Refugees' Perceptions of Health and Healthcare Accessibility

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in partial fulfillment of the requirements for completion of the
Health Science Scholars honors program in the College of Natural Sciences at
The University of Texas at Austin

Spring 2020

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I intend to submit a copy of my Health Science Scholars thesis to the Texas ScholarWorks Repository. For more information on the TSW, please visit https://repositories.lib.utexas.edu/.

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Rachel David Date

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Acknowledgements

My thesis could not have been finished without the help and support of various individuals.

Dr. Robert Ambrosino, my thesis mentor and supervisor, was instrumental in helping me shape and guide my thesis throughout the entire process. I am greatly appreciative of his invaluable support and guidance.

I am thankful for the entire staff of Refugee Services of Texas, who supported me as I first learned more about the refugee community as an intern. Furthermore, this thesis would not have been possible without the help and support of the staff and volunteers at Hope Medical Clinic. I am proud to serve as a volunteer at this clinic and to learn from countless inspirational individuals and patients whose resilience and determination in the face of tremendous adversity reminds me constantly of the importance of my work.

I also want to thank Dr. Rebecca Wilcox, the other faculty in the Health Science Scholars (HSS) program, and my peers in HSS who were always there to encourage me and support me through every step of this process, from when this thesis was just an idea in freshman year to this paper.

Finally, to my family and friends whose unwavering support and encouragement throughout this process were so appreciated, I am always grateful for your support.

Abstract

In recent years, the United States has set the lowest caps for refugees able to enter the country than any other time in our nation's history. These changing policies are resulting in funding cuts for refugee resettlement organizations that help support refugees in all areas, including healthcare. Because of this, healthcare disparities and barriers for this population are becoming increasingly apparent. While research has identified the major barriers and disparities for refugees in healthcare, the impact of culture on refugees' *perceptions* of healthcare has not been researched. This thesis seeks to determine the cultural differences, if any, in perceptions of health and healthcare among resettled refugees from different countries of origin. Refugees' perceptions were studied through thematic analysis of eleven semi-structured interviews. These interviews were conducted with refugees from different countries of origin, regarding their experiences and perceptions of health and healthcare in their home country compared to in the United States. Qualitative analysis of interview responses indicated language differences and financial cost as main driving factors in all individuals' health perceptions, regardless of country of origin. Gaining a better understanding of the cultural perceptions of health and healthcare may help healthcare providers more effectively treat this population.

Introduction

The U.S. Citizenship and Immigration Service defines refugees as "people who have been persecuted or fear they will be persecuted on account of race, religion, nationality, and/or membership in a particular social group or political opinion" (U.S. Citizenship and Immigration Services, 2009). Currently, these individuals come from over 60 countries from around the globe (National Immigration Forum, 2019). Throughout the world, the number of total refugees has reached an all-time high of 70.8 million people since 1945 (Krogstad, 2019).

For decades, the United States has resettled more refugees than every other country in the world combined (Connor & Krogstad, 2018). Krogstad from the Pew Research Center explains how this has dramatically changed beginning in 2016; in 2020, the U.S. now has lower caps for refugees able to enter the country than ever before. Krogstad (2019) went on to say that in 2016, the cap for total refugees that could resettle in the U.S. was 110,000, compared to only 30,000 refugees in 2019. Furthermore, Krogstad states that in 2020, the cap is set even lower, to only 18,000 refugees. In the state of Texas specifically, Texas Governor Greg Abbott recently announced that the state will no longer accept new refugees (Romo, 2020). This is a dramatic change, as Texas has historically resettled one of the largest number of refugees, almost 10% of all refugees entering the U.S. (Romo, 2020). In 2019 alone, around 2,500 refugees were resettled in the state (Krogstad, 2019).

These major changes to refugee policy have resulted in uncertainty for the over three million refugees already resettled in the U.S. who still regularly rely on resettlement agencies for support (United States Department of State, 2020). While these refugees are not covered by government-provided insurance after eight months, many local resettlement agencies continue to

support refugees in multiple areas, such as transportation to medical clinics and limited financial support. This shift in support for refugee resettlement in Texas and the U.S. could result in reduced funding and increased difficulties for resettlement agencies, such as Refugee Services of Texas, in continuing their support for refugees already resettled in Texas. Furthermore, some medical clinics primarily serving refugees, such as the Refugee Health Screening Clinic in Austin, receive funding from federal grants that allows the clinic to provide certain free health services to the refugee population (City of Austin, 2020). The recent changes to refugee policy noted above could cause a financial burden on such clinics, thereby decreasing their ability to provide healthcare for the refugee population in Austin.

As the ability for organizations to effectively serve refugees is put at risk, the health disparities experienced by resettled refugees are becoming increasingly apparent. Apart from an initial basic health screening to prevent any refugees with contagious diseases from entering the U.S., all other healthcare must be arranged by the refugees themselves (National Immigration Forum, 2019). Included among the many health disparities experienced by the refugee population are lower rates of health screenings due to language barriers and perceived cultural differences from providers (Afkhami & Gorentz, 2018) as well as lower rates of preventative screening tests due to lack of awareness of the importance and availability of such screenings (Kue et al., 2019). The self-identified largest obstacles to seeking healthcare by refugees include language barriers and differences in cultural beliefs (Morris et al., 2009).

The focus of recent research in the area of refugee health has been to determine the healthcare barriers experienced by this population and potential ways that these barriers may be addressed. While this is a valuable line of inquiry, the healthcare barriers have been clearly identified by now and potential solutions proposed by researchers such as Morris et al. (2009).

An area that has not been considered or researched in as much detail is the impact of culture and mindsets of resettled refugees regarding access to health and healthcare. Researchers in this area are gaining a better understanding of the role culture plays in the actions of refugees seeking healthcare-related services (Jia et al., 2017). A better understanding of a refugees' culture and cultural beliefs can help healthcare providers be more effective in their interactions with this population. As millions of refugees have resettled in the U.S., many of whom have resettled in Texas, it will be valuable to determine the cultural perceptions of refugees in Texas (Pew Research, 2019).

