The term "social group" included in the definition of a refugee refers to any set of human beings who either are, recently have been, or anticipate being in some kind of interrelation (UNHCR, 2002). Examples of a social group can be the Lesbian Gay Bisexual Transgender community, Muslims or in this case, refugees.

An asylum seeker on the other hand is an individual who claims that they are a refugee but their claim has not yet been definitively evaluated. (UNHCR, 2013) When persecuted, these individuals' lives are often in danger, leading them to either being killed, or them fleeing to other countries. On arrival to their new acquired land is when they are then classified as "refugees".

When one is forced to flee from their homes, for the same reasons as refugees mentioned above, but end up remaining in their own country and have not crossed any international border, they are referred to as Internally Displaced Persons (IDP) . Finally, if a refugee was to return to his or her own country, often when it is safe to do so, they would be referred to as a "returnee" (UNHCR, 2013.)

We can classify refugees as minority populations in a foreign land due to the fact that they are of different cultures and races and have different beliefs and practices. According to the Office of The High Commissioner for Human Rights (OHCHR), inter-ethnic and inter-racial tensions rooted in power struggles and aggravated by socio-economic inequalities are on the rise. Because national, ethnic and religious minorities are often vulnerable in these conflicts, persons who flee their countries for fear of persecution (like refugees) can therefore be classified as members of minority groups (OHCHR, 2011). They could also be referred to as individuals more susceptible to illness and death, a factor to which being a member of a minority group highly contributes (OHCHR, 2011).

Refugee Demographics

According to the 2012 UNHCR Global Trends Report (GTR), 45.2 million people worldwide could be classified as either refugees (15.4 million), internally displaced (28.8 million) or seeking asylum (937,000). When these individuals claim refugee status, they are most commonly hosted by developing countries. Such countries are host to over 80% of the world's refugees, compared to 70% ten years ago (GTR, 2012)

Refugees worldwide. The majority of refugees are from African and Middle Eastern countries (UNHCR, 2014). Table 1 below, which is a representation of the top 10 countries of origin of refugees, depicts this. One might note that the top 5 countries in this table, consisting of Afghanistan, Somalia, Iraq, Syria and Sudan are dominantly war affected countries.

Table 1
The top 10 countries of origin of refugees

Rank	Country of Origin	Refugees
1	Afghanistan	2,585,605
2	Somalia	1,136,142
3	Iraq	746,424
4	Syria	728,218
5	Sudan	558,468
6	Democratic Rep of Congo	509,188
7	Burma	215,312
8	Colombia	111,778
9	Eritrea	247,795
10	China	193,337

The top ten countries that host refugees include, Pakistan, Iran, Germany, Kenya, Syria, Ethiopia, Chad, Jordan, China and Turkey (UNHCR, 2013). Taking a look at both representations of the table and the top 10 hosting countries, many African countries are presented as both countries where refugees come from and resettle. These individuals risk their lives to seek refuge. For instance, in as recent August 2013, the UNHCR reported that within the first six months of the year, 45,000 people crossed the Gulf of Aden to reach Yemen by boat, from Africa. In 2012, a total of 107,500 people made the same journey (UNHCR, 2013).

These numbers will only increase. Currently, the UNHCR reports that rises in conflict, violence and human right abuses continue to create new displacement emergences in sub- Saharan Africa. This organization anticipates supporting 0.3 million more refugees and asylum seekers, than the approximate 3.1 million in 2012. Increasing violence in The DRC, Mali, Somalia and Sudan will require protection and assistance and that in Africa alone in 2014, as many as 11 million people will be of concern to the UNHCR. (UNHCR- Global Appeal, 2014-2015)

Although many refugees flee to neighboring countries, the top three countries for resettlement were the U.S. (1,359,533), Canada (221,013) and Australia (211,240) (Refugee Council of Australia, 2013). Other countries in the top 10 of this data were Sweden, Norway, Denmark, New Zealand, Finland, Netherlands and United Kingdom. (Refugee Council of Australia, 2013) In 2012 alone, the U.S. was ranked first with a total of 66,286 refugees, in countries where refugees resettle (UNHCR, 2013). Bearing this information in mind it is highly likely that many of these individuals from Africa will eventually resettle in the U.S. For example, in Figure 2 below, which represents the distribution of refugees by country in the U.S, we can see that African countries like Somalia, Sudan and The DRC represent a large number of refugees by country, with Somalia being the highest (UNHCR, 2013).

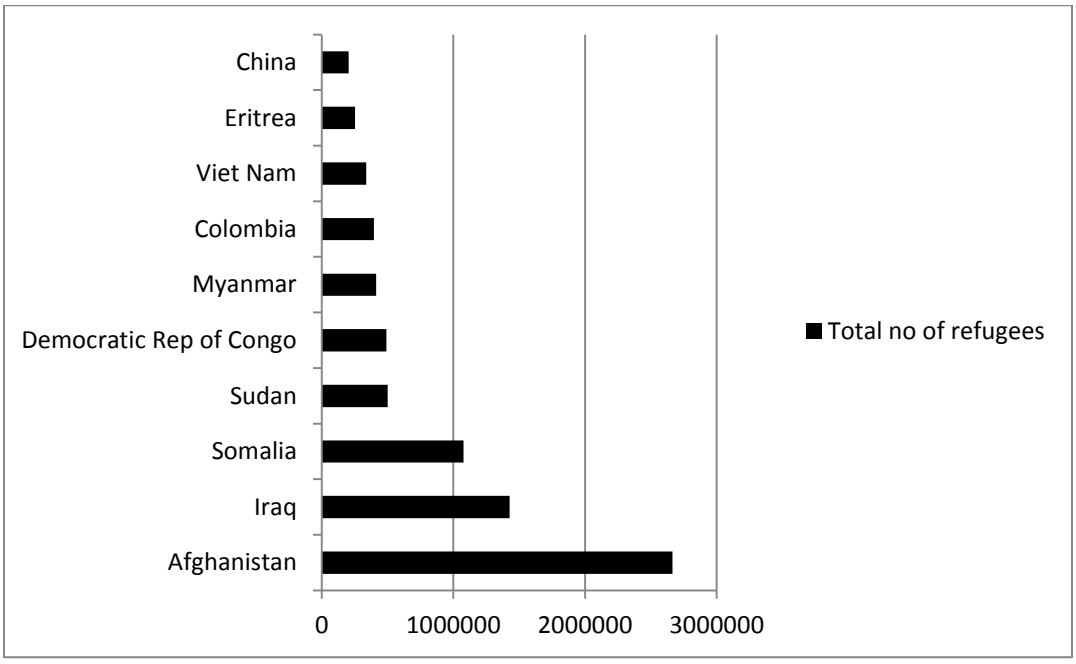

Figure 2: Total number of refugees by country in 2013. This figure represents the distribution of refugees by country in the U.S.

It is important to note that some of the refugees that come from countries like Somalia may return to their home countries once they are stable, but many are still in need of international protection (UNHCR- Global Appeal, 2014-2015). UNHCR together with International Organization for Migration (IOM), the World Food Programme (WFP) and other organizations form pilot programs which support refugees who return to their countries of origin (UNHCR, 2013).

Refugees in Idaho. Refugees in the US, including African immigrants, have quadrupled in numbers since 1990 (Terrazas, 2009). In Idaho, the number of refugees from all over the world, totaled to 5,431 in the years 2001-2011 (IOR, 2013). Figure 3 represents this information in a pie chart; the actual figures can be found in Appendix A.

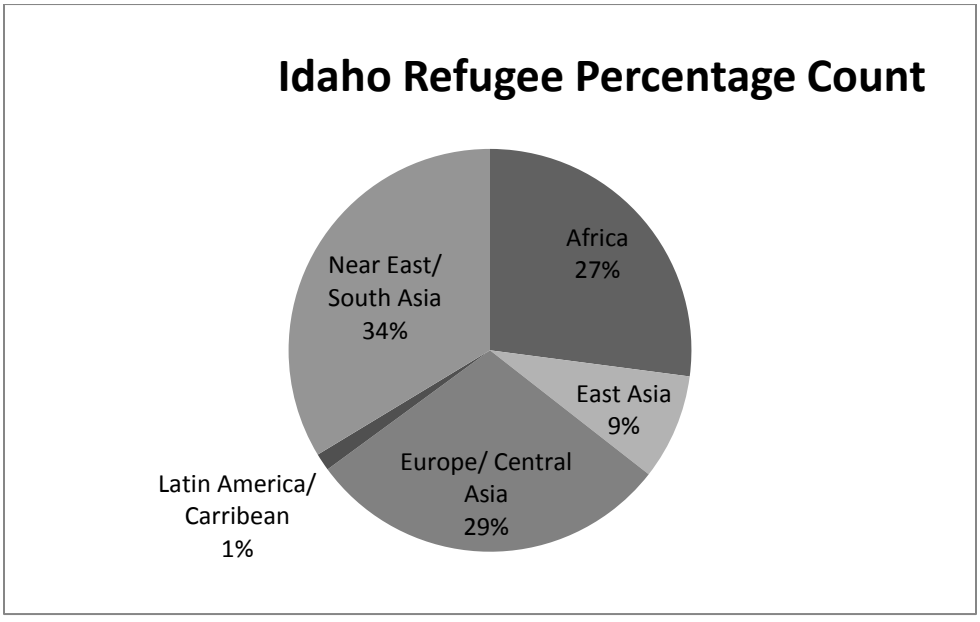

Figure 3: This figure represents the Idaho refugee percentage Count.

According to the chart above, Africa is the third largest population of refugees in Idaho. The top 5 countries in Africa where refugees came from between the years 2001 and 2011 are Somalia (504), The DRC (327), Burundi (262), Sudan (104) and Eritrea (69) (UNHCR, 2012) Due to the instability in these African countries, their numbers are anticipated by the UNHCR to be rapidly growing.

Resettlement in the U.S.

Resettlement in the U.S. is determined by the executive branch of the government. Every year, after consulting with congress and other agencies, the President of the U.S determines the designated nationalities and processing priorities for refugee acceptance for the following year. He also sets annual ceilings on the total number of refugees who may migrate to the U.S. from different countries in the world. Once these quotas are set, individuals apply and are interviewed by a Bureau of Citizenship and Immigration Services Officer (BCIS officer) who accepts, approve or denies their cases (IRC, 2013).

Once accepted refugees undergo various medical exams, vaccinations and treatment if necessary and finally limited cultural orientation. They are then required to sign a promissory note for a travel loan administered by the International Organization for Migration (IOM), which they are required to pay back when they settle down in the U.S. All data for accepted applications is sent to a refugee processing center in Washington DC, where different cases are assigned to different local agencies. These agencies then decide where the refugees are distributed within the U.S. (IRC, 2013 & IPC, 2010). Although the legal aspects of resettlement are addressed in this section, factors related to health status and healthcare access are significant.

Lifestyles.

Upon arriving to the United States, refugees' struggles seem to escalate other than decrease. According to the Robert Wood Johnsons vulnerable populations' portfolio, research carried out by the Lake Snell Perry Mermin/Decision Research team established that immigrant and refugees families live difficult lives as they adjust to new communities and new cultures (Robert Wood Johnson, 2006). Once again they are met with a number of challenges. These situations, however, are somewhat better than the constants of living in fear and psychological trauma that they may have faced from being raped, being abused and/or watching their loved ones being slaughtered before them.

With immigrating to a new country and culture come major obstacles including cultural, linguistic, mental health and employment challenges. Even though they may be considered better challenges, they should not be ignored as some of these factors can prevent them from reaching their full potential as contributing members of society.

When the refugees leave their native countries and societies, they lose not only their belongings but their family networks and friends (UNICEF New Zealand, 2013). Due to the fact that they have fled to the U.S. without the privilege of carrying what little they have, they are brought to their country of refuge, supported for a couple of months and expected to support themselves thereafter.

When brought to the United States, the government provides basic assistance to refugees through the organization that is responsible for them. During their first 30 days, they are oriented to the U.S. and provided with basic needs such as housing, food, and clothing. Eventually, they qualify to get an 8 month limit of Refugee Cash Assistance

(RCA), to apply for a social security card, to enroll the children in various schools and to be referred to various employment services (IRC, 2013 & IPC, 2010).

