

Health-Seeking Behavioral Patterns among Refugee Groups – A Case-Study in South-central Kentucky

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Abstract

Each year, thousands of people get displaced from their homes due to genocide, famine, civil wars and other crises in their countries. The United States has traditionally been receptive to resettling refugees. These refugees view resettlement as an opportunity to obtain proper health care. Due to the diverse cultural identities of refugee populations, it is essential to research complex culturally dependent healthcare utilization patterns. A purposeful sample of four refugees from the Burmese, Congolese and Iraqi refugee communities in south-central Kentucky- completed interviews. They shared experiences and insights from their cultural points of view. Results showed demographic factors directly impacted access through nationality and language, while social factors and beliefs impacted access through religion, acculturation, health insurance, transportation and the level of cultural competency of a health care facility/provider. These findings would contribute to the popular health and policy-making debates that surround the well-being of this culturally diverse population.

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Introduction

As refugees settle in their host countries, it becomes imperative for public health professionals to give attention to their health status and wellbeing. As a requirement in most host countries, a health assessment is conducted at the port of entry. On entering their host country, refugees are classified as foreign-born immigrants, hence, few studies have explored the health of refugees during the first few years following resettlement (Lipson, Weinstein, Gladstone & Sarnoff, 2003). There is also the opportunity to have a health assessment performed, preferably within the first 90 days of arrival, at the site of resettlement. A low level of healthcare utilization often has been assumed to be an indicator of better health. However, a low level of utilization of health services may be the result of other factors which could lead to poorer health (Surood, 2008). This is true for refugees. The use of formal healthcare, however, is constrained by the lack of knowledge, limited resources and access to care, as well as cultural differences in illness and help-seeking behavior (Leclere, Jensen, & Biddlecom, 1994). Awareness about healthcare services may be an important variable of utilization that requires more attention.

The extent to which refugees use healthcare facilities depend on different cultural inclinations, hence, all refugees do not utilize healthcare services equally. Refugee groups use services based on different cultural experiences and the value that each culture places on health and wellness also emigrates with them (Ivanov & Buck, 2002). Refugees are a category of immigrants, but their status avails them of the benefits that are also available to citizens, including healthcare and other social support. To serve this class of immigrants (refugees) appropriately, it is essential to understand the unique cultural beliefs and values that influence their use of healthcare services, health status and health outcomes.

This study provides insight into and data about the refugee community in southcentral Kentucky, and similar suburban areas, examining useful information about the expectations or needs of refugees as consumers in the healthcare system of the U.S. The central research question of this study was: What are the health-seeking behavioral patterns among refugees at their nearest local health facility? For this study, local health facility includes the health department, urgent care clinics, departments of hospitals, and local clinics.

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Table 1 Interview Questions

No.	Interview Questions
Q1	How important to you is taking care of your health?
Q2	What health concerns do you have, for example; heart disease, myopia, diabetes?
Q3	Describe your experiences with your health concerns?
Q4	What type of things do you think are important in the people or the system that provides you with healthcare? e.g., interpreters, bulletins in native language etc.
Q5	What affects your ability to receive medical services when you need them? For example, transport, health insurance, finances, language
Q6	How have past experiences with healthcare affected the way you approach it now? For example, making an appointment, interpreters, health cost/expenses?
Q7	Why do you go to the doctors or healthcare provider that you do? For example, is it because of cost, interpreters, and location/proximity?
Q8	How often are you not able to see a doctor when you want to?
Q9	What do you think works well in the healthcare system? For example, appointment times, interpreters, friendly environment?
Q10	What do you think should be changed in the healthcare system to make it easier for you to receive healthcare? For example, local transportation/accessibility, decrease cost/ affordability
Q11	How do you get to a clinic/hospital/doctor if the need arises?
Q12	Is there a difference in men and women experiences with healthcare providers?
Q13	What do you find most surprising about the healthcare system here in the United States as compared with your country?

Significance of Study

Considering the extent of ethnic diversity in the American population, surprisingly few empirical investigations exist on healthcare service use among refugees. Little is known about the extent to which the healthcare system addresses the needs of these individuals. However, the study is more informative about certain refugee groups. To shed more light on the healthcare needs of these minority groups, this study explored culturally associated patterns in healthcare use, but is limited about the extent to which the healthcare system addresses the needs of the refugee population.

The intersection of healthcare and immigration policy appears to work in variance with refugees. Little research has been conducted regarding the utilization patterns of this population and the ways health care could be provided with low cost access. Such information could assist with the development of future health services and program planning to support refugee health and well-being (Kiss, Pim, Hemmelgarn & Quan, 2011). Secondly, building an equitable evidence-based research model in this area is needed; it is an important step in determining whether refugees have adequate access to healthcare services. This study examined reasons these services are used, or underutilized, and whether culture indeed plays a role. Possible outcomes to this study may assist with the development of future health services and program planning to support refugee health and well-being.