This thesis seeks to determine the cultural differences, if any, in perceptions of health and healthcare among refugees from different countries of origin that have resettled in Austin, Texas. There are 12,000 refugees that are resettled in Austin, and since 2000, the majority of refugees resettled in Austin have come from Afghanistan, Burma, Bhutan, Cuba, Iraq, Iran, Nepal, Democratic Republic of the Congo, Somalia, Ethiopia, and Eritrea (City of Austin, 2020). Due to the large number of refugees resettling in Austin, there are many refugee resettlement organizations and other community partners supporting refugees, including Refugee Services of Texas, Caritas of Austin, and Casa Marianella. This thesis will focus on Austin, as the way this city and organizations within the city responds to refugees are fairly representative of other large cities in Texas.

Based on interviews conducted with a small sample of refugees resettled to Austin, Texas and observations made at a refugee medical clinic, this thesis identifies major themes in the way this population perceives their own health and healthcare experiences and the way culture influences their health behaviors. The exploratory study represented by this thesis will determine a baseline for the way that different cultural experiences of refugees affect their perceptions of

their health and the various barriers they experience in accessing healthcare. Specifically, this thesis seeks to answer how financial and language barriers, chronic health conditions, and changes in lifestyle are affecting the health of resettled refugees in Austin.

Background

Official Terms Relating to Resettlement

There are many different terms used to officially describe the status of an individual who has resettled in a country other than their home country (International Rescue Committee, 2018). A *refugee* is defined as "an individual that has been forced to leave their home country due to war, violence, or persecution" (International Rescue Committee, 2018). They are not able to go back to their home country unless the environment has become safe for them to do so. The official status of a refugee is determined by the United Nations Refugee Agency or another governmental organization. Individuals who have achieved refugee status receive certain benefits and protection outlined in international laws, such as those prohibiting countries from forcibly sending the resettled refugees back to their home country, as well as those ensuring human rights protections given to any citizen of the host country, such as freedom of religion (The UN Refugee Agency, 2020). In the U.S. specifically, individuals deemed refugees have the ability to become lawful permanent residents and citizens.

An *asylum seeker* is an individual who has fled their country of origin due to fear of danger or persecution from their home country but who has not received a legal refugee status from the country they are applying to reside in. These individuals must request refugee status from the government of the country in which they are currently living; however, achieving this status is not guaranteed, regardless of the situation of the applicant.

An *immigrant* is an individual who makes the choice to leave his or her home country and resettle in a different country. Immigrants who are documented also undergo a screening and approval process from the country they are moving to and have received official paperwork and approval from that country. A key distinction is that documented immigrants are free to return to their home country. Undocumented immigrants, however, have not undergone the official screening process, and therefore, do not have the proper documentation to reside legally in a new country.

Lastly, a *migrant* is an individual who moves often to different places, either within one country or between multiple countries. Like immigrants, migrants make a conscious choice to leave their country and have the ability to return to that country (International Rescue Committee, 2018).

In this thesis, the focus will be on individuals that have been given refugee status, as the refugee experience and the challenges that come with it are unique from that of any other group described above and could result in unique barriers and perspectives for individuals of this population.

Refugee Resettlement Process

According to the website of the National Immigration Forum (2019), the resettlement procedure for refugees wishing to enter the U.S. can be a complex and drawn-out process that lasts up to two years. The United Nations Refugee Agency is an international organization that begins the process of screening individuals who may qualify for refugee status (The UN Refugee Agency, 2020). This organization, along with U.S. Embassies, nongovernmental organizations, the Bureau of Population, Refugees and Migration in the Department of State, and other partner

organizations in the U.S. and abroad are able to refer refugees to the United States Refugee Admissions Program to be formally considered for resettlement in the United States. The processing time from initial review to the final approval of an individual to enter the U.S. as a refugee can take, on average, 18 to 24 months (National Immigration Forum, 2019). The length of time for approval could rise if the regulations and requirements regarding refugees and refugee resettlement become more restrictive over time.

For the U.S. specifically, after an individual has been selected to start the process of being resettled, there is a biographic information screen, vetting from the Department of Homeland Security and multiple other intelligence agencies, such as the FBI and CIA, an in-person interview with the refugee, a basic health screening to check for contagious diseases, a cultural orientation course, an establishment of which refugee resettlement agency the refugee will be using in the U.S., and a final security check at the airport upon their entry into the United States (National Immigration Forum, 2019). While there are multiple official steps and requirements that must be met before a refugee enters the country, this amount of detail or information is not provided after the refugee has entered the country. While the refugee may be directed to a resettlement agency in the U.S. that helps to refer and provide the individual with initial resources and recommendations, the refugee must navigate their new country and environment mostly on their own. Navigating this process on their own with a lack of information can be very challenging for refugees who have just moved to a new country and culture, especially after coming from a difficult and often dangerous home environment.

The website of the Office of Refugee Resettlement includes details on how the U.S. provides various resources for the first eight months after the arrival of a refugee in the country. These services include financial and medical support, case management services, English

language classes, and job training classes, all of which are offered to help enable refugees to become acclimated to their new home. With regards to health-related resources, refugees are provided with Refugee Medical Assistance (RMA), which is a temporary, eight-month medical insurance for the individual and their children (Office of Refugee Resettlement, 2019). After this eight-month period, the refugee no longer receives RMA or any of the other federal resources and must apply for insurance on their own, as well as vouchers for gas or support getting transportation to clinics from refugee resettlement agencies.

Refugee Health Barriers

There are many barriers to healthcare experienced by resettled refugees in the U.S. These barriers lead to challenges accessing healthcare and a hesitation to access critical health care services.