With these services, they are expected to adapt to a new culture and lifestyle within a short period of time, and expected to establish local livelihoods. However this is very difficult to achieve (IRC, 2013, Benjamin, Widner, 2002.) Within this period of time, these individuals with limited education are expected to learn English and find ways and means to survive in their new country. They have low levels of education and literacy due to the fact that they are coming from areas of long standing conflict with interruptions of schooling (Burton, John-Leader, 2009.)

According to an Iowa report one of the most important challenges to reducing health disparities amongst ethnic minority populations is associated with language and communication (Grey, et.al., 2006). Another Iowa report by the same group people on Refugees from East Africa stated that some refugees have the ability of learning English and adapting to their new lifestyle quickly. However others, like those from Somalia and Sudan, that are known to have amongst the lowest literacy in the world, particularly women, may have a difficult time and thus take a much longer period. (Grey, et.al., 2007). As soon as the government and the other responsible parties cease to support them fully, they are left impoverished. This leads to their facing numerous obstacles to many things including access to adequate health care. For example, they face transportation difficulties and lack of insurance: hence they avoid going for care due to fear of medical expenses. These are factors that will be addressed in detail later in this paper.

Health Issues. Some of the major health problems and/ or diseases that were prevalent amongst the refugee population about a decade ago, according to Ackerman (1997) included: Post Traumatic Stress Disorder (PTSD), Tuberculosis (TB), nutritional deficiencies, intestinal parasites, chronic hepatitis B infection and lack of immunization. Currently, CDC encourages medical providers to pay more attention to the diseases that have long latency and are associated with severe morbidity such as TB, Hepatitis B and Strongyloides, for individuals who have been in the U.S. for more than a year (CDC, 2012). Providers are also encouraged to prioritize health conditions when dealing with refugees of a particular country of origin. For instance, the top three documented diseases for the Bhutanese population are: anemia, vitamin B12 deficiency and mental health. (CDC, 2012) Other research such as that from CDC (2010) includes Sexually Transmitted Infections (STI's) as factors to be considered when dealing with refugee populations. This review covers the three seemingly more common health problems which are PTSD, TB and STI's, specifically Gonorrhea and Syphilis.

Post-Traumatic Stress Disorder (PTSD) is a mental disorder caused by traumatic events in one's life. Symptoms of this disorder include reminisces of ones' horrible experiences in different forms such as nightmares. These nightmares tend to arouse emotions of anger and instability can result in ones inability to live a full productive life (NIMH, 2012).

According to Bolton, (2007) the rates of PTSD vary widely (4% to 86%), depending on the sample being studied in any given population. For depression, which is a major symptom of PTSD, the range is from 5% to 31%. In the United States, Scientists such as Ramin and Segar (2011) bring up the argument that, not only does

mental illness affect an individual in his/her daily life, but it also creates barriers to accessing healthcare. Other factors that they face may contribute to PTSD incidence. These include poverty, stress, unemployment and family instability (Craig, 2008).

Newman described the association between refugee status, mental health and human rights (2007). He carried out his research on how to include human rights when handling refugees - as he considers these individuals to be a highly traumatized group, who had experiences of systematic oppression, loss, displacement and violence exposure. He claims that these are the factors that make them mentally unstable and thus often lose their human rights within the society. He reviewed the impact of mandatory prolonged detention on their mental health and the significance for their recovery and adaptation.

For instance, a UNHCR 2013 report stated that the recurrent conflict in The Democratic republic of Congo's North Kivu province has displaced a number of civilians and exposed women, children and even men, to rape. A UNHCR spokesman in the same report in July 2013 claimed that since 2013, 705 sexual violence cases were reported, where 603 of these were rape. Between January and July in the year 2012, the Survivors of Sexual and Gender Based Violence (SGBV) included 288 minors and 48 men. Most of these cases are said to be committed by armed men and out of the 705 cases mentioned above, 434 were enacted with armed elements. (UNHCR, 2013)

In the same region, human rights are also violated in other ways. In 2013, UNHCR reported murders of at least 15 civilians, a number of abductions, forced labor, beatings and illegal taxation (UNHCR, 2013). This is a representation of only refugees

in one country, leaving one to wonder what would be the statistics covered if other countries were included.

Tuberculosis (TB) is described as an airborne disease, which affects mainly the lungs and other parts of the body-including kidneys, spine or the brain. TB is characterized by coughs, fever, fatigue, weight loss, night sweats, chills and loss of appetite (CDC, 2010). Between the years of 1993 to 2008, CDC reported 7,000 to 8,000 cases of TB amongst foreign-born persons. The top 12 countries of origin of foreign-born persons included countries like Vietnam, Philippines, Ethiopia and Korea, where most refugees are from (CDC, 2010). In 2007, 57.8 % of 13,293 new cases of TB in the U.S. were diagnosed in foreigners-including refugees (CDC, 2010). Annual arrivals of hundreds of thousands of refugees are likely to contribute greatly to the TB burden amongst foreign- born persons in the U.S. (Liu, Weinberg et.al. 2009).

To address this issue, CDC is collaborating with different organizations to improve screening of immigrants and refugees, by testing recent arrivals from countries with high rates of TB. Medical screening guidelines have been set for individuals like refugees who seek permanent residence in the U.S. (CDC, 2009).

Sexually Transmitted Infections (STI's) such as Gonorrhea and Syphilis are also common issues amongst these populations (CDC, 2010). These diseases are more common to refugee women from Sub-Saharan Africa (Ortashi et.al 2004). Gonorrhea is caused by a bacterium and is characterized by an infection in the uterus, fallopian tubes, urethra or even the eyes, mouth, throat and anus of an individual (CDC, 2012). Syphilis is another common STI, caused by a bacterium as well. Syphilis is characterized by sores on the external genitals, the lips and in the mouth (CDC, 2012). STI's can be

considered as major health problems as they are painful and hard to deal with. When an individual does not seek treatment for some of these diseases, they can become blind or even die (CDC, 2012). Because of the nature of these diseases, they are embarrassing to address.

Having all these issues and diseases in mind, we can conclude, refugees require medical attention. Unfortunately, being a refugee group in a foreign country, they are likely to face certain health disparities that cause them to lack sufficient health care. Norm and Corr (2010) attempted to elaborate on these barriers to health care listing them as follows: discrimination, language, religious, educational, cultural, economic, social and political barriers.

Barriers to Healthcare for Refugees

In order to explore the impact of refugee status on healthcare access, Ramin and Segar (2011) recorded, coded, and analyzed information from focus groups and comprehensive interviews with a total number of 35 asylum seekers and 15 provider/ advocacy organization representatives. In their study they categorized barriers to health care access into three groups:

a) Internal- such as by mental illness fatalism, mistrust and perceived discrimination. This includes the effects of PTSD and the impact of the community on this population.
b) Structural, including affordability, limited services inadequate interpretation, resettlement challenges such as shelter, food and employment insecurity: healthcare for urgent care only and poor cultural competency. This also includes

their financial situations and the barriers that they face when it comes to receiving healthcare, such as the presence of interpreters.

c) Barriers in social assimilation due to the complexity of their newly acquired home and lack of community support. These barriers include the challenges that they face navigating around a foreign land, and the limited support from individuals who do not understand where they are coming from.

Healthcare Disparities. Because refugees are minority populations in a foreign land due to the fact that they are of different cultures, races and have different beliefs and practices as well as being individuals more susceptible to illness and death, certain disparities can arise. Disparities such as that of their health, where they cannot afford and/or acquire adequate healthcare due to their impoverished lifestyles and lack of knowledge. Refugees are also of different ethnic groups and origin and thus their medical care providers may not have adequate knowledge or even have any familiarity with their medical issues.

Patient factors. As mentioned previously, this group of people can be classified as minority groups that face certain disparities. The reasons as to why there are disparities amongst this group of people due to the following three categories:

***Patients have different attitudes towards their clinicians*.** Coming from a third world country where they have possibly not received proper modernized healthcare, refugees may have little or no experience with western medicine causing them to relate to their clinicians differently (Elliott and Segal, 2013). They may therefore experience fear and anxiety when they are faced with these unfamiliar medical practices. They may also develop either an attachment to for one specific care giver and not want to see

anybody but them, or vice versa, where it would be hard to place them with a health care provider that would meet their needs (AHRQ, 2011).

A clear illustration is revealed from a focus groups carried out in Boise, by the Saint Alphonsus Medical Group providers and leaders and refugee agencies such as the IRC, who came together to attempt to determine the reason refugees were not receiving appropriate health care. This project was entitled "Culturally Appropriate Resources and Education (CARE) Maternal/Child health clinic in Boise Idaho." The focus group participants included: Somali- Bantu individuals and refugees that frequently visited, Boise Pediatrics, Women's Health, Schools for Pregnant Teens and Community Partners. (Widener, et.al, 2010)

Due to refugees' previous history trauma and abuse, a focus group assessment revealed that, pelvic exams in particular, practiced on the refugee patients, made them very anxious and uncomfortable. A nurse revealed that on one occasion, she had to stay with one woman holding her hand for 45 minutes, to gently reassure the patient, before and during the exam. Some patients also revealed in this study that they did not like going to hospital or clinics due to the fact that they feared other medical exams, they were unfamiliar with the medical system, their appointments took longer and that too much was expected of them(Widener, et.al, 2010). Results from this study indicate the need for specialized care for refugees that would address the emotional impact of health exams on emotionally and/or sexually traumatized patients (AHRQ, 2011).

Cultural conflict or barriers may arise. Most of these older generation refugees, despite the fact they are in a new cultural environment, insist on being faithful towards

their traditional practices which are misunderstood by cultural outsiders. Practices include bearing of many children even if parents cannot afford to sustain those children's well-being; the rejection of the use of contraceptives, polygamy and wife inheritance, which increase the chances of sexually transmitted diseases; and female circumcision practices such as clitoridectomy, excision and infibulation, which are common amongst the Somali- Bantu populations (Department of Health and Human Services, 2009; Parve & Kaul, 2011). In relation to culturally-specific health practices, refugees are often not familiar with Western medicine, therefore, reacting with fear and avoidance when accessing care (Widener, Hobbs et.al 2010). This unfamiliarity in combination with histories of physical and emotional trauma has been said to make refugee women fearful of physical examinations and anxious about medical screenings and tests that use unfamiliar equipment (Ekstein, 2011).

Healthcare System factors:

Language Barriers

Because refugees are most often non-English speaking or speak limited English, it is difficult to communicate with their providers regarding their actual medical condition or health needs. (AHRQ, 2011) Due to the increasing number of refugees in the United States, there is a high demand for interpreters who can teach refugees so as to eradicate this issue of language barriers.

Healthcare institutions have developed policies and procedures to prevent the use of family members to interpret for their patients. The Office of Civil Rights, U.S. Department of Health and Human Services has particularly discouraged the use of children as interpreters in cases where refugees are accompanied by a minor, (Gilbert,

M.J. 2005). Gilbert in his case study also mentions that there may be other barriers, such as religious, spiritual and moral issues, to the use of minors in healthcare settings. For instance it may not be considered appropriate for minors to discuss topics like sexual practices, obstetrics and domestic violence (Gilbert, M.J. 2005).

Some of the major reasons as to why minors, other family members, or untrained persons should not be used is due to the following concerns associated with (a) role reversal, where the child ends up being the one to have to process information and provide support to the parent, (b) editing, where not all the information is revealed to the parent as the child will be doing so in support of their personal views, (c) mistakes, where the child is not knowledgeable enough, (d) guilt, where the child feels as if they are the cause of misery as they are the ones conveying the message, (e) omissions, where the adult leaves out the crucial but sensitive information they do not want the children to know about and lastly, (f) confidentiality, where the children may not fully understand patient provider confidentiality and reveal information to others (Gilbert, M.J. 2005).

Now for example if a Somali woman at St. Alphonsus cannot use her husband or daughter to translate for her some problems may arise. They may not be comfortable with the interpreter provided to them due to unfamiliarity or fear that their health issues will be disclosed to other community members.