Methods

To get detailed perceptions on the influence of culture, the researcher incorporated a qualitative research, narrative inquiry genre with individual interviews to obtain information. These interviews allowed the researcher not only to collect thoughts, feelings, and reflections on cultural diverse health-seeking behaviors but also to integrate and analyze the information culled for further in-depth understanding and clarity of the research questions and topic.

IRB

The study was approved by the Institutional Review Board at Western Kentucky University.

Participants and Data Collection

A purposeful sample of four interview participants: one Burmese, two Congolese and one Iraqi, ranging in age from 38 to 75 years with an average age of 56.5 participated in the study. All participants consented and were excited to be of help for the entire interview process. Each interviewee spoke Basic English without the need for an interpreter. Educational attainment on the average was at least a high school degree from their respective countries, and all four subjects were married. Three of the four were gainfully employed; the 75-year-old Burmese immigrant was retired. The sample consisted of three Christians and one Muslim. During the interviews (audio recorded), individuals were encouraged to express themselves as best as they could and to ask questions if an interview question was unclear. It allowed the researcher to probe for sentiments and deep-seated cultural values to gather further information not possible under the constraints of a questionnaire.

Although all participants were asked about general community issues, some participants were asked to describe their personal experiences. Thirteen interview-structured questions (IQ) included the following: Refer to **Table 1**.

The interview question guide was developed to explore the cultural characteristics, barriers, need-related health issues, and level of cultural competency of services used with the aid of the Andersen-Newman conceptual model on healthcare service utilization (Andersen & Newman, 1973). All participants consented to audio taping the interview; each lasted an average of 50 minutes. After the study was described and consent obtained, lively discussion and examples were stimulated by questions. Transcripts were prepared from each recording. A grounded theory approach was used to analyze the transcripts. Grounded theory is simply the discovery of emerging patterns in

data (Walsh et al, 2015). Each transcript was re-read and then coded for themes and repetitive patterns. Data saturation was reached when the researcher could not identify new themes manually.

Results – Study Themes

The study research questions constituted the framework for exploring the existence of cultural influence on the use of healthcare services through the lens of the four interviews. Central themes identified include: (a) Importance of taking care of one's health, (b) Refugees' barriers to use of available healthcare services, (c) Perceptions on physical and psychological state of health, and (d) Issues of cultural competency of the healthcare system regarding knowledge about foreign disease conditions or ailments.

Importance of taking care of one's health

All four respondents believed that good health was important for working effectively and contributing one's quota to the American society (being a taxpayer) and the local community, and for paying domestic bills. In addition, good health provides peace of mind and this, in turn, is necessary to maintain their daily activities.

Refugees' barriers to use of available healthcare services

The Burmese point of view (on barriers to use of health services) was that refugees not only have challenges with transportation, they also have inadequate health insurance coverage. It is safe to say that most Burmese refugees favored proximity in the use of healthcare services.

“Most refugee [according to my experience/observation] do like to go to the doctor nearest to them”.

He also added that language could be a barrier:

“The greatest problem of most refugees from Burma arriving in Bowling Green, is language. Most of them haven't gotten the chance to learn English. A person without a sound knowledge of English surely would face many difficulties in communication. Therefore, the first important thing is education. The necessary organization should provide opportunities or programs so that refugees could learn English until they can speak and write English, so that what they say could be easily understood by an American listener or speaker”.

Views expressed by the two Congolese refugees on barriers were that not only was transportation a challenge, but, also the affordability of public transportation.

“We need transportation, it's really a big problem in our community because most of us don't have transportation, we've (refugees) missed so many doctor appointments. Therefore, we decided to start the association ARIKY (Association of Rescue and Intervention of Kentucky), because of this kind of issues”.

They also added,

“I think we still have more challenges as refugees. One is transportation, even if we call 911, some people can't afford the ride. Another is getting a driver's license because

of the language barrier. So current challenges include, transportation, interpretation and translation”.

Similarly, the Iraqi interviewee identified transportation and language barriers as the two main limiting factors to accessing available healthcare services.

“The first thing I would talk about is the transportation – it is very important to the patient. S/he is ready to stay at home and stay sick [without transportation], plus it is linked with the language barrier. So, if s/he can't speak English and has no means of transport that's a big problem, just like it happened for one of the refugees”.

Another reason he gave was the feeling of camaraderie with the healthcare professional,

“For example, most of the Iraqis go to Morgantown city because there is a doctor there that speaks Arabic. They feel that they can communicate and understand the doctor well”.