The main barrier to accessing care by members of the refugee population is their inability to speak the English language. This presents a significant challenge when trying to communicate with healthcare providers (Morris et al., 2009). An example of this is the difficulty refugees have of not being able to appropriately explain the health issues they are facing or understanding the treatment plan given to them. These language barriers could also lead to patients' misunderstanding and possible misuse of medications, which could lead to further health complications and even death (Morris et al., 2009). Furthermore, due to their limited command of the English language, many refugees are not able to make healthcare appointments on their own. Researchers Swe and Ross (2010) showed that in many cases, refugees were "passive patients" in that they always accepted what the doctors said, even if they did not fully understand the reasoning behind it. Swe and Ross also found that in healthcare related visits, refugees often

expressed very vague symptoms. Using only vague symptoms could lead to difficulty for the healthcare provider to accurately identify the primary issue of the individual and frustration on the part of the refugee and the provider due to this lack of clear and detailed communication. In such cases, friends or family members were used as translators to facilitate encounters between the refugee and the provider by translating additional details as needed if the refugee was unable to communicate this information in English.

The high financial cost of using health services and the lack of insurance has also been identified as a barrier among members of the various resettled refugee groups (Sastre & Haldeman, 2015; Swe & Ross, 2010). One study found that refugees reported that their lack of insurance made it difficult to find physicians that would provide health services and that the high cost of medical services was a major barrier in accessing healthcare (Sastre & Haldeman, 2015). Similarly, in a study by Swe and Ross (2010), refugees discussed how after resettling in the U.S., they initially received financial support through Medicaid and refugee resettlement agencies, but that this support lasted, on average, for only four months. After this period, they experienced many challenges determining how to pay for the healthcare that they needed.

Differences in culture was another major barrier in accessing care. Researchers Morris et al. (2009) found that the cultural barriers affecting healthcare were manifested in various ways, such as female resettled refugees feeling uncomfortable receiving care from a male provider, which often resulted in the individual simply avoiding going to the doctor. Morris et al. went on to say that while some medical group practices have addressed this issue by providing cultural sensitivity training to their physicians, research has shown that no culture is the same, and that cultural sensitivity training for physicians specific to one refugee group cannot be generalized to all groups.

Other health-related disparities identified in this population include that refugees used health services and preventative services at a lower rate than other populations, which is expected for a population like this with a poor understanding of health knowledge (Swe & Ross, 2010). When refugees were asked why they were not using medical services, such as emergency services or specialty health clinics, many stated that they did not know these services were available or that they did not know the purpose of such services (Swe & Ross, 2010).

As the many health barriers for this population are evident, this thesis seeks to determine differences in cultural perceptions among refugees from different countries to better equip physicians to effectively interact with refugee patients regarding the specific barriers and challenges they face.

Refugee Health Disparities

As there are many healthcare barriers experienced by resettled refugees in the U.S., there are many healthcare disparities that result from these barriers. Examples of these disparities include lower rates of use of preventative health screenings, such as gynecological exams, lower than expected rates of use of medical services, and low rates of mental health screenings (Afkhami & Gorentz, 2018). These examples could all lead to poorer health outcomes for these individuals when compared to other individuals appropriately utilizing these resources.

When researching the reasons why there are lower rates of preventative health services among the refugee population, Morris and his colleagues (2009) determined cultural health beliefs to be one of the main contributing factors. They went on to explain that many refugee-serving organizations have noticed that refugees were not familiar with the concept of preventative services or why they were needed, as this was not a common concept in their home

country. Many refugees in the study reported that they were used to going to the doctor only if they felt sick – for most refugees, preventative health services were not available in their home country, so they were not aware of the need for such services. Morris et al. concluded that due to these cultural differences in health beliefs, it is vital that health care providers are able to provide culturally competent care and are explicit in explaining the treatment and healthcare options available for their patients.

Furthermore, the disparities detailed above were those observed in the individuals who are able to access medical care to begin with. For some refugee individuals, after their eight months of federal insurance that they are provided with, they may not be aware of or able to access medical care or health services on their own and may feel as they have no way to address their health needs (Afkhami & Gorentz, 2018).

Some argue that the type of health disparities described above are present for any individual who has resettled to the United States from a foreign country and not an experience unique to those given refugee status. However, research by Sharif et al. (2018) has shown that it is not simply the experience of resettling in a new country that contributes to differences in health outcomes, but instead, something specific to the refugee experience. The researchers compared the health experiences of refugees to those of immigrants in the same area of the U.S. and found that higher rates of health disparities were unique to refugees. In addition, the refugees were at higher risk for developing chronic diseases when compared to the immigrants.

A study by Morris et al. (2009) also found that refugee individuals were at higher risk for chronic diseases, such as diabetes and hypertension, after resettling to the U.S. The researchers hypothesize that this could be caused by the increased levels of stress from the forced migration,

"changes in diet or activity level, stress associated with acculturation and lack of access to or utilization of health services" (p. 536).

Furthermore, Sharif et al. (2018) found that the refugees had lower self-perceived health-related quality of life when compared to immigrants, which is notable as self-rated health is often used to predict mortality. In another study by Edberg et al. (2010), researchers found that refugees self-reported worse health status when compared to the average American. These results are important to note as these self-perceptions of health can impact an individual's overall well-being.

Culture and Health Behaviors

The health disparities experienced by this population can influence the health behaviors of this population. This thesis will look to determine the differential impact that culture can have on health behaviors in this population, including the relationship between the cultural background and beliefs of an individual and their perceptions of accessibility to health and healthcare.