Insurance and other payment issues

Most immigrants and refugees face barriers to obtaining health insurance, a factor that could prevent them from seeking health services. A study mentioned previously conducted by the Lake Snell Perry Mermin/Decision Research team

indicated that amongst the individuals from the 32 focus groups that were conducted, consisting of refugees who had live in the United States for no more than 10 years, most of the participants did not have insurance and were not receiving preventative care (Robert Wood Johnson, 2006). Another study revealed that the barriers related to refugees included coverage gaps due to the obstacles that they faced when attempting to enroll in the public insurance programs they sought (Morris et al., 2009).

Due to their limited ability to work or their limitations of job opportunities, having insurance through their work place was not an option, and for those who may qualify for some insurance, financial hardship came about due to the many insurance fees, co-payments and out of coverage prescriptions (Morris et al., 2009).

Provider Challenges

In addition to cultural factors is the fact that providers have limited knowledge in diverse cultural practices and hence they find it more difficult or more time consuming to attempt to meet the needs of the refugee mothers effectively. This is evident in many research projects, including one by researchers in University of California in San Diego that found that one of the top perceived major healthcare access barriers included the cultural competency of physicians (Morris et.al. 2009). Another illustration of this issue is evident in the CARE Maternal/Child health clinic once again, where provider knowledge of diverse cultural practices was identified as an issue, to the extent that they identified providers as not being fully equipped to address the cultural and emotional needs of expectant refugee mothers (AHRQ, 2011).

Healthcare process factors.

Some factors can be related to providers' lack of cultural competence; however these factors not only apply to providers but people within the healthcare system that interact with refugees.

A. Stereotyping:

This can be defined as "…a fixed, overgeneralized belief about a particular group or class of people (Cardwell, 1996)." It also can be defined as the process by which people use social categories such as race and sex in acquiring, processing and recalling information about others. Considering the fact that refugees can be placed in these different social categories, they are more likely to be stereotyped. The problem with stereotyping when it comes to refugees and healthcare is that healthcare providers may make generalizations about them. In Canada, a study looking at barriers to health care for refugees established that some providers were hesitant to attend to refugee patients as they stereotyped them as being more challenging. This was due to the fact that they had more complex health needs, took longer appointment times, presented language barriers, and/or involved complicated payment and insurance issues such as delays and lower financial compensation (McKeary & Newbold, 2010).

B. Prejudice or Bias

Psychologists refer to prejudice as an unjustified or incorrect attitude (mostly negative) towards individual based on their membership in a social group. (McLeod, 2008) Being minorities, refugees are more likely to receive prejudicial attitudes, such as not being intelligent (due to being non-English speaking, or lack of education).

A study was carried out where researchers recorded actors of different races who presented themselves to providers with the same symptoms for cardiac disease. Physicians referred white male, black male and white female hypothetical patients for cardiac catheterization at the same rates, but they were less likely to refer black female patients using the same symptoms. (Schulman et al. 1999)

Ryan and Burke (2000) performed a clinical study that found that doctors were more likely to ascribe negative racial stereotypes to minority patients. Finucane and Carrese (1990) with their study they came to the conclusion that physicians were more likely to make negative comments when discussing minority patients' cases. All these research illustrations suggest that healthcare providers' diagnostic and treatment decisions, as well as feelings about their patients, are influenced by race or ethnicity and thus leading to disparities in health care that patients receive.

Interventions to address the barriers

From an ethical perspective, health disparities should be addressed due to the fact that they are unjust. Clearly considering all information previously discussed, we can conclude that refugees groups are certainly vulnerable to injustice as they consist of people living in poverty, they consist of racial, ethnic and religious minorities, they are non-English speakers, most have disabilities from the war and they are obviously recent immigrants.

Social justice should be applicable to all especially when it comes to healthcare situations. It would not be fair for one to be subjected to all the burdens within the United States such as paying of taxes, obeying the law of the land and being exposed to risk, but not to be able to receive the same treatments when it comes to their health.

When refugees are subjected to poor care, this in the long run may lead to poorer clinical outcomes than the current miserable situations they are already facing, and higher mortality rates, a factor that undermines their lives as well. To attempt to deal with these issues, we could apply the World Health Organization (WHO) tactics, where in their 2008 international public health report entitled, 'Closing the Gap in a generation,' The report names the responsible actors for these roles as being multilateral agencies, WHO, the National and Local Government, the Civil Society, Research Institutions and the Private Sector. The report also lays out the various social determinants of health that are affecting people in different countries, and further recommend what our top priorities as public health officials should be. They claim that individuals should:

a) improve daily living conditions by empowering and women and children, to prepare them for their futures.
b) tackle the Inequitable distribution of power, money and resources which involves addressing inequities according to the type of population being dealt with, including governmental support and dedicated, willing participants.
c) measure and understand the problem and assess the impact of action by training a strong workforce on how to tackle the social determinants of health and educating all on the social determinants of health.

Other authors such as Whitehead (2007) suggested various actions that one could attempt to reduce health inequalities. Although somewhat similar to the suggestions from the WHO articles, her wording covers a different direct aspect as to what is required of those responsible for closing the health gap. These actions include: strengthening those

who are affected and their communities by giving them training and jobs to earn a better living, improving living and working conditions and finally promoting healthy macro-policies.

Despite the various ways that community and the government can help them, individuals also have a responsibility for their own health. Health inequities can be influenced by personal choices in life. The principle of Health Equality requires that everyone has equal opportunities and suggests that if one does not take advantage of those equal opportunities before them then we cannot consider this situation as unjust.

Conclusion

In conclusion, most refugees have suffered from the countries that they came from and are seeking a better lifestyle in the United States. This study aims to examine the barriers that they have towards their healthcare and the challenges that they face when they come to the U.S. This literature review has explored the possible barriers that have been documented in the past. By getting individuals' personal opinions, the present research may identify barriers that may not have been covered in the past. Suggestions as to how to address these problems may also arise from the results of the study. In order to eradicate these barriers towards healthcare for refugee population, the factors mentioned in this paper should be addressed accordingly.

CHAPTER III: METHODS

Purpose of the study

The purpose of this study was to explore the experiences of African refugees in accessing health care within Boise Idaho. This project was to identify various avoidable circumstances that negatively impacted the health of refugees. The results of this study would attempt to create a large impact on improving healthcare for the refugee population as a whole. This section focuses on the use of document analysis (reading and analyzing documents) and interviewing as the main sources of research information, and data collection strategies to address the following three study aims:

1. To identify the major socio-cultural and economic factors influencing health among refugees through the refugees' perspectives.
2. To explore refugees' perceptions of effectiveness of various health programs and services in both improving health and protecting their human rights.
3. To determine the most effective as well as the missing factors in programs that have already been implemented in regards to refugee health care.

Research Design

In order to conduct this study appropriately, a multi method qualitative approach was used as follows:

Firstly, document analysis, also referred to as content analysis, of public records from local, state and national programs, which have aimed to improve the lives/health of

refugees, was performed. This process has been defined as, "a research method for the subjective interpretation of the context of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p.1278). The researcher developed questions that were intended to be answered through the document analysis, and also used this method to provide information on issues faced by the refugee population as a whole — as well as point out the current programs addressing refugee healthcare needs. The researcher was also able to establish factors such as the most successful methods that had been implemented in other programs. Information was initially sought from journals, research reports, newspaper, magazine and journal content, and government and NGO statistics.

Thereafter, one on one interviews with refugees' were conducted as a second source of information, to create a dialogue with participants in order to explore perceptions and experiences of refugees. The main subjects of interest were the barriers to healthcare, specifically economic and cultural, as they related to refugees' whose whole way of life had changed since they came to the U.S.

These qualitative approaches were more suitable for the type of research being conducted as the researcher accessed information from the past through the secondary method of researching previous studies, and accessed newer information from interacting with individuals that were more likely to be new immigrants within Idaho, when carrying out the primary research.

Data analysis and interviewing qualitative methods were also chosen due to the fact that the study population consisted of individuals who had none-Western

backgrounds and English was not their first language. Therefore by using qualitative methods the researcher would be able to understand and represent the lived experience of individuals- based as closely as their perspective as possible (Elliott, Fischer and Rennie, 1999), thus enabling us to better understand refugees experiences with healthcare in the U.S.

Study Area

Documents were acquired from a systematic review of interventions for refugees from the online database entitled Agency for Healthcare Research and Quality (AHRQ). AHRQ was a website owned by the U.S. Department of Health and Human Services, whose mission is to, " produce evidence to make health safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services(HHS) and other partners to make sure that evidence is understood" (AHRQ, 2014).

The keywords that were searched from the AHRQ's Website: "http://www.ahrq.gov" was the terms "refugee" or "refugees." Using the inclusion and exclusion criteria, the documents were considered if they met the following criteria: a) included quantitative, qualitative or mixed methods results, b) were written in English, c) included refugees, their challenges, health interventions and any suggestions for improvement for the innovation.

The reviews were excluded if it was not conducted in the U.S.; if it did not target both the male and female refugee population, as well as if it was not focusing mainly on the refugee population. For example a study that discussed mainly on the Hispanic

population, but mentions refugees as part of the vulnerable populations would be excluded.

This information collectively was used to determine what had been done in the past to help refugees settle in their newly acquired land in regards to their health.

The interview research was conducted within Boise, Idaho. Areas targeted were residential areas that had numerous numbers of African refugee residents. Boise, Idaho had been selected as the study area due to the fact that it is the home to main resettlement agencies such as The World Relief Organization, The International Rescue Committee as well as other independent health organizations such as Tidwell Social work services and The CARE maternal clinic that targeted refugee populations. The researcher was also under the assumption that refugee populations within Boise had more experience with the healthcare system in the U.S as compared to residents of smaller cities and towns.

Research Setting and Target Population

The participants targeted for this study were African male and female refugees that migrated to Boise, Idaho within the past 5 years and were over the age of 18. These years were chosen due to the possibility of comparing the views of newly migrated refugees to those who had been in Boise for a longer period of time. This study primarily focused on refugees who spoke English language.

Two personal community contacts volunteered and were utilized to select and recruit English speaking African refugee participants for the interviews. These contacts identified possible participants and discussed the purposes of the research with those

refugees. The first contact was Susan Kagwira a self-employed Swahili language interpreter who has a lot of experience with African refugees. The second volunteer was Emanuel Ndikubwimana a former African refugee, who has been in the United States since he was about 8 years of age. These contacts acted as a cultural liaison for the researcher. They suggested and identified possible participants with more valuable information. With the advantage of them knowing the participants personally, they introduced them to the researcher. When necessary, they also discussed the purposed of the research with the potential participants, but did not conduct any interviews. After the initial introduction, the community contact stepped out and the one on one interview was conducted.

Snowball sampling was also used. Participants were asked to recommend other friends of family members who may be interested in participating. Participants who meet the recruitment criteria of the study and were willing to participate in the study were recruited. There were no penalties for refusing to participate in the study.

To determine the sample size of the refugees, the saturation method was used. Data was collected and analyzed until the researcher reached a point of saturation. This is when the data being collected does not shed any further light on the issue being investigated, and hence no more information can be collected (Glaser and Straus, 1967).

Conceptual framework

This project followed the PEN-3 model which centralizes and integrates culture in the study of health behaviors and intervention development within groups such as refugees. Using this model the researcher examined how cultural context shapes health

beliefs and practices, as well as the role of family systems in enabling or nurturing positive health behaviors and outcomes. Lastly using the third domain, this model was used to examine the cultural practices that created positive, neutral and/or negative impacts on refugee health (Ethnicity and Health, 2014). All these factors were explored through the adaptation of the model to the research instruments which will be used to guide the analysis of documents and development of the interview guide.

Research Instruments

Document Analysis Guide: This guide as depicted in (Appendix B) consisted of 6 questions, which were used for the purpose of the document analysis of the AHRQ articles which discussing programs established and implemented in Boston, Massachusetts; King County, Washington; Boise, Idaho and Chicago, Illinois. Questions in the guide had been adapted from the PEN-3 model focusing on culture, in order to establish factors such as the role of the refugee as an individual in regards to their health, the challenges faced by the refugees in the various states, the impact of culture and language, and the methods that had been implemented or suggested to improve refugees' health status within the U.S.

