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Understanding Refugees' Perceptions of Health Care in the United States

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ABSTRACT

Ongoing conflicts around the world have resulted in record numbers of refugees. Given the unique health care needs and access barriers refugees face upon resettlement in the United States, we aimed to better understand refugees' perceptions of US health care as the first step to quality improvement initiatives. We used a qualitative approach by conducting 4 focus group interviews with refugees from Iraq, Eritrea, Somalia, and Bhutan. We identified 3 common themes: conflicting expectations, miscommunication, and varying levels of trust and satisfaction. Findings support in-person interpreters, cultural competency training, and integrated primary health care delivery models with stronger connections with resettlement agencies.

Keywords: culture, health care access, primary care, refugees

The Syrian civil war and persistent and new conflicts in the Middle East, Africa, and Asia have resulted in the highest number of displaced persons since World War II. At the end of 2014, there were 59.5 million displaced persons, of which 19.5 million had to flee to neighboring countries, classifying them as refugees, and the other 38.2 million were displaced within their home country.[1] President Obama authorized 70,000 refugees to be resettled in American communities in 2015. As the global refugee crisis extends, in particular the Syrian crisis, the United States announced to accept more refugees, with 85,000 in 2016 and 100,000 by 2017.[2]

Many refugees arrive with preexisting health issues that they acquired as they fled their homeland and resided in refugee camps. Compared with general immigrants, refugees are more susceptible to infectious disease, malnutrition, and mental health issues, which can be correlated with their experiences of fleeing war and living in refugee camps.[3,4] Beyond a thorough health assessment completed upon arrival, the US government has provided various services to help address the health needs of this vulnerable population. These health programs aid in the process of meeting the demands of adjusting to a new society and becoming self-sufficient citizens.[5]

Still many newly resettled refugees are not only confronted by barriers to accessing health care services that many low-income Americans face including limited transportation, financial restraints, and unstable housing, but they also face barriers related to language, culture, unfamiliarity with the US health care system, and traumatic life experiences.[6] Lack of trust in health care providers has also been cited as a barrier for refugees accessing health care and using preventive care.[7,8] Even though preventive care is underused among refugees, they seem to use episodic health care more frequently than general immigrants.[8,9] As more refugees arrive to the US, they will need access to primary care. Because the majority of nurse practitioners (NPs) work in primary care, they play a crucial role in the delivery of preventive and coordinated care, which must reflect awareness and sensitivity of cultural diversity.[10] Understanding their perceptions about health care in the US is the first step in preparing NPs to provide culturally sensitive, compassionate, and patient-centered care to this population with a unique set of challenges.

Our aim for this study was to gain better understanding of newly resettled refugees' perceptions of US health care since arriving to a city in the Midwestern US. By collecting and analyzing their stories

and including them in quality improvement initiatives, we hope to break down barriers, decrease health disparities, and improve quality of care. Information obtained from this study enhances our understanding of refugees' perceptions and preferences while providing direction for future targeted solutions.

METHODS

We conducted 4 in-depth focus group interviews with 39 refugees who 1) were clients of an urban Midwest refugee resettlement agency within the past 5 years; 2) were age 18 and older; and 3) were originally from Iraq, Eritrea, Bhutan, or Somalia. These 4 groups were chosen because they were the 4 major refugee groups arriving in the city at the time of the study. By having 4 different nationality groups, both similarities and differences among these groups could be assessed. The institutional review board of the university and the resettlement agency granted written approval for the study.

The participants were recruited as a convenience sample. Four bilingual caseworkers from the resettlement agency were identified to serve as recruiters. These bilingual recruiters were provided a script to recruit a maximum of 10 eligible clients from their nationality group.[11] The recruiters invited participants through telephone and face-to-face communication because they met them routinely at the resettlement agency. The caseworkers were key to the recruitment process because they are in close contact with refugees during their first few months in the US.

We hired a professional interpreter for each focus group session (Arabic: Iraq, Tigrigna: Eritrea, Nepali: Bhutan, and Somali: Somalia). Before each discussion session, the interpreter read the informed consent form in the participants' language and ensured that they understood that their participation was voluntary. After the participants provided written informed consent, the interpreter helped them fill out the demographic information form. Participants were identified by numbers during the focus groups that corresponded to the numbers on their demographic forms to deidentify the data and promote confidentiality. The signed informed consent forms were stored in a locked file cabinet in the first author's office, and the audio recordings were stored on a password-protected computer.

Each discussion session began with an icebreaker question.[12] This was followed by general questions in the moderator's guide. The first author moderated all 4 groups in English while the interpreter provided real-time interpretation to capture the conversations between the moderator and the participants while being audio recorded. Because of feasibility issues, only the English data on the audio recordings were transcribed. A limitation of this study is that the non-English content on the recordings was not back translated. All 4 group interviews took place in a conference room in the resettlement agency at times that were convenient for all involved. Each focus group session lasted approximately 2 hours. A $10 gift card was given to participants at the conclusion of each focus group session to thank them for their time and effort.

Data were analyzed using the phenomenological approach of Colaizzi. This method of analysis is suitable for cross-cultural interactions and conversations in order to try and avoid making assumptions or coloring the data with preconceived ideas of a group of people.[13] To follow this structure of data analysis, the first author listened to the audio recordings of the focus groups and transcribed the English data verbatim (H.W.). After the recordings were transcribed, the first author and 2 coauthors with extensive qualitative research experience read through the transcripts individually and identified emerging themes and key phrases (K.H. and R.Y.). The 3 authors then met jointly to read through the transcripts out loud together. They discussed the meaning of key quotes that surfaced across all 4 focus groups as well as data that were variable among the focus groups. They categorized the themes with codes under main categories and divided them into subthemes. This process was repeated until agreement was reached on themes, subthemes, and key quotes characterizing the 4 focus groups. The process of rereading the transcripts, having multiple researchers review the raw data both individually and collectively, and the process of iterative analysis until attaining consensus ensured the scientific rigor.[14]