Research has shown that the culture of an individual's environment can have an impact on their health and their health behaviors (Jia et al., 2017). Cultural and societal perceptions and norms of individuals in a community can play a role in their health beliefs, such as the cause of disease and what is the best approach to addressing sickness (Metusela et al., 2017). In a study on refugees from Myanmar by Swe and Ross (2010), refugees stated that they hold social community to a great importance and often bring family members or community members to their healthcare appointments to help as a translator and for support. Furthermore, refugees have stated the positive role that their cultural community plays after resettling, explaining how their

community supports them in numerous ways, such as "loaning money to pay for prescriptions and medical costs and by serving as translators, emotional support, and a source of knowledge about how the health care system works" (Morris et al., 2009, p. 535). The importance these individuals place on their cultural community and the way this community supports the health behaviors of these individuals shows the impact that culture and the cultural community of an individual can have on their health.

Cultural beliefs and norms can also affect an individual's health behaviors. In a 2014 study by Oli et al., the researchers discussed the way cultural mindsets regarding health can influence the health-related behaviors of individuals. In this study, in-depth interviews with Nepalese individuals revealed that a common health belief among members of this group was that diet had an important effect on overall health and well-being. However, most individuals from this study were unaware of any effect that physical activity could have on health. Furthermore, a study by Morris et al. (2009) found that "culture directly affected refugees' concept of prevention services, independence, expectations of care and stigma around health conditions – all of which influenced their health care choices" (p. 535).

This study was aligned with observations the researcher of this thesis made at the medical clinic where this study was conducted. One Nepalese patient's primary concern when she came in for her appointment was that she had been dieting and "starving herself" for months in an attempt to lose weight. When she was weighed during her appointment intake, she was disappointed to see that she had not lost much weight. When discussing this with the doctor, the doctor asked about her physical activity habits and what she did for exercise. The patient laughed in response and said that she was a mom and did not have time for exercising. When the doctor went on to explain how physical activity is also a vital component to managing weight, the

patient seemed confused and again asserted that she had been dieting for months. The doctor again informed the patient of the numerous positive effects of exercise and how diet alone may not be sufficient for lasting and healthy changes to weight. These exchanges illustrate the way cultural mindsets can affect the health beliefs and behaviors of individuals.

Based on the research noted above showing the importance of culture and its role in developing the health beliefs and the health behaviors of individuals, this thesis investigates cultural influence on health experiences and health behaviors among different ethnic groups of resettled refugees. With this knowledge, healthcare providers for this population will be better educated with information that will allow them to better serve these individuals with targeted techniques specific to their needs and health beliefs.

Methods

Study Sample

Participants in this study were individuals who had refugee status and who had resettled in Austin, Texas between 1986 and 2015. The study was conducted between January and February 2020 in Hope Medical Clinic, a medical clinic whose main patient population consists of both refugees and individuals without medical insurance in Austin. This clinic sees over 300 patients a year. The study sample was a convenience sample with a voluntary population. Participants were selected by asking individuals after their appointment was finished if they were interested in taking part in the study. To be included in the study, the individuals had to at least be 18 years old, be in the U.S. with the refugee status, and be comfortable speaking in English, or have someone with them who was able to act as a translator.

Data Collection

Data were collected through interviews conducted with the study participants and observations from the researcher at the clinic. The semi-structured interviews were conducted through open-ended questions related to the individual's health and healthcare experiences in their home country as well as here in the United States. The participants were asked of any changes they had noticed in their health or the healthcare process from their home country when compared to the U.S. Participants were also asked about their lifestyle habits and occupation before and after resettling in the U.S., and if there was anything they wished their doctor in the U.S. knew about their health and healthcare experience. The complete list of questions approved by the University of Texas at Austin Institutional Review Board (IRB) is attached as the appendix to this document. Note that due to time constraints, a truncated list of questions was used in this study.

An ethnographic data gathering strategy was used by asking open-ended questions to the participants. Depending on the response, follow-up questions were asked for more detail to augment or clarify initial responses. All interviews were conducted in English – some participants had a family member or friend act as a translator for the duration of the interview. In the cases where a translator was used, additional questions and clarifications were asked to ensure that the responses of the participant were represented accurately.

Data Analysis

The verbal responses of the individuals were transcribed verbatim to text. The qualitative data were analyzed by comparing the transcripts of the interviews to the observations and informal discussions made by the researcher with the study subjects. These observations

included the way patients interacted with their family members or friends who had come to the clinic with them and the types of questions asked by these individuals. Informal discussions included conversations the researcher had with individuals at the clinic outside of the formal interview setting. Common or underlying themes were identified from available responses and observations by the researcher. Responses to questions not answered by all participants due to time constraints or questions that participants chose not to respond to were not analyzed. These questions included queries about mental health issues faced by study participants and the social support network of the individual.

Ethical Considerations

This study was approved by the UT IRB. The purpose of the study as well as the format of the interviews were discussed with potential participants. If the individual agreed, the interview was conducted in a private room and the individual was informed that they could withdraw from the study at any time without penalty, including their ability to receive subsequent care from the clinic. Participants were also informed that their information would be kept confidential – their names or other identifying information would not be recorded anywhere, and all notes would be kept on a secure laptop accessible only by the researcher.

Throughout the course of the interviews, participants who voiced a concern regarding their health or healthcare were provided with the appropriate resources, such as relevant educational materials and/or referrals to other community organizations.

Results

Demographics of Participants

This study included eleven participants from five different countries of origin. Table 1 includes information on selected demographic variables of interest to the study. As can be seen from a review of the table, about half of the participants were women (n=6). More than half of the participants country of origin was Nepal (n=6) followed by Iraq (n=2), Afghanistan (n=1), Cuba (n=1), and Pakistan (n=1). The majority of participants had been in the U.S. for four to ten years.