Interview Guide: The interview guide consisted of 20 questions which included demographic information and their experiences accessing healthcare in the U.S. (See appendix C). A copy of the interview guide was handed to the participants. This enabled them to follow along, as the questions were being read out loud by the researcher. The anticipated time required to answer these questions was approximately 60 minutes per participant- depending on their literacy and fluency in English. Interview questions were

adapted from the PEN-3 model, addressing mainly refugees' culture, their personal identity and their relationships and expectations.

The guide covers a vast range of information classified in two sections. The first section entitled Personal Information includes socio-demographic information, such as the gender, age, country of origin, educational level, marital status and language. In addition, questions address the number of years they have been in the U.S, their careers (if any) in their previous countries of origin, the number of children under the age of 18 as well as the number of dependents they are responsible for, and the number of refugee friends they have in Idaho. All questions in this section are close-ended, requiring short-specific answers. The last second section, entitled Health Related Questions, is the main section of the guide, which will be the basis of this study. All questions are open-ended and reflect the cultural competency domains from the PEN-3 Model. Questions address the refugees' attitudes about and experiences with the healthcare system. Barriers and facilitators for accessing care, including health insurance, resources, knowledge and the role of culture and/or religion will all be explored. See appendix C for a list of questions.

Pre-Testing

A total of five participants were interviewed prior to conducting the study, using the interview guide. This pretest was conducted to determine whether the responses would be beneficial towards the study; to determine whether the wording on the questionnaire needed improvement; and/or to estimate the time needed to conduct the interview.

Data Collection Techniques

The document analysis focused on different programs that have aimed to improve the lives/health of refugees. Using the instrument in appendix B, The researcher would be able to establish factors such as the differences between local and national initiatives, the most successful methods that have been implemented among others. Information was initially sought from journals, research, reports, newspapers, magazine, and government and NGO statistics but only the articles in the AHRQ website were selected.

Interviews with refugees focused on the barriers to healthcare, specifically economic and cultural, as they related to refugees whose lives had changed since they came to the U.S. One on one interviews were conducted with the refugees in a mutually agreed upon time and location. Potential participants were contacted and the purpose of the research was explained to them. After obtaining their consent, the interviews begun.

All subjects that the researcher obtained information from were informed about the study prior to the process. None of the participants were involved in the study without their knowledge. A waiver of documentation of consent was requested and approved by the Institutional Review Board (IRB). By excluding the participants' signature on the consent form, in the process of obtaining consent, the researcher reduced the possibility of the refugees being exposed to a higher risk of being identified. Through this method, the researcher could also gain the subjects trust, encouraging them to be more open and truthful when conducting the interview. All the information acquired from the qualitative methods mentioned above was gathered by mainly note taking. No information was

withheld from the subjects in regards to the research of the project other than any information that did not concern them as an individual.

Data Analysis

All responses from the document analysis guide were gathered through note taking and input into excel. The interview guide data was gathered using the qualitative data analysis mobile phone application for android phones, known as ATLAS.ti, along with note taking. The ATLAS.ti software was used specifically for interview data organization and management. Thereafter, excel was used for the interview data. This information underwent the qualitative content analysis processes of preparation, organizing and reporting (Elo and Kyngas 2007). The purpose of using these three methods was to attempt to make sense of the data.

Subsequently, the data from the interview guides was handled in two ways. Information from note taking was analyzed ideographically and transcribed from notes to statistical software for analysis known as Microsoft Excel 2010 and the data obtained from the ATLAS.ti Mobile application was downloaded to the desktop version of ATLAS.ti, to utilize the programs analysis tools. Data information from the document analysis guide was handled separately from the interview guide using Microsoft Excel as the main analysis software. Collectively this information was handled using the commonly practiced methods of analyzing quantitative data in the following way:

First, the data was identified, coded and then categorized into patterns and themes. Interesting factors were placed on the right hand margin of the excel document whereas the emerging themes were placed on the left hand side of the document. The

numbers of categories were then shrunk by selecting, ordering and clustering them into similar groups (Patton, 2001). Results from this analysis helped the researcher know the views of the refugees, thus revealing the information needed for the research. . By comparing the results from the document analysis to the experiences of the refugees, the researcher was able to determine if the recommended programs are addressing the needs of refugees interviewed in this study.

Limitations

As in many research programs, some limitations were anticipated. Such issues included the possibility of language barriers arising as well as the uncertainty of the willingness of the subjects to participate in the study. Another issue that was expected when collecting data was that the researcher was not guaranteed to get all the questions answered by each participant and hence could only gain access to partial information.

The study also represented a small fraction of the refugee population and hence it would not be wise to generalize the results to apply to all the African refugee populations. Lastly, the use of qualitative analysis as a choice of collecting data could lead to inaccuracy due to self-reported data being unconfirmed.

To deal with these challenges, on noticing a respondent having difficulty with answering the questions, the researcher rephrased the questions in order to elicit the information sought for the study. To ensure that the participants answered all the questions of concern, the researcher ensured that ample time was set aside during the meetings. The researcher also made certain beforehand that the questions were simple, brief and to the point.

The researcher also ensured that there was uniformity in the number of questions answered to avoid skewing the data being collected. Many refugees were targeted and the researcher attempted to establish a relationship of trust before conducting the interview using eye contact, being open about the study and making certain that they understood that sensitive information would be handled in a private manner.

Chapter IV: QUALITATIVE STUDY RESULTS

This chapter presents the analysis of documents collected from the Agency for Healthcare Research and Quality (AHRQ) Innovations Exchange website that described effective evidence-based programs that address refugee health along with interviews with local African refugees. It outlines the outcomes of this research through a detailed interpretation of the conducted interviews and further describes the results for the interviews in the context of best practices that were identified in the AHRQ programs.

Identification of Documents

The analysis of existing documents was one of the methods used to enable the researcher to determine the issues that refugees face as a whole throughout the United States. Other purposes of using this method of research are identifying current programs that address refugee health care needs, establishing the differences between local and national initiatives, and discovering the most successful methods that have been implemented by various programs throughout the United States.

Searching the AHRQ website using the terms, "refugee" or "refugees," initially resulted in 21 literature search results classified under the title, "Innovations." The results gave a description of different programs for the target population. An additional eight documents related to refugee health were classified under the title, "Quality tools." These were quality improvement measurement tools and information used for refugee populations, which would enable one to conduct studies. They include the refugee health screener, the oral health exam and other various tool-kits. These eight documents were

considered to be anecdotal data, as they were not descriptions of the innovations themselves.

Each of the 21 documents were assessed for inclusion in the document analysis based on the following criteria: qualitative, quantitative or mixed methods results, written in English, and included refugees, their challenges, health interventions and suggestions for improvement for the innovation. However the search did not only focus on the African refugee population, as most of the programs did not single out a group of refugees according to their country of origin.

Amongst the 21 documents only five innovative programs were considered as potentially relevant for this study, as they fully met the requirements of the inclusion criteria. Apart from meeting the inclusion/exclusion criteria requirements, these documents covered the diverse services commonly required and offered to the refugee population. These included trauma, mental health, disabilities, home health services and oral health. None of the studies focused on the participants' age range, or number of years that they had been in the U.S; thus it was unclear if these participants in these studies were representative of all refugee populations.

Description of Program Documents

The first program identified in the document search was the Harvard Program Refugee Trauma (USDHHS, 2008). The Harvard Program in Refugee Trauma (HPRT) was developed, in Cambridge Massachusetts, in 1981, with the aim of promoting the recovery of refugees from the trauma that they have received from various forms of acts of violence and torture (HPRT, 2011). Its vision is to introduce modern medical services

to members of our society who in spite of their great suffering have little access to care. This program not only focusses on African female refugees, but the whole population of refugees, vulnerable populations, immigrants, mentally ill and racial minorities (USDHHS, 2008).

The founders of the program attempted to address the issue of limited, inadequate and inappropriate or no access to mental health services for refugees who have experienced trauma. It therefore developed and promoted the use of a unique approach to identify and treat these individuals. This approach involved instilling cultural competence and acceptance in program staff by employing trained workers of the same ethnic background as the refugees, encouraging healthcare providers to abandon theories opinions and biases, using organized interviews to identify and diagnose victims, using long-term treatment plans that aimed to provide recovery and rehabilitation and, lastly, monitoring trauma victims continuously (USDHHS, 2008).

A second program identified was 'The Pathways to Wellness Program. This innovation was implemented in 2010 by the Asian Counseling and Referral Service, Lutheran community Services Northwest, Michael Hollifield, MD, Public Health Seattle and King County, to identify and provide appropriate treatment to refugees new to the U.S. at risk of mental health problems (USDHHS, 2013).

A 15 question screening tool was used to assess refugees who were prone to mental health symptoms such as depression, anxiety and traumatic stress. Those who tested positive were referred to a Pathways program where they would be linked with a

counselor. The counselor would formally assess, diagnose and provide treatment if needed (USDHHS, 2013).

A pilot test with 251 refugees revealed that the program enhanced access to mental health for refugees, as 30 percent of those screened tested positive for significant distress and approximately 70 percent of these individuals were able to be connected to a counselor (Drexel University, 2013).

The third program was entitled, ' The community Connections for Refugees with Disabilities program' (USDHHS, 2011a). In this program, Balfanz-Vertiz describes an AHRQ innovative program that identifies newly arriving refugees with congenital and acquired physical disabilities, and assists them with obtaining rehabilitation and social services, in order to increase their independence and their ability to lead productive lives. It was implemented in 2007 by the Schwab Rehabilitation Hospital and Sinai Health System (as sited in USDHHS, 2011a).

These two hospitals discovered that there is an influx of refugees arriving in the U.S with disabilities who are lacking adequate access to culturally competent medical care and community-based social services. They therefore identified those arriving with congenital and acquired physical disabilities through proactive screening. Those who were identified were evaluated weekly and referred to appropriate healthcare providers for the services they needed. The hospitals further provided the refugees with medical and rehabilitation services such as medication, therapy, orthotics and prosthetics and adaptive equipment (USDHHS, 2011a). Other elements of this program were the

provision of transportation to hospitals for appointments, interpretation services and cultural competency training for the program's hospital staff (USDHHS, 2011a).

An analysis of the program after 6 months of implementation revealed that they managed to help about 100 refugees from different countries, and it was reported that in the year 2010, 45 disabled refugees received services through the program (USDHHS, 2011a).

The Refugee Home and Curbside Care Program aimed at reducing barriers to accessing healthcare and social services was implemented in 2008, in Boise, Idaho, by The Saint Alphonsus Medical Center and the Federal Way Clinic. The program attempted to tackle the issue of refugees not receiving services that they qualified for under the State- administered Medicaid or Refugee Medical Assistance programs. Issues included long waits for initial screenings and referrals, unfamiliarity with the U.S. healthcare system and limited transportation (USDHHS, 2011b).

The program identified newly arriving refugees through resettlement agencies and provided home visit and curbside care services. These visits involved physicals, routine healthcare and the assessment of the need for specialty and follow-up care and services by physicians and nurses. The visits were pre-organized and an interpreter was available in person or by the use of a phone when needed. After the care was established additional services included arranging follow-up care and ongoing contact with resettlement agencies (USDHHS, 2011b).

The program reported that it increased the number of refugees receiving healthcare services and enhanced continuity of care. In 2010, 368 individuals were attended to in

their home. Within the first three months of 2012, 227 patients were reported to be seen (USDHHS, 2011b).

Finally, Zea describes a program that involves the provision of oral health literacy and access to dental services for refugees and asylum seekers in Massachusetts (as sited in, USDHHS, 2009). The program activities include services for both refugees and medical practitioners by incorporating culturally sensitive oral health screening into medical examinations. It was first implemented in 2001 by Boston Center for Refugee Health and Human Rights, Boston Medical Center, Boston University School of Dental Medicine, Massachusetts Department of Public Health and The Refugee Health Assessment Program (USDHHS, 2009).