Table 1

Demographic Composition of Study Participants

Characteristic	n	% of Total
Sex		
Male	5	45.5%
Female	6	54.5%
Country of Origin		
Nepal	6	54.5%
Iraq	2	18.1%
Afghanistan	1	1.9%
Cuba	1	1.9%
Pakistan	1	1.9%
Years in the U.S.		
0-5	5	45.5%
6-10	5	45.5%
10+	1	1.9%
First Language		
Nepali	6	54.5%
Dari	1	1.9%
Arabic	2	18.1%
Spanish	1	1.9%
Urdu	1	1.9%
Marital Status		
Married	10	90.9%
Single	1	9.1%

Total number of children		
0	2	18.1%
1	1	9.1%
2	2	18.1%
3	3	27.3%
4	3	27.3%

Themes

A qualitative analysis of the interview results and the researcher's observations revealed five main themes, listed in order of prevalence: 1) high costs of medical care; 2) drastic change in career or lifestyle; 3) learning of a chronic health condition after resettling in the U.S.; 4) perception of a greater difficulty to access physicians in the U.S. versus one's home country; and 5) language barriers in accessing and utilizing healthcare. Each of the themes identified is discussed in further detail below.

High Costs of Medical Care

One theme identified among study participants regardless of country of origin was the challenges they experience securing medical care due to the high cost of care. After the initial 8 months of public health insurance (Refugee Medical Assistance) provided to all refugees, the refugees must find ways to pay for their health-related needs, including costs associated with appointments, testing, and medications, on their own. Many study participants discussed the need to drive long distances to find community health clinics, such as Hope Clinic, that would offer reduced cost or free services and medications. A participant from Iraq described that after coming to the U.S., he would only go to see a doctor if he was very sick, as he did not have Medicare or any other type of medical insurance. He went on to say that going to the doctor in the U.S. is more difficult than in Iraq because healthcare in the U.S. is expensive, and he had many financial obligations. A participant from Nepal spoke of the way she found it more

convenient to go to the doctor in Nepal when compared to the U.S., as healthcare in Nepal is free.

Obtaining quality healthcare for individuals with chronic health conditions is cost prohibitive, and cost can become a major barrier. One participant from Iraq spoke of the way that his 8-months of health insurance had stopped for him and his family and that it has been extremely challenging to secure healthcare for his wife or children due to the high cost of medical care. He went on to say that both he and his wife have chronic health conditions that require daily medications that they cannot afford. He described the helplessness he felt when he applied for medical insurance and was told that his income was too high to qualify for Medicaid benefits, yet he did not make enough money to pay for healthcare on his own. The prohibitive cost of obtaining healthcare for individuals and their families was a common occurrence among study participants who were initially eligible for public health services funded through the Texas Medicaid program, but after they found a job, they made too much money to qualify for that program. They explained that while they may have made more money than the Medicaid cutoff, this was not enough money to cover their medical care bills.

Career and Lifestyle Change

Another common theme identified among study subjects from all countries of origin was the major change in their career and lifestyle after resettling in the U.S. One participant from Afghanistan spoke of how she used to be a teacher for sixth and seventh graders and now is a stay-at-home mom because her teaching accreditation was not recognized by the licensing authorities in the U.S. Another individual from Iraq spoke of how he was a board certified physician in family medicine and worked at a hospital as well as owned a health clinic – here in

the U.S., he is working as a security officer while he tries to secure licensure to practice in the U.S. Many participants also described the way that their change in career had led to changes in their levels of physical activity. One such participant from Nepal spoke of how he used to work outside in the fields everyday cutting wood and now works in a restaurant and almost never goes outside anymore because he does not have time.

Chronic Health Conditions after Resettling in the U.S.

When asked about health challenges experienced after coming to the U.S., many study participants spoke of how they learned of a chronic health condition after arriving in the U.S. One individual from Nepal spoke of how her high "blood pressure started when [she] came here." Another individual spoke of how he "started medication for blood pressure and in Nepal, [he] never needed to use pills." One participant from Cuba spoke of how in Cuba, he "did not have diabetes or high blood pressure, but now [he] has gotten" these conditions. Another individual from Nepal described how she has diabetes and how she "just found out after coming here."

For some individuals, it was evident that they had not been tested for chronic conditions in their home country as they had only been to the doctor for emergencies, so it is possible they may have had undiagnosed chronic conditions while they were in their home country. For other individuals, however, they spoke of how they had been tested for these types of chronic conditions in their home country and had not been diagnosed before coming to the U.S.

Multiple individuals described the way that they were more active in their home country and others spoke of how people in their home country were not as quick to take medications as they are in the U.S. When one participant was asked if he took any medication in his home

country, he laughed and stated that only "rich people in Nepal need to take medication. We the poor were always going out and making money, so we are not just sitting around taking pills." Other participants said they are taking more medications in the U.S. compared to what they took in their home country.

Challenges Accessing Physicians for the Nepalese

One theme unique to study participants from Nepal was the perception that it was easier to go to the doctor and seek healthcare in Nepal compared to that in the U.S. All participants were asked whether it was easier to access healthcare in the U.S. or their home country, and all the Nepalese participants stated that it was easier in Nepal. This is notable as all other participants from other countries of origin, except two who cited higher financial costs, stated that it was easier to access care in the U.S.

Participants spoke of how in Nepal, it "is easier because of language and [that] no appointment is needed. You can just go in and meet with the doctor." This perception of greater ease resulting from something as simple as not needing to make an appointment was stated as a main issue for multiple Nepalese individuals. Another participant from Nepal spoke of how "in Nepal, it is easy because you do not need to make an appointment – you can go anytime to meet the doctor." Yet another Nepalese participant spoke of the difficulties he faced after first resettling in the U.S. trying to see a doctor. He explained how he "had to make an appointment and struggle[d] with English." Another Nepalese participant noted that she found it easier to go to the hospital in Nepal as "they check you in right away" unlike in the U.S. where this is a wait time.

Language Barriers

Language barriers and the difficulties this caused when trying to access care was another main theme that emerged from this study. One Nepalese participant explained that it was easier to see a doctor in Nepal "because of language." Another participant from Nepal reported that the one thing she wishes was different about healthcare in the U.S. was that there would be "an interpreter all the time for [patients] so that they don't need to wait for someone to translate for them." This was echoed by another participant from Nepal who spoke about how his biggest health challenge after coming to the U.S. was the English language and the way that this language barrier inhibited his ability to make appointments at health clinics.

For five of the eleven interviews the researcher conducted, a translator was used. Four of these translators were children of the study participant.

Discussion

Study Implications

The results of this study have several implications for guiding the actions of healthcare providers and other individuals serving the resettled refugee population in the U.S. It is important that healthcare providers are cognizant of the healthcare barriers experienced by this population and that they do what they can to help mitigate these challenges. Whether this means informing patients of ways to get coupons for medications or working to have in-person translators available at the clinic to help serve patients as needed, it is imperative that healthcare providers continue to find the most practical solutions of best serving this population with the often limited resources they have. As providers and refugees identify new challenges or resources they need

that would allow for more meaningful interactions, communities and refugee organizations can work to see if these needs can be met.

High Costs of Medical Care

The high cost of medical care was the most prevalent theme identified by study participants. Based on this finding, clinics and physicians can be trained and educated on being cognizant of this major barrier and provide practical suggestions as appropriate. This could include substituting lower-cost medications that are also effective, informing patients of ways to get coupons for medications, and educating individuals on affordable ways for them to manage their health.

One example of taking this barrier into consideration was seen by the researcher of this thesis at Hope Medical Clinic. During an encounter at the clinic, the physician educated a patient on a cost-effective way to make a heating pad, by heating rice in a sock, as the patient was unable to afford purchasing a heating pad. Simple recommendations and alternatives like this could be very effective in better addressing the needs of this population while taking into consideration this financial barrier.

Major Career and Lifestyle Change

With regards to major career and lifestyle changes, it is clear that these dramatic changes in jobs, lifestyle, and daily routines had a significant implication on the health and well-being of study subjects. This can include personal aspects, such as the personal identity of an individual that may change due to career changes. It can also include physical aspects, as the normal

exercise levels and activity levels of an individual can change, which can impact the overall health and well-being of the individual.

Many study participants spoke of how they had specialized jobs in their home country, such as a physician or a teacher, but now they are not able to continue in this profession due to licensing or language barriers. This inability to continue in their profession and self-identify with the groups that they belonged to, which was an important part of the individuals' identity, could lead to mental health concerns, such as anxiety disorder, depression, and post-traumatic stress disorder (Smeekes et al., 2017).

With regards to physical health, multiple participants spoke of how they were experiencing major differences in their physical activity levels due to changes in their routine. Lack of understanding regarding the way these changes in lifestyle and activity could have impacts on various aspects of their health, including their weight, often led to frustration for the individual. If healthcare providers are aware of this gap in knowledge, they can incorporate the importance of physical activity into their communication with patients and help to educate patients on the way changes in their lifestyle can have an impact on overall health and well-being.

Thus, a holistic approach to providing health care for members of the refugee population is critical to their long-term health. This type of holistic care would include considering the individual's specific psychosocial needs in addition to their physical needs. Such an approach could result in reduced morbidity and ultimately mortality for members of this resettled refugee population. Researchers Afkhami and Gorentz (2018) discuss the "invisible affliction" of behavioral health and mental health struggles faced by the refugee population due to the unique challenges they face, such as major lifestyle changes and the stigma they fear they would

experience if they were to discuss their emotional needs. The researchers go on to say that by increasing the availability and accessibility of behavioral health screening at organizations that serve refugees, as well as by educating physicians of this stigma their patients may fear so they can foster a safe environment for them to share these emotions, we can work to better address both the emotional and physical needs of this population.

To be truly effective, healthcare providers working with the refugee population should take a trauma-informed approach to the care they provide to ensure that the services they offer lead to the best results. The U.S. Department of Health and Human Services, Center for Substance Abuse Treatment (2014) describes the trauma-informed approach as care provided under the assumption that the individual receiving care is a trauma survivor and someone who should be supported as they heal. In this type of care, providers must consider the traumatic experiences and journey that these individuals have faced and allow this to guide the interactions and care in a manner specific to the individual and their needs.

If providers are aware of these major lifestyle shifts that occur for these individuals, they can better educate them on community resources available for them, such as English language classes, that would enable the individual to work toward finding a profession that is in line with their overall goals. Furthermore, through a trauma-informed approach, providers can better address both the physical and emotional needs of resettled refugees.

Chronic Health Conditions after Resettling in the U.S.

The theme of learning of chronic health conditions after resettling in the U.S. shows that it is important for healthcare providers to be aware of these perceptions regarding taking medication and chronic health conditions to better educate these individuals and ensure that they

are taking the proper medications. Understanding these perceptions will allow providers to address the underlying issues, such as lack of exercise for individuals who may have had much more active lifestyles prior to coming to the U.S., that could be contributing to these chronic conditions. Furthermore, by understanding the distrust some patients have for costly medications that may be vital for them to manage their health conditions, providers can better tailor their communication about the need and function of these medicines in ways that will be more meaningful for the individual. Providers can also suggest practical solutions, such as coupons for patients' needed medications to help with the cost. Understanding the cultural perspectives and beliefs of these individuals, such as the Nepalese man who stated that medications were only taken by the rich, is important so providers can better educate individuals about incorrect assumptions, and be watchful for certain chronic conditions, like hypertension or diabetes, that these individuals may not even be aware of.

Challenges Accessing Physicians for the Nepalese

Another theme identified by this study was the challenges accessing physicians for Nepalese individuals specifically. They spoke of language barriers and the need to make an appointment to see the doctor as the main reasons why they thought seeing a doctor was more challenging in the U.S. when compared to Nepal. One way to address this barrier is for healthcare providers to schedule the next appointment for the individual while at the current appointment and sending a reminder as the appointment approaches. Scheduling regular appointments, especially for individuals with chronic conditions that need regular medication refills, could go a long way in helping these individuals get the care that they need. This small step implemented at clinics could help not only the Nepalese patients, but all patients, become

more motivated to seek regular health screens and check-ups and to be more diligent about seeking help for their healthcare needs.