The program was formed due to the discovery that refugees and asylum seekers who migrated to the U.S tended to have unique health concerns including those involving oral health. It therefore implemented free weekly dental sessions which included culturally sensitive oral health history interviews, screening, referrals and one on one health education. Not only did this program provide services to the refugees but included increasing the cultural competency of the medical providers. Education and training was offered to those who conducted health assessments or provided medical care to newly arriving refugees (USDHHS, 2009).

The outcome of this program was that it demonstrated that 90 percent of refugees evaluated between the years 2002-2006 needed immediate or near immediate dental care. The program also facilitated access to dental care and oral health education (USDHHS, 2009).

Document Analysis results

The document analysis guide (see Appendix B) was used to analyze the five previously described AHRQ Innovation documents on refugee health. Each AHRQ innovations program was evaluated based on factors adapted from the PEN-3 model such as the role of refugees as an individual in regards to their health, the challenges faced by all refugees, the impact of culture and language, and the methods that have been implemented or suggested to improve refugees' health status within the U.S. The resulting analysis identified three themes, major health challenges, impact of culture on health and language barriers and solutions. All of these themes converged to depict a common relationship between the challenges faced by refugees regardless of their origin and their newly acquired land of resettlement.

Major Health Challenges:

One purpose of the research study was to identify the main challenges faced by refugees in regards to their health. Similarities between the documents with regards to these challenges were analyzed and three subthemes emerged. Increase in the prevalence of health problems, lack of access to care and medical services, and culture in relation to refugees and their healthcare providers were the three major subthemes that were identified in the data.

Increase in the prevalence of health problems. Four out of the five articles selected to be analyzed in this study illustrated that regardless of the location of resettlement of refugees, or the selected health problem being faced there was either a high prevalence or an increase in prevalence of the problem. For example, Hollifield

et.al, when discussing the high risk of mental health problems amongst new refugees stated that King County, Washington alone had an increasing number of refugees from the Middle East, Asia and Africa who exhibited mental health symptoms on arrival. They also identified research conducted by Fazel et al. (2005) that found that 9 percent of adult refugees had PTSD and 5 percent major depression (as sited in USDHHS, 2013).

Balfanz-Vertiz also supported this theme when discussing the identification and support of refugees with congenital and acquired physical disabilities. She stated that there were a high number of refugees with disabilities, with the statement that in Illinois alone, 19 percent of the refugees had a disability (as sited in USDHHS, 2011a).

In addition to health outcomes, refugees experiences higher rates of risk factors. In Zea's discussion of oral and dental health for refugees and asylum seekers, the author stated that there was an increase in the risk factors for poor oral health such as, poor diet and nutrition, lack of access to oral health and prevention and treatment before and after they arrived to the United States, lack of water fluoridation and torture related injuries to the mouth and face (as sited in USDHHS, 2009).

Lack of access to care and medical services. All five studies reported lack of access to medical care and medical services as a challenge in various forms. This included factors such as a) limited transportation, where most refugees depended on public transportation, making it difficult to get to their appointments; b) Lack of some forms of screening on arrival to the U.S, especially when it came to the unavailability of psychiatrists or other medical professionals who could evaluate the medical and therapeutic needs of those with congenital and acquired disabilities); c) barriers to

accessing care, including access to social services and community resources. These barriers were described in various forms, such as the lack of knowledge of individuals with disabilities as well as the cost of care, limited English proficiency and fear of unfamiliar medical practices. Together, these factors can lead to significant long-term adverse consequences that are irreversible and costly (USDHHS, 2008; USDHHS, 2009; USDHHS 2011a; USDHHS, 2011b; USDHHS, 2013).

Culture in relation to refugees and their healthcare providers. Three studies reported the impact of culture on the perceptions and behaviors of both health care providers and the health care providers and refugees. Molica reported that issues can arise when care is given to refugees based on faulty assumptions (as sited in USDHHS, 2006), whereas Balfanz-Vertiz claimed that health care providers tended to not extend their cultural competence in caring for refugees to understanding the cultural perspectives and attitudes of those with disabilities (as sited in USDHHS, 2011a). Molica and Balfanz-Vertiz also described the impact of inadequate cultural competence on the part of the individual provider (as sited in USDHHS, 2006; USDHHS 2011a), whereas Greenberg focused on the refugees' lack of knowledge. In Greenberg's description of the Physician-Nurse house calls program, the author related the cultural impact of health to the unfamiliarity of the refugees with the U.S health care system. He claimed that many refugees had little knowledge of the U.S health care system and Western medicine and therefore did not understand the services that they were entitled to (as sited in USDHHS, 2011b).

Impact of culture on health

Four of the studies stressed the importance that health care workers for the refugee populations understand the culture of the individuals they serve due to culture being a barrier to effective healthcare. When it came to the refugees screening tools, it was important that these were formulated into culturally sensitive tools. An example of this is clearly illustrated in an innovation which focused on creating culturally sensitive screening and follow- up for arriving refugees (USDHHS, 2013). They designed versions of the screening tool in multiple languages in order to be sensitive to the refugees' native cultures. A refugee would not understand the term "blue" which in the U.S denotes melancholy or sadness and think that it was just a color, and the word had no emotional connotation (USDHHS, 2013).

Language Barriers and Solutions

Three factors demonstrated the importance of addressing language when it came to refugee healthcare. First, limited English-language proficiency can be a barrier to accessing healthcare and thus lead to long term adverse effects. Zea, supported this statement by stating that language was one of the factors that often hindered refugees in need of dental services from seeking treatment (as sited in USDHHS, 2009). This was also evident in the screening program whereby Hollifield M et al., stated that language was one of the major barriers to screening effectively (as sited in USDHHS, 2013).

Secondly, catering to language barrier issues can be costly. This is evident in The Physician-Nurse House calls program, which stated that they had to include three

companies who offered phone language interpretation services for their program to be successful (USDHHS, 2011b).

Finally, when interpretation services were offered the programs were successful. When targeting newly arriving refugees for screening for mental health problems, Hollifield M, et al., developed a screening tool in different languages which led to an identification of a larger number of individuals who were at risk and connected them with a counselor (as sited in USDHHS, 2013).

Developing Successful Health Interventions

In order to improve the health of refugee populations' common methods that were illustrated in the programs included screening, training of cultural competence and acceptance and follow-up and ongoing monitoring of refugees.

Screening: All programs implemented some form of screening method to make their program more successful. Mollica in the HPRT program, utilized initial semi structured interviews to identify and diagnose victims (as sited in USDHHS, 2008). Hollified et.al, used the scoring method to identify refugees at risk for mental health problems (as sited in USDHHS, 2013). Balfanz-Vertiz, Greenberg, and Zea used similar screening methods as well. These methods were pro-active screening, the provision of physical examinations, interpretation services, free dental sessions and culturally sensitive interviews amongst others (as sited in USDHHS, 2009; USDHHS, 2011a; USDHHS, 2011b).

Training of cultural competence and acceptance: Cultural competence and acceptance training was encouraged for all healthcare providers. For example, the HPRT

program required the use of workers from the same cultural background who would work closely with the healthcare providers. They also encouraged the health care providers as a whole to abandon all perceived notions, including theories, opinions and biases about refugees (USDHHS, 2008). Both the disabilities program by Balfanz-Vertiz and the oral health and dental care programs by Zea achieved this by stating that the providers underwent training and education to help meet needs of the refugees that they were serving (as sited in USDHHS, 2009; USDHHS, 2011a).

Follow-up and ongoing monitoring: All five articles found this to be an important method of improving refugee healthcare. This care would be provided at a set period of time- every 6 months as demonstrated by Mollica (as sited in USDHHS, 2008), or as needed as in the case of the assessment of mental health refugee victims in Seattle, Washington by Hollifield et.al., (as sited in USDHHS, 2013).

Successful Outcome of Interventions Access to Healthcare:

The main theme reported by all five articles when discussing the outcome of their interventions was better access to healthcare. Mollica reported that for the trauma victims in Boston, there was an increase in those who were experiencing cessation of symptoms and returning to their relatively normal physical and mental abilities (as sited in USDHHS, 2008). Hollifield et.al pointed out the enhancement of access to mental services for at risk refugees as well as the increase of connections of these individuals with various counselors (as sited in USDHHS, 2013). As for Balfanz-Vertiz and Zea since the target populations in both articles had demonstrated a need, there was an

increase in access to medical services and care (as sited in USDHHS, 2011a; USDHHS, 2009).

Other positive factors were demonstrated to result in better health outcomes through accurate and early identification of health needs and appropriate integrated services. These included the validation of screening tools such as the use of the Hopkins Symptom Checklist-25 (HSCL-25) as being an effective method to use when screening refugees for psychiatric symptoms by Mollica. This was validated by the fact that the (HSCL-25) was well received by the refugee patients and was believed to offer effective screening methods for anxiety and depression symptoms as well as being very helpful when evaluating trauma victims (as sited in USDHHS, 2008).

Secondly, some interventions led to the identification of those at risk or those who needed care. For example, Hollified et.al, revealed that even though refugees underwent screening for physical health problems during the resettlement process, mental health disorder screening was often ignored. The screening method therefore used in their program was mentioned to be a quick and effective way to identify high risk individuals (as sited in USDHHS, 2013). Zea, used culturally sensitive interviews to identify those with oral health issues amongst the refugee patients (as sited in USDHHS, 2009).

Lastly, there was better continuity of care including social services as demonstrated by the Refugee Health House Calls Program (USDHHS, 2011b). Greenberg revealed in his program that due to the fact that Boise had limited access to public transportation, a program that would bring the services to the patients' home would improve continuity of care by providing basic primary care in the 8 month window

of Medicaid eligibility. Through his program, many elderly and disabled refugee patients in need of routine care for chronic illnesses were getting better medical attention (as sited in USDHHS, 2011b).

Sustaining Interventions:

Because the documents consisted of varying innovations, different methods were used to ensure that the programs kept functioning even after the original funding ended. These methods may be adapted to work in other programs as well.

Mollica, described multiple methods to ensure sustainability. One was to change from the use of informal interviews to the use of screening instruments in order to engage their participants. The author described the need to develop ways to understand pharmacology in relation to ethnic groups and provided the example that Whites tended to need higher doses of anti-depressants in comparison to other ethnic groups. Program developers also encouraged healthcare providers to focus on specific symptoms such as pain or insomnia and not conditions or diseases such as PTSD and lastly, to evaluate their progress over time and make necessary adjustments (as sited in USDHHS, 2008).

Hollifield et.al., encouraged tracking changes amongst the refugee populations and adapting accordingly. An example given was the development of a screening tool in the appropriate language of refugees arriving from a new region due to world events. Another method that was suggested to ensure that this program was a success was to monitor the proportion of positive screens, so as to determine if upcoming problems required further investigation and remediation (as sited in USDHHS, 2013).

Balfanz-Vertiz, suggested the method of integrating one's program into an existing organizational structure based on the need. They therefore integrated their program into the Sinai Health System Hospital after the leaders determined the need for a disabilities program for the growing number of refugees who were disabled and lacked access to care and services. They also sought grant funding from organizations that supported the needs of refugees (as sited in USDHHS, 2013).

The methods suggested by Zea, could be applied to other programs as well. These methods included prioritizing cultural sensitivity when dealing with refugees and their unique concerns; ensuring that their tools were up to date and accurate and lastly co-locating to cut back on costs as services and equipment may all be available in one location (as sited in USDHHS, 2009).

Lastly, Greenberg, suggested the importance of working closely with other organizations, specifically the resettlement agencies to ensure that the refugees were receiving the appropriate care. This program also suggested the importance of investing in an electronic medical record system whereby providers can access medical information outside the hospital environment (as sited in USDHHS, 2011b).

The document analysis revealed many useful measures that could be replicated by new and/or developing programs in order to make them successful. Such measures included, taking action before a problem became worse; creating better channels to receive healthcare; developing and testing of screening measures; incorporating culture and religion to reach out to the refugee communities effectively; being aware of the changes amongst the population of refugees they are dealing with and adapting to their

needs accordingly; and finally, monitoring and evaluating the progress of the programs and identifying what more can be done to sustain them.