Language Barriers

With regards to the theme of language barriers, there are many implications to consider. For the older children of resettled refugees serving as a translator for their family members, this puts a unique pressure on them – they often seek broad involvement with their peers and may also be working to help support themselves and their families in ways that their non-refugee peers may not understand or need to for their own families.

It is important here to note the difference between interpretation and translation, as in many cases, the researcher of this thesis observed that the child translating was greatly abbreviating the responses of their parent during the interview. This resulted in some of the information and details from the participant to be lost in this process of conveying the information in English. Furthermore, when considering the healthcare interaction, if the child serving as the translator is interpreting the information from the physician or their parent instead of directly translating, this could lead to potentially harmful consequences if not all the information is being shared between the physician and the patient. Due to this increased risk for miscommunication, it is crucial that clinics work to increase the number of in-person translators available at the clinic. Having translators trained to directly translate with limited interpretation could help reduce this barrier and challenge of communication. Furthermore, clinics could emphasize to the family member translating that it is vital that all information is directly translated, and if there are any doubts that this is occurring, the physician should use a translator line to reduce this risk of miscommunication.

These participant responses of identifying language barriers as a major challenge are very much in line with the previous research published regarding the main healthcare barriers experienced by resettled refugees in the United States as being language and communication barriers (Morris et al., 2009; Swe & Ross, 2010).

It is important to note that the implications of this study discussed above could be adapted and used for other underserved populations that also experience health disparities at greater rates, such as uninsured populations and ethnic minorities (Vanderwielen et al., 2015). These underserved populations experience similar challenges to refugee populations, such as challenges paying for health services, differences in cultural perspectives, and language barriers (Vanderwielen et al., 2015). The applications determined in this thesis, such as focusing on person-centered care with a trauma-informed approach, providing cost-effective alternatives, scheduling regular appointments, and increasing availability of translation services can be utilized for these other underserved populations. These steps can help address the barriers experienced by these populations and improve their overall care.

Cultural Understanding as a Priority

Researchers have differing opinions on what the priorities for action should be in the area of refugee healthcare. Some argue that addressing barriers to health should be the main priority (Afkhami & Gorentz, 2018). While this is an important area, there is an abundance of research already focused on exploring this area. For example, with regards to the language barrier that was identified as one of the most significant challenges by this population, researchers have discussed solutions including video interpreters to help with nonverbal communication, language banks, as well as increased English language classes for the refugees

(Morris et al., 2009). This can be seen at Hope Medical Clinic, as the clinic uses an interpreter phone line for patients needing translators and also has volunteers who are able to come to the clinic and help with translating.

With regards to the confusion many refugees face when trying to navigate the complexities of the healthcare system in the U.S., which leads to many health needs and personal health information being missed during moves between clinics, researchers have recommend that clinics adopt a standardized initial health screening so no information is missed (Mirza, 2013). This was an issue encountered at Hope Medical Clinic, where the interview participants of this study were recruited from. For some of these patients who went to different clinics depending on which was more convenient for them, they did not always bring their most recent lab results and other vital health information as they moved between clinics. To address this issue, the Hope clinic now emphasizes to their patients before their appointment to remember to bring all health records they have, regardless of how old they may be. This challenge of not having the most up-to date paperwork and files in addition to the language barriers led to patients not clearly communicating their concerns or full medical history. This in turn often led to appointments taking longer than necessary, as the primary reason for the visit was stated by the patient in passing or only much later in the appointment because the physician did not have all of the pertinent information.

Another researcher believes addressing literacy should be the priority, as higher levels of literacy were associated with higher levels of health literacy (Levine et al., 2004). However, prior research has shown that by first developing a greater understanding of the cultural mindsets and perceptions of this population, this will allow for more effective interactions in any situation, including literacy education. An example of this seen in this thesis is the perception of some

participants stating that taking medication is only for the rich. Simply addressing and improving the health literacy of such individuals in how to properly take medications will not address the deeper beliefs of these individuals, which may not lead to lasting or meaningful health belief or behavior changes.

Limitations

This study was subject to several limitations that ought to be addressed in future studies of this kind. This study used a small sample size, which limits the generalizability of results to refugees from different countries of origin resettled in the U.S. The study participants were individuals who were recruited from a medical clinic, so this may influence their level of knowledge and understanding of their health and the healthcare system in the U.S. As this was a convenience sample, a majority of the study sample were individuals from Nepal, so the results and subsequent interpretations of themes are largely relevant for individuals from Nepal.

The study participants were limited to those who could speak in English or who had someone present to translate for them. In the case that translators were used, there was a risk that not everything the participant was saying was being directly translated verbatim and that the translator was interpreting the answers, which could affect the analysis of the responses and results. Finally, the interviews and analysis did not control for other variables, so there may be other confounding factors that are affecting the results and interpretation of themes observed from this study.

Future Work

The limitations identified above help guide future work that would be beneficial for this population. To help reduce the possibility of confounding factors influencing the results, future studies should control for variables such as age, income, or education level. In future studies, it would be useful to have a larger sample size with a more even distribution of individuals from various countries of origin who might have different cultural perspectives and health beliefs. As research has shown, each culture has unique perspectives that cannot be applied to other cultures, so including a larger sample size of countries would allow for the analysis of more cultures. Furthermore, study participants should be recruited through various community locations, such as cultural centers and refugee resettlement agencies, instead of a single medical clinic. This broader recruitment method would help provide a wider, more representative range of perspectives, including individuals who may not be aware of the clinic or other health services available to them.