Interviews

Description and Background of Participants

Seventeen subjects were interviewed with the help of personal community contacts. These contacts acted as liaisons by introducing me to the refugees. The participants in this study were also selected through snowball sampling where the refugees who were being interviewed were requested to recommend any family members or friends who would be willing to participate, however, these efforts were minimal. The interviews were conducted in English between November 8th and November 26th 2014. Each interview averaged 45 minutes in length and ranged between 30 minutes to 60 minutes.

Amongst the participants, there were 10 (58%) female refugees and 7 (42%) male refugees ranging from 18 to 45 years of age (see Table 2). The mean age was 35 years. The most common country of origin among the participants was The Democratic Republic of Congo 42% (n=7), followed by Tanzania at 18% (n=3). The remaining seven participants were from Togo, Sudan, Burundi, Ethiopia, Rwanda, Somalia, and Eritrea.

The language other than English most commonly spoken by the refugees who were interviewed was Swahilli, followed by French. Other languages included: Kirundi, Mina, Kibemba, Kizugua, Kirundi, Tigrinya and Kisomali.

Government Assistance. The categories of financial assistance that the government provided to the participants interviewed and their families included: Medicaid, food stamps, Social Security Income (SSI), housing and daycare.

Thirty five percent (n=6) of the participants were married whereas the other 65% (n=11) were single, divorced, widowed or separated. Most of the participants were currently employed (71%). In regards to their level of education, 41% of the participants were illiterate and had no form of formal schooling in both English and their native language. The distribution of educational levels amongst the other participants included some elementary education (18%), secondary education (12%) and college education (29%). A complete demographic profile of participants may be viewed in Table 2.

Table 2.

Characteristics of the Respondents.

Characteristic	**All respondents (N=17)**	**Percentage (%)***
Age		
Mean (35)		
< 29 yr	6	35
30-39 yr	6	35
40-49 yr	4	24
< 59 yr	1	6
Marital Status		
Married	6	35
Single	11	65
Sex		
Male	7	41
Female	10	49
Work Status		
Employed	12	71
Unemployed	5	29
Education		
Elementary	3	18
Secondary (Senior high school)	2	12
College	5	29
Illiterate and no schooling	7	41
Country of origin		
Congo	7	41
Tanzania	3	18
Burundi	1	6
Somalia	1	6
Ethiopia	1	6
Eritrea	1	6
Rwanda	1	6
Togo	1	6
Sudan	1	6

* Percentages may not total 100 because of rounding.

The results from this study follow the responses of the refugees to the interview guide questions in Appendix C, which sought to find the various common challenges that English speaking African refugees face in Boise, Idaho regards to healthcare. Amongst the themes, the participants' responses tended to relate to how long they had been in the U.S. and to their age. Those who had been here for more than 3 years and who were younger reported themselves to be more comfortable with the system. The major themes derived from the responses are summarized in Figure 4 below and are described in the following section:

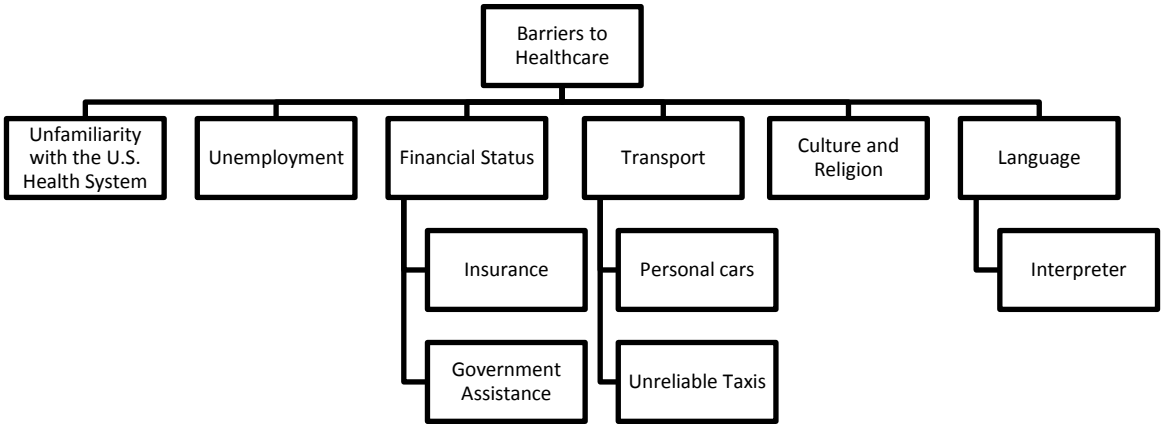

Figure 4: A figure representing the major themes and subthemes of health challenges for African refugees in Boise, Idaho

Unfamiliarity with the U.S. Health System

Unfamiliarity with the U.S. health system was a common challenge reported by the female participants who were interviewed. The participants reported that they were not only unfamiliar with the U.S healthcare system but also with diagnoses and treatments. English language ability did not affect these barriers, with participants stating that despite their competency in spoken English, these challenges still existed. For example, one participant stated "Most often, I do not understand the type of medications given to me at the clinic, making me feel like I am unable to better my health."

Another participant reported feeling as though the U.S possessed uncommon illnesses in comparison to the diagnoses that she was familiar with, and did not know whether to associate the difference to the type of food or the weather. She stated, "Like the flu, everyone in Congo got the common cold now and then. In the U.S however, the flu is more of a life and death situation."

Impact of Unemployment on Health

Despite the fact that the participants had worked in previous positions in their countries of origin, this was not the case on coming to the U.S. Some of the participants had professional jobs such as nursing and teaching and non-professional jobs such as babysitting and hawking of goods. This study however revealed that there was no specific relationship between the level of the participants education and / or experience and having a job, as both the educated and non-educated and the experienced and non-experienced were employed in the U.S.

According to the participants, other factors are what determined their status of employment. These factors included one's inability to work due to medical issues, such as trauma and head and back injuries from war, one's role as a mother, the lack of qualifications and the lack of fluency in English. One participant also singled out the fact that her age made it hard for her to work. She stated, "If it were not for my age, I would work hard and live the American dream of being successful. Now I can only stand upright for so long."

The participants who had been or who were currently unemployed revealed that unemployment could indeed be challenge to health amongst individuals. The female participants who were unemployed responded by revealing the psychological impact of unemployment on one's mental health. One described herself as being miserable as her health issues made her incapable of working, while the others described themselves as being depressed from being idle. Two other participants did not like the fact that they did not have extra money to spend on various things that they needed including their own medical expenses.

Financial Status as a Barrier to Health

Health insurance. Three of the male participants reported that they did not have health insurance even though they were employed. Most of the other participants were either on Medicaid, or had insurance based on their employment. One participant stated that, "Health insurance is expensive, and because I do not get sick very often, I put my money towards other expenses."

Another male participant reported. “Very often I am afraid to get a medical bill and hence I avoid going to the hospital. However, I recently got a job that has health benefits and since it is almost the beginning of the year, I am trying to decide if I should take advantage of this opportunity and sign up for health insurance.”

Transportation. The participants were asked if their place of residence had anything to do with them receiving healthcare. Most of the participants admitted that they did not choose their place of residence based on how close they were to a healthcare facility. One participant reported, “So far, the apartments that I have lived in were selected by the IRC or with help from my social worker. However, I can admit that I requested a home big enough for my large family.”

When asked the ease of access to transportation when seeking healthcare, 11 out of the 17 participants reported that they had their own means of transportation and hence this was not an issue. One participant in this group mentioned that despite the fact that he had a vehicle, it was not as reliable; and this often brought about issues when trying to transport his family around Boise. Another participant often faced challenges when he had to share one vehicle between him and his family members as it was not readily available for him to utilize. Others relied on their friends to transport them whenever they needed to run errands, including their medical appointments.

Dangerous driving conditions and fear of being involved in an automobile accident due to hazardous road conditions was another common issue. A female participant from The DRC stated, “Driving oneself to the hospital is hard especially

during the winter. My first experience with driving was in the U.S and driving in the winter makes me anxious, as I am scared of skidding on the road."

The refugees also mentioned their other option for transportation, which was the use of taxi services paid for by either Medicaid or various hospitals. One of the participants appreciated the fact that these services were available to her, however, she felt frustrated as they were often not reliable. This was based on the fact that sometimes they would either not show up or bring her to her appointment on time, but when leaving her appointment, there would be a delay of up to about an hour, to pick her up. She continued, "Sometimes, I don't like going to the hospital at all because I hate waiting for the taxi!" Another gentleman explained his explained his frustrations with the taxi system as follows: "I remember a couple of months ago, two times, the taxi came to pick me up, but they took me to the wrong clinic. By the third time, when a taxi came to my house to take me to a very important appointment, I was very upset and refused to go."

Culture and Religion

The participants were asked if culture or religion played a role in the decisions that they made in regards to their healthcare. Some participants could not think of anything that they practiced or believed in, that played a role in their decisions towards receiving healthcare. One male participant admitted, "While in Rome, do as the Romans do! I strive to learn and adapt to the American culture, so that I can fit in."

Amongst the participants who felt that their culture or religion impacted their healthcare decisions, one participant stated that since moving to America, they often battled the issue of keeping their cultural beliefs; however being in a foreign land, they

had no option but to adapt, because everything was so new and different to them. She continued to defend her statement by saying, “In my country, I always was taught that western medicine was more effective than our traditional doctors. I therefore feel as though I have to adapt.” In relation to this, another participant felt otherwise. She stated, “Sometimes I do not feel comfortable with the physicians’ diagnosis, as I do not believe in it. I just don’t understand this health system!”

Cultural beliefs seemed to affect participation in common western medical treatments and practices. A female participant from The DRC stated, “No blood Transfusions for me!” On inquiring further, she admitted that this was more of a personal family belief, handed down through her family, rather than the culture of her community. She continued, “My parents always warned me against medicine from a plane.” By this she was referring to Western medicine.

Another participant revealed the impact of cultural beliefs by combining the use of herbal medicine in addition to strong religious beliefs. She stated, “Sometimes it is very hard to decide when it is time to go to the doctor. I am very used to the African way of life, where I would try and treat myself first in various ways. Hot water, lemon and ginger would always cure a cold. Along with that, I would pray constantly for my health.”

Gender roles or care by providers of the opposite sex was a barrier to some of the participants in this study in relation to cultural beliefs and/or religion. One participant from Somali stated, “As you can see, my body is fully covered. As a Muslim, we do not reveal our bodies to anyone but our husbands. The very first time, I went into a clinic and

they were to perform a scan to see my heart, I had to reschedule as the person assigned to perform the test was a man."

Another informant believed that gender played a big role when it came to healthcare as being an interpreter, there were many situations where it was too awkward for him to be able to help the patient efficiently. Another female participant claimed that gynecological exams were not the most comfortable for her, regardless of whether it was a male or female attending to her. These exams invaded her privacy. However she understood the importance of some of the exams. She also claimed that she came from a culture where she was taught to be independent and was used to wanting to learn for herself, other than listening to a doctor.

The interviews disclosed useful themes that reflected the experiences of refugees within Boise, Idaho. Such themes included factors such as unfamiliarity with the U.S Health system, their work status, education, culture and religion and factors in relation to their financial status. The interviews also revealed a reflection of the assistance that refugees receive from the government. All this information could be useful in determining ways of helping the refugee populations, as programs can be focused on areas that are more dominant and crucial amongst these populations.

Chapter V: Discussion

Summary

The purpose of the research was twofold: to identify common challenges and effective practices based on model healthcare programs documented in the Agency for Healthcare Research and Quality (AHRQ) website and to identify the common challenges that African refugees in Boise, Idaho encounter when accessing health care. A multi method qualitative data analysis was the method applied to this research where the data was derived from document analysis of five refugee programs listed in the AHRQ website, as well as from one on one interviews with 17 refugees. The data was analyzed to identify common themes.

The results from the document analysis were compared to the results of the interviews in order to explore the experiences of African refugees in accessing health care within Boise, Idaho. The overriding goal was to identify the various avoidable circumstances that negatively impacted the health of the African refugees who had been in the U.S for five years or less.

This chapter will discuss the major findings, as well as identify the significance and implications of this research.

Discussion

Document analysis. Information from the document analysis was obtained from the AHRQ innovations exchange, a website owned by the U.S. Department of Health and Human Services. The purpose of the innovations exchange is that it is supported by the

Agency for Healthcare Quality and research, a government agency focused on improving healthcare through research on evidence based programs. The innovations exchange is one method of disseminating information about local programs (AHRQ, 2014).

The AHRQ's Innovations database was searched to identify documents describing programs related to the health needs and programs for refugees. The purpose of the document analysis was to identify the issues that diverse refugee populations' in the U.S face. The articles in this study included programs established and implemented in Boston, Massachusetts; King County, Washington; Boise, Idaho and Chicago, Illinois.

In the document analysis, various significant themes arose in regards to refugee healthcare. Themes included an increase in the number of refugees with health problems and barriers to accessing health services, many of which were at the healthcare system level, such as limited and costly interpretation services and lack or culturally competent medical staff. In addition patient-level barriers included limited transportation, English-language competency and cultural practices and beliefs also created barriers to care.

The studies analyzed identified how the current programs were addressing refugee health care needs within their respective regions. The common successful methods used to address refugee health needs included, screening tools to identify and diagnose the refugee victims not only on arrival to the U.S but during their stay, training of cultural competence and acceptance for the health care providers and the ongoing monitoring and follow-up of programs initiated. These methods resulted in better health outcomes through accurate and early identification of health needs and appropriate integrated services.

Methods that would ensure the sustainability of effective refugee health programs despite depreciation of funding that were identified in the document analysis included: the ongoing monitoring of post screening methods, seeking of additional sources of funding and the continuous tracking of the refugee populations to identify the changing needs of the population and adapting to those needs.

Interviews. Interviews with seventeen refugees in Boise, ID were conducted and analyzed by the researcher. Results identified the major themes and responses of the health challenges derived from the participants. These results included factors such as the issues that arise from their unfamiliarity with the U.S. health system, their employment and financial status, challenges with transportation access and finally, the effect of culture and religion on their health.

A review of the refugees' post-resettlement health challenges as opposed to their health status upon arrival to the U.S revealed various factors that stood out. Even though the refugees revealed that they were comfortable with the systems set in place to help them, some barriers and issues needed to be addressed. Firstly, a number of refugees portrayed the effects of unfamiliarity with the U.S. system. This included the frustrations that came about from not understanding their diagnoses and medications, due to language barriers and the difference in the healthcare system.

Secondly, the impact of unemployment on healthcare, where individuals who were incapable of working were depressed from being idle and frustrated, as they could not afford to pay for things that would better their health, such as gym memberships. Unemployment had an impact on their financial statuses as well, whereby income

determined whether they could afford insurance or not. It is important to note, however, that 31 percent of the refugees were still under Medicaid plans offered to them by the government.

Transportation as a barrier to healthcare was the fourth theme reflected in this study. Even though most of the participants had their own means of transportation, challenges such as the unreliability of their cars and fear of driving in harsh weather conditions due to the hazardous nature of the roads. For those who did not have cars, the taxi services that were available to them, were not very reliable.

Lastly, culture and religion brought about significant challenges amongst the refugees decisions towards their health. Some revealed that they strove to adapt to their newly acquired way of life, while others battled the new practices introduced to them as they would go against their beliefs and practices.

Similarities between the document analysis and interviews. The major health challenges within the U.S from the document analysis somewhat concurred with the responses from the interviews carried out with refugees within Boise, Idaho. The document analysis and the interviews both portrayed the possibility of an increase in the prevalence of the health problems. Zea (2009), when discussing the oral health program for refugees and asylum seekers in Massachusetts, revealed that lack of proper diet and nutrition, as well as access to oral health and prevention and treatment led to this increase, while some of the participants interviewed revealed health issues such as depression and increase in blood pressure as impacts of being unemployed on their health, thus leading to an increase in this prevalence.

Another similarity between the two methods of research included the lack of access to care and medical services. This was a common theme amongst all the studies analyzed as well as most the interviews. This factor came about in many forms. Such examples included issues related to transportation and the barriers to accessing care such as unfamiliarity with the U.S system, language and access to social services and community resources.

Differences between the document analysis and interviews. There were certain differences revealed from the research from the document analysis and the interviews. The document analysis covered refugees from different states within the U.S, while the interviews focused on African refugees within Boise, Idaho. Various health problems were therefore highlighted more in the document analysis such as mental health issues (PTSD and trauma), disabilities and poor oral health. Health problems revealed from the interviews included, depression and high blood pressure.

In comparison to the document analysis, as anticipated the interviews revealed a more personal view of the refugees' experiences. For example, the interviews revealed the refugees individual health challenges while the document analysis revealed the effects of not taking action in caring for refugees. The document analysis achieved this by introducing themes such as a high prevalence in refugees with a certain health problems, as well as means and ways of caring for refugees and sustaining the programs to care for them.

Taken together, the findings in this study have demonstrated that there are various systems that have been put in place, that are working for the provision of healthcare for

refugees. However, although these systems have been implemented, this research further suggests that, since there are a growing number of refugee populations, a little bit more effort has to be expended to improve existing initiatives to develop new ones to meet the health needs of refugees.

How the results fit into the literature

The barriers and issues found in both the document analysis and the interviews coincided with the information presented in the introduction and literature review of this thesis. Ramin and Segar (2011), after conducting interviews with asylum seekers and provider/advocacy organization representatives, categorized the barriers to health care access into three groups: Internal, structural and lastly barriers in social assimilation. Widener et al., (2010) also summarized factors that undermined the health statuses of refugees. These factors could be grouped into Ramin and Segars' categories as follows: Fear and anxiety due to unfamiliarity of medical practices (Internal factors), obstacles to care (Structural factors), and limited provider knowledge of culturally diverse populations (social assimilation).

In this study, the barriers to health care access by Ramin and Segar are evident. In the document analysis, looking at the category of internal factors which Ramin and Segar (2011) described as factors such as mental illness, fatalism, mistrust and perceived discrimination, Mollica, 2006 and Hollifield et al., 2013 revealed the effects of trauma, PTSD and other mental health problems as barriers for refugees and the consequences if not tackled. In the HPRT program, Mollica described their approach towards the trauma refugees using strategies such as advocating for cultural competence and acceptance, and

the importance of healthcare providers abandoning of perceived notions (USDHHS, 2008). Hollifield et.al also mentioned the lack of screening of the refugees arriving in the U.S despite the fact that there was a high prevalence of mental health problems amongst them. Lack of screening often led to significant consequences such as their inability to function and thrive in the U.S (USDHHS, 2013).

In the interviews, internal barriers were reflected in circumstances such as ones inability to work due to medical issues including trauma, and the unfamiliarity with the U.S Health System, including diagnoses and the administration of their medication. Two refugees admitted that they often did not heed to the advice given to them by their providers because they were unfamiliar with their medical diagnoses. These results reflected the need for addressing issues of trauma inflicted refugees who have little, faulty, inadequate, and inappropriate and lack of access to internal health services.

For structural factors, which were described by Ramin and Segar (2011) as affordability, limited services, inadequate interpretation services, resettlement challenges and financial situations, themes in both the document analysis and the interviews in this research revealed similar factors such as, the effects of unemployment, financial status of the refugee populations and insurance. Unreliable transportation and language barriers were some of the more common obstacles to care amongst the refugees interviewed.

Barriers in social assimilation such as the challenges they face when navigating a complex health system and the limited support from the community is the third category in Ramin and Segars, (2011) classifications of barriers to health care and is also depicted in this research. The Pathways to Wellness Program revealed the challenges faced by

refugees at risk for mental illness stating that if not treated they would have long-term health issues and have a hard time functioning within the American society. The need for culturally competent healthcare providers amongst refugees strengthens the barriers in social assimilation as well. For example, Zea's Oral Health Program not only provided services to refugees but also focused on increasing the cultural competency of the medical providers (USDHHS, 2009).

From the interviews, barriers in social assimilation could be exemplified to one of the major challenges reported by the participants' unfamiliarity with the health system, diagnoses and treatments. This could lead to worse circumstances such as the mismanagement of their medications. A solution to this obstacle is the provision of culturally competent care by trained providers who could communicate health information that is appropriate for the patient.

Social assimilation could also be related to the challenges faced by the participants as they adapt to American culture. For instance, when a Muslim participant requested a female provider or interpreter and the hospital was not able to meet their demands due to unavailability at the time led to ineffective appointments, as the participant only revealed to the provider what she felt she was comfortable with.

Strengths

The strategies' used to conduct and report the study led to better results than if only one method was used. By using qualitative methods the researcher was able to examine the information in depth. For example, using multiple data sources led to more valuable information, enabling the researcher to represent the refugee population as a

whole. The selection of effective programs also contributed towards better results as it empowered the researcher with information to try and establish what more needed to be done for the refugees to better their health.

When it came to conducting interviews, having participants with a wide range of diversity in terms of their demographics provided an advantage. Such diversity included the fact that their ages ranged from 18 to 45 years, the presence of both male and female participants, the different levels of education and selection of participants from different African countries. This enabled the researcher to obtain better and diverse data towards the research.

Limitations

This research had notable limitations that could be classified into two: a) methodological limitations and b) Principal investigators limitations:

Methodological limitations: One limitation of this study when it came to the interviews was the fact that the refugees' interviewed spoke English; therefore, experiences of non-English speaking refugees was not included in this study. Not interviewing non- English language speaking refugees, therefore, did not depict the major impact that language has, as a barrier for refugee health. For instance, knowing English would not depict the struggles of being able to get a job in a foreign land or the challenges met by not being able to communicate with their health care providers effectively, as even those who spoke English incurred some barriers. It is important to note that asking of questions in the refugees native languages may have led to different results.

Another limitation was the sample size of the interviews. Only a total number of 17 refugees were interviewed. This study used qualitative methods with the purpose of exploring and describing the experiences of refugees; therefore data saturation rather than sample size was important. Because of time limitations and the difficulty in recruiting participants, further interviews were not conducted, so data saturation cannot be ensured. This made it somewhat difficult to find significant relationships from the data and also, the researcher cannot confirm that their responses would be applicable to all the African refugee populations within Boise. However, the results of the qualitative study could inform the development of questionnaires for a quantitative study with a much larger sample size and these results could be used to generalize.

Another major limitation that comes about with qualitative studies and the use of interviews is the issue of self-reported data leading to biased reporting. By using qualitative methods the principle investigator may have encountered various biases such as, selective memory (where events that took place were omitted in the research) and exaggeration (where the data was reported as more significant than it actually was).

Finally, the data analysis was all conducted by the investigator and no team approach was used to come up with a consensus on the themes. The investigator therefore used triangulation of themes to ensure that the results were' trustworthy'.

Principal investigators limitations: The investigator underwent some significant limitations when conducting the study. Firstly, there were access limitations. Despite the fact that there were two community resources used to help connect with the refugees, it was hard to find refugees who met the required criteria for the research. This therefore

led to the investigator trying to find means and ways to identify refugees who were willing to participate.

Communication challenges were common amongst members of this study. Out of the 17 participants, not all participants fully answered all the questions. For those who were willing to answer the questions, the investigator tended to have to rephrase the questions multiple times, which may have created some bias in the results: for example, giving the participants examples, may have introduced ideas into their minds.

Safety was a concern for the female researcher. Interviews were conducted in the participants' homes: therefore, some of the prospective male participants recommended by the community contacts were excluded, in fear of the investigators safety. These individuals may have had valuable information towards the study. Future studies can therefore use a team approach to interview participants, or partner with a clinic or community organization so that interviews can be conducted in a public setting.