It would be valuable to have a pool of diverse translators for each language to reduce the risk of miscommunication during the interview process and to prevent limiting the diversity of potential study participants due to language constraints. Having a diverse pool of translators would also allow for a wider range of responses and richer meaning of those responses. In many interviews of this thesis, participants would provide a brief response to the researcher but continue the conversation in their native language with the friend or family member who had accompanied them. In other instances, the participants would struggle to explain a concept in English and often give up and state that that was all they had to say. Having translators would help enable these conversations to continue in a deeper, more meaningful way with greater detail from participants.

Finally, establishing a relationship with the individual through longer interview times in a less formal setting could allow for greater insights gained from the individual through more questions and more in-depth answering for each question. With more time for interviews, it would have been beneficial to ask questions such as do you feel like you have a strong support system here in the U.S. and other questions relating to the emotional and psychosocial needs of the individual. This line of questioning would provide a more holistic picture of the overall well-being of the individual with both physical and emotional aspects. Furthermore, it would be interesting to understand more about the health beliefs of individuals and how culture plays a role in this with questions such as what causes sickness and what are ways to prevent sickness.

In future studies, it would be useful to consider if the applications of this study could be adapted and made more specific for other underserved populations that also experience health disparities at greater rates, such as uninsured populations and ethnic minorities (Vanderwielen et al., 2015). By focusing on these populations and their unique perspectives, the initial solutions presented in this thesis could be made more specific and effective for their needs.

Conclusion

This study has showed a baseline of the type of research and findings that can be accomplished related to cultural perspectives and health beliefs of resettled refugees and how these differing perspectives can impact the health behaviors of individuals.

There is clearly more work to be done to understand the unique challenges refugees resettled to the U.S. face, not only when they first come to this country, but for their entire lifetime. Members of the resettled refugee population have shown tremendous resilience against daunting odds and many barriers to their healthcare. Refugee organizations and other clinics

serving refugees should continue to not only raise awareness of the challenges faced by this population, but to also continue to call for the U.S. healthcare system to be more responsive to the unique healthcare barriers and healthcare needs of this population. Only when healthcare providers who regularly serve refugees take the time to learn, understand, and make changes in their practice regarding the specific cultural needs and perspectives of the resettled refugee population will there be progress made toward addressing healthcare disparities experienced by this group. As this can be challenging for physicians already working with limited resources and many patients, we as a community have the power to raise awareness of this need, to donate resources and time to refugee-serving clinics and organizations, and to call on our policymakers for improved health policies that address the many barriers faced by this population as discussed in this thesis.

Through better understanding the unique cultural perspectives of resettled refugees, we will be able to provide more culturally competent care and work toward better empowering these individuals to live a healthier tomorrow. This thesis has shown the importance of using a holistic approach with trauma-informed care that addresses both physical and psychosocial needs in healthcare to best address the unique perspectives of refugees. It is important to realize that the value of using this person-centered approach is not limited to the refugee population, but can also be extended as a best practice for all individuals.

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Appendix

Interview Questions

Demographic information

Age (to nearest birthday):

Sex (M, F):

Ages and sex of all children:

Marital status:

Country of origin:

First language:

Secondary language(s):

1. What is your country of origin and what year did you come to the U.S.; how long have you been in the U.S.?
    a. Could you tell me a little about your life before coming to the U.S.? What was your daily routine like?:
    b. In the U.S.?:
2. What was your experience with healthcare in your home country?:
3. When would you go to the doctor?
4. Were there any difficulties you faced trying to access care?:
    a. If you have kids, what about them?
5. Do you have an idea of what caused this sickness?
6. Now in the U.S., when do you go to the doctor?
    a. Are there any difficulties you face trying to access care or when at the doctor?

7. Do you have any known health conditions?:
8. What have been some of your biggest health challenges or changes in health after coming to the U.S.:
9. What have been some of your biggest health improvements after coming to the U.S.:
10. Have you found it easier or harder to go to the doctor after coming to the U.S.?
11. Any differences in health you notice in general between your home country and the U.S.
12. Is there anything you wish your doctor knew or that was different about healthcare here:
13. Did any family members make the journey with you to the U.S.? If so, which ones?
14. Where are you currently living?
15. How many people are living in the same apartment or house with you? What is the relationship of each person to you?
16. Overall, how would you describe your health (poor, fair, good, very good, excellent)
17. Do you have any known health problems?
18. For which problems, if any, did you receive care from the place you were living jU.S.t before you came to the U.S.?
19. For which problems, if any, are you receiving some type of care now?
20. Where do you go to receive health care?
21. How do you pay for health care that you are receiving?
22. What barriers exist to your receiving health care?
23. When you do receive health care, from whom do you receive it?
24. Do you have any mental health problems for which you are aware?
25. Can you turn to a friend or family members for help when you are sick or are in need to formal health care? If so, to whom can you turn.

26. Can you turn to a friend or family member for help when you are feeling down or are anxious? If so, to whom can you turn.
27. What is the worst experience you have had when receiving health care in the U.S.? Probe for clarification.
28. What have been some of your biggest health challenges or changes in health after coming to the U.S?
29. What have been some of your biggest health improvements after coming to the U.S?
30. Have you found it easier or harder to receive healthcare after coming to the U.S?
31. What can be done, if anything, to improve upon the health care services you are currently receiving?
32. Where will you go to get health care in the future?

Author Biography

Rachel was born in Austin, Texas in 1998. She grew up with her parents Joshua and Sujatha and her sister Hannah. Rachel graduated from Westlake High School and joined the University of Texas at Austin as a Biology major in the Health Science Scholars program. While at UT, Rachel was involved in organizations including GirlAdvocates!, Freshman Research Initiative, Global Medical Training, Reading Aces, and HOSA – Future Health Professionals. She plans to graduate in May 2020 with a Bachelor of Science and Arts in Biology Honors with a Business minor, Health Communication minor, and a Forensic Science certificate. After graduating, Rachel is attending medical school at UTMB to obtain a MD/MPH degree to pursue her passion of working toward bettering health equity and global health.