Recommendations for future studies

Despite the limitations discussed above the inadequate availability of quantitative research on refugees especially within Boise, Idaho, suggests that the results of this study would produce useful information on bettering the health of the refugee population as a whole. Strategies recommended to improve future studies include:

a) The training of more bilingual interpreters to work with non-English speaking refugees. This would include a larger spectrum of participants who would highlight the impact of language on not only refugee

healthcare but other factors such as employment, adaptation to their new land and fitting into the society as a whole.

b) The conducting of research over a longer period of time and preferably during the summer. This may lead to more viable information and the availability of more participants.

c) Coordination with refugee agencies such as World Relief and International Rescue Committee, so as to connect with an even larger diverse number of participants. This would also eliminate safety issues for the investigator as organized meetings can be carried out in the various agencies that they are collaborating with.

Conclusion

Despite the fact that various strategies have been developed and set in place to assist refugees, results of this study indicate that there is a need to improve these methods, as well as develop newer programs, that would cater to the growing number of refugees within the U.S.

The ideal program would highlight factors such as, supporting culturally competent programs for the health care providers, encouraging community support and encouraging refugee involvement with projects within the community to be able to adapt efficiently, providing easily accessible on-site interpreters verses the use of phone interpretation and the creation of awareness of the needs within this minority population. In addition to reaching out to the Refugee agencies, outside resources such as church organizations should be encouraged when developing such programs.

The ties between the existing community and arriving refugees should be strengthened. This includes their community, health care providers and families. Seeing the positive impact of refugees within our society such as the growth of cultural diversity and their impact on the stimulation of the economic development, would help strengthen these ties. With the willingness of all parties to work together and understand each other's cultures this may help cater to the diverse and evolving needs of this population, especially when it comes to their health.

CITATIONS

Airhihenbuwa, C.O. (1992). Health promotion and disease prevention strategies for African Americans: A conceptual model, in Health Issues in the Black Community, eds R.L.

Airhihenbuwa, C.O. (1989). Health education for African Americans: A neglected task, Health Education, 20, 9-14.

Airhihenbuwa, C.O. (1995). Health and Culture: Beyond the Western Paradigm. Thousand Oaks, CA: Sage.

Airhihenbuwa, C.O. (1999) Of culture and multiverse: renouncing "the universal truth" in Health. Journal of Health Education, 30, 267-273.

Agency for Health Care and Disparities (2011) "Culturally Responsive Maternity Care Clinic Enhances Access to Care for Expectant Refugee Mothers and Their Children" Retrieved February 2012 from US Department of Health and Human Services Website: *http://healthdisparities.virginia.edu/2010/08/15/african-refugees-to-united-states-lack-access-to-adequate-health-care/*

AHRQ Innovations (2011). Refugee Trauma Program uses Novel approach to promote recovery for victims of violence, other trauma: Retrieved February 2012 from Website: *http://www.innovations.ahrq.gov/content.aspx?id=2351*

AHRQ Innovations (2011). Culturally Responsive Maternity Care Clinic Enhances Access to Care for Expectant Refugee Mothers and Their Children: Retrieved February 2012 from AHRQ's Website: *http://www.innovations.ahrq.gov/content.aspx?id=3150*

Child Injury Prevention Methods. (2012). Ecological Model. Retrieved October 20th 2012 from Queensland Government Website: *http://www.health.qld.gov.au/chipp/what_is/ecological.asp*

Clinical issues in refugee healthcare: (2011) The Somali Bantu population: Parve, Julie DNP, FNP-BC, APNP; Kaul, Teri PhD, FNP-BC, APNP Retrieved in Septermber 2013. www.tnpj.com The Nurse Practitioner. Vol 36, No 7

Cobb TG (2010). "Strategies for providing cultural competent health care for Hmong Americans." Journal of Cultural Diversity 17(3): 79-83.

Croker C, Reporter R, Redelings M, Mascola L. Strongyloidiasis-related deaths in the United States, 1991-2006. Am J Trop Med Hyg. Aug 2010;83(2):422-6.

Elo, S. & Kyngas, H. 2008. The qualitative content analysis process. Journal of Advanced Nursing, 62(1), pp. 107-115.

Geltman PL, Radin M, Zhang Z, Cochran J, Meyers AF. (2001). "Growth status and related medical conditions among refugee children in Massachusetts, 1995-1998." American Journal of Public Health 91(11).

Glaser, Barney & Strauss, Anselm (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing Company.

Health Matters: A Pocket Guide for working with diverse cultures and underserved populations.

Michele Yehieli and Mark Grey (2005). Intercultural Press.

Health for all Iowans. (2010) "Somalis, Sudanese, and other refugees from East Africa" Center of Excellence on Health Disparities, Retrieved February 2012: from UONI's website:

www.iowahealthdisparities.org/documents/somalissudanese.pdf

International Rescue Committee (2010) The International Rescue Committee at a glance Retrieved February 2012 from IRC's Website:

http://www.rescue.org/irc-a-glance

Health Education Planning Models (2001) –"A review of the literature- Part 2" Retrieved

March 2012: From MSU's Website:

MSUCares.com

Idaho Office for Refugees. Information and resources, 2011. Retrieved October 2013 From IOR's website:

http://www.idahorefugees.org.

International Rescue Committee (2010) The International Rescue Committee at a glance Retrieved February 2012 from IRC's Website:

http://www.rescue.org/irc-a-glance

International Rescue Committee (2010) The International Rescue Committee at a glance Retrieved February 2012 from IRC's Website:

http://www.rescue.org/irc-a-glance

Living in America Challenges Facing New Immigrants and Refugees. Robert Wood Johnson Foundation. August (2006)

Maroushek SR, Aguilar EF, Stauffer W, Abd-Alla MD Malaria among refugee children at arrival

in the United States. Pediatr Infect Dis J. 2005 May;24(5):450-2.

Migration Information Source. (2009) "African Immigrants in the United States." Retrieved February 2012: from MPI's website:

http://www.migrationinformation.org/USfocus/display.cfm?id=719#17

Mirza M, Luna R, Mathews B, Hasnain R, Hebert E, Niebauer A, Mishra UD. *Barriers to*

Healthcare Access Among Refugees with Disabilities and Chronic Health Conditions

Resettled in the US Midwest. Retrieved September 2013 from Pub Med.

M. Edberg (2007) Essentials of Health Behavior Social and Behavioral Theory in Public Health

Health Belief Model, Retrieved from : p.35-39

Morris MD, Popper ST, Rodwell TC, Brodine SK, Brouwer KC. Healthcare barriers of refugees

post-resettlement. Journal of Community Health 2009;34:529–38.

National Cancer Institute. Theory at a glance*: A guide for health promotion practice*,

2nd edn. US National Institutes of Health no T052. (Online) 2005. Retrieved October 2013 from NIH's website:

http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf (Accessed 7 December 2011).

National Institute of Mental Health (2012) Post Traumatic Stress Disorder, Retrieved Dec 2012

from NIMH Website:

http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-dis

/index.shtml

Newman L. (2007) *Seeking asylum-trauma, mental health, and human rights: an Australian*

perspective. Centre for Developmental Psychiatry & Psychology, Monash University,

Clayton, Victoria, Australia. Retrieved September 2013, from Pub Med website.

O'Mahony J, Donnelly T, 2010 Immigrant and refugee women's post-partum depression help-

seeking experiences and access to care: a review and analysis of the literature. J Psychiatr

Ment Health Nurs. 2010 Dec;17(10)

Ramin A, Segar N (2011). "Barriers to health care access among refugee asylum

seekers." Journal of Health Care for the Poor and Underserved 22(2): 506-522.

Refugee Women's Alliance (REWA) (1985): Empowering families and Strengthening

communities Retrieved September 2013: from Infinite Futures' Website:

www.rewa.org

Sheikh M, Pal A, Wang S, MacIntyre CR, Wood NJ, Isaacs D, Gunasekera H, Raman S,

Hale K, Howell A (2009). "*The epidemiology of health conditions of newly arrived*

refugee children: a review of patients attending a specialist health clinic in Syndey."

Journal of Pediatrics and Child Health 45: 509-513.

Specific Aspects of Refugee Problems in Africa, Human Rights Journal 111-3-70. 6

1951 Convention as note 1 above, art 1A (2).

The UN Refugee Agency (UNHCR) Global Trends Report: 800,000 new refugees in 2011,

highest this century Retrieved April 29th from UNHCR's Website:

http://www.unhcr.org/4fd9e6266.html

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2008). Refugee trauma program uses novel approach to promote recovery for victims of violence, other trauma. Retrieved from AHRQ Health Care Innovations Exchange *website: https://innovations.ahrq.gov*

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2009). Oral Health Program Enhances Access to Culturally Sensitive Dental Care for Refugees and Asylum Seekers. Retrieved from AHRQ Health Care Innovations Exchange website: *https://innovations.ahrq.gov*

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011a). Identification and support of refugees with disabilities enhances access to culturally competent rehabilitation and social services. Retrieved from AHRQ Health Care Innovations Exchange website: *https://innovations.ahrq.gov*

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011b). Physician–nurse house calls reduce barriers to health care and social services for new refugees. Retrieved from AHRQ Health Care Innovations Exchange website: *https://innovations.ahrq.gov*

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2013). Resettlement agencies team with county to enhance access to culturally sensitive screening and follow-up for arriving refugees at risk of mental health problems. Retrieved from Retrieved from AHRQ Health Care Innovations Exchange website: *https://innovations.ahrq.gov*

Mollica RF. *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World* . Orlando, FL: Harcourt, Inc., 2006.

Whitehead. M. (2007). A typology of actions to tackle social inequalities in health: *A typology of*

actions to reduce health inequalities, 474-475, 473-478. Retrieved from JECH Online's

Website:

jech.bmj.com

Widener M, Lipscomb M, Hobbs J, et al. An innovative model of maternity care for refugee populations. A presentation to the Seventh National Conference on Quality Health Care for Culturally Diverse Populations. October 18, 2010.

Wieland ML, Tiedje K, Meiers SJ, Mohamed AA, Formea CM, Ridgeway JL, Asiedu GB,

Boyum G, Weis JA, Nigon JA, Patten CA, Sia IG. J Immigr Minor Health. Retrieved

2013 Sep 20.

http://www.unhcr.org/pages/49c3646c1d.html

APPENDIX A

Pie Chart Data for Refugee Admissions

Number of refugees admitted in the U.S between 2000 and 2009

Year	**Number of refugees admitted**
2000	72143
2001	68925
2002	26765
2003	28305
2004	52840
2005	53738
2006	41094
2007	48218
2008	60107
2009	74602

APPENDIX B

Document analysis:

Section A:

State	Year of Publication
Author	Target Population

Section B:

1. What are the main challenges faced by refugees in regards to their health?
2. What is the impact of culture on refugee healthcare?
3. What impact does language have on refugee healthcare?
4. What health interventions have been adapted to improve the health of refugee populations?
5. What were the outcomes of the interventions?
6. What needs to be done to sustain the interventions?

APPENDIX C

Interview Questionnaire

An overview of questions for Refugees Date

Section A: Personal Information

Gender: Age: Marital Status:
Educational Level: Country of Origin: Language:

1. How many years have you been in the U.S.?
2. In your country of origin, did you have a career?
3. How many children under the age of 18 do you have?
4. Whom do you support financially other than your children?
5. How many refugee friends do you have and how often do you interact with them?

Section B: Health related questions

6. How would you describe your health?
7. How often do you seek healthcare services?
8. Do you have a preference for seeking medical care in a hospital or a clinic?
9. Do you have health insurance? If not, why?
10. Are you currently employed?
11. If not employed, what are some of the reasons why you are unemployed?
12. How does being unemployed impact your health?
13. Do you receive financial assistance from the government? If so, what type of assistance?
14. How easy is it for you to get transportation when you need it?
15. Does where you reside have any impact on you receiving health care?
16. How are the rights, obligations, and opportunities different for refugees compared to U.S. citizens?
17. Do you have a preference for a provider when you go to a health institution and why?
18. What are the challenges you face in the U.S., mostly in regards to health?
19. What in your opinion are the right channels to follow when seeking healthcare?

20. How does culture or religion play a role in the decisions you make in regards to health?