Perceptions on physical and psychological state of health

Through the interview questions, the refugees provided insight about perceptions of their physical and psychological state of health. The 78-year-old Burmese immigrant presented age-related diseases such as cataracts, hypertension, and a case of hyperuricemia as his main health concerns. However, the Congolese viewed their health concerns in a different manner. According to them, before arriving in the U.S., they passed through screening and health checks and were cleared of all forms of chronic or infectious disease. Thus, they came into the U.S. with a clean bill of health. However, having lived for a few years in the U.S. and beginning to work in different factories, they began to develop some health concerns, such as eye infections, earaches, or headaches. The Iraqi refugee, as a certified medical interpreter, noticed that most refugees have high cholesterol levels and complain of joint and back pains.

Regarding the difference in men and women experiences with healthcare providers, the Burmese immigrant remarked that there is a clear difference:

“Men prefer men doctors and the ladies prefer lady doctors in Burmese culture”. He added that religion played a role... “It's also a concern with the religion Buddhism. Even among Burmese Christians, women should be treated by women doctors only, men likewise”.

The Iraqi claimed it was about culture:

“In our culture, it is not acceptable that a female, if pregnant or with other medical concerns sees a male doctor” He continued: “She needs to see a female doctor [like a gynecologist]. They prefer that because it is part of our culture”.

The Congolese participants indicated a different perspective, and thought religion was based on the individual, whether male or female. Both genders may have personal preferences and religion may not play a significant role in their choice of healthcare provider.

Issues of cultural competency of the healthcare system

regarding knowledge about foreign disease conditions, presentations or ailments

This theme sought to examine the issue of cultural competency of the healthcare system regarding knowledge about foreign disease conditions or ailments presented by immigrants, such as the case of Ebola in the U.S. or the outbreak of the Zika virus. Also noted was the availability of services such as interpreters, refugees would naturally gravitate toward these interpreters. The Burmese interviewee said...

“The health departments should provide basic health education pamphlets and occasional health education talks translated in Burmese language on certain topics that are important to refugee health”.

The same views were shared by both Congolese refugees, with practical examples:

“An example of language barrier - there was a pregnant lady, we took her to the hospital, and the health professional said, “No you’re not ready to deliver now, you can go home”. She could not argue, and she went home. After 2 hours, she delivered at home. I think the problem was an existing language barrier, so we need interpreters”.

The Iraqi believed that interpreters are needed; however, effective interpreters must fully understand the culture of that patient:

“An interpreter that understands the patient and can communicate the same to their health care provider bridges an important gap, due to differences in culture and beliefs. The interpreter should be an expert in the patient’s culture and can aid to avoid many points of misunderstanding between the health professional and patient”.

Generally, the interviews ended on a note of admonition, motivating refugees to learn the English language, obtain a job, and encourage others in the community to do the same and an appeal to the health care system to improve its quality of service to accommodate the increasing influx of refugees.

Discussion

The results show that lack of language supports, difficulties with accessing specialty care, unfamiliarity with referral procedures, limited information on finding services, confusion about the roles of different health professionals, and overall difficulties with navigating the healthcare system are all reported healthcare barriers from the perspectives of refugees (Mirza et al, 2013). Also, language barriers can reduce the quality of care, while the use of trained interpreters can improve access, quality, and patient satisfaction (Ponce, Ku, Cunningham, & Brown, 2006). Moreover, to date, published research has indicated that immigrants face significant challenges regarding healthcare access. Such challenges include lack of health insurance, lack of interpreters, discrimination based on race or accent, and lack of understanding on the part of doctors regarding immigrant or cultural perspectives on illness (Wafula & Snipes, 2013)

Limitations

The sample of four refugees is only a small representation of the general refugee population in southcentral Kentucky. Hence, there is inadequate generalizability of the study results. The

study did not compare the use of Western healthcare services against informal or local alternatives to determine whether it was culture-centric or a thing of preference. Refugees also have the tendency of conveying second-hand information, i.e. information based on what they were told by other refugees, or their personal understanding of the situation, and, not necessarily their own personal experiences. Hence, subjective opinions.

Conclusion

Healthcare disparities and problems with healthcare access exist among refugees, (Douangmala et al, 2011) and continues to be an increasing public health concern. This study explored the relationship between refugee culture and the actual use of available healthcare services. Demographic factors directly impacted access through nationality and indirectly through language and religion, while social factors and beliefs impacted access through acculturation, health insurance and the level of cultural competency of a health care facility or provider. Without realizing the need to use services, there would be no attempt at accessing these services, hence, utilization may not occur (Guendelman, Angulo, Wier & Oman, 2005). Therefore, there is the continued need for awareness.

Ethical Standards

All procedures involving human participants were in accordance with the ethical standards of the institutional research committee i.e. the author sought approval from the Institutional Research Board at Western Kentucky University. More so, informed consent was obtained from all individual participants. The authors; #1, #2, #3 and #4 do not know of any existing conflict of interest due to this submission or significant financial contribution or funding that would have affected the outcomes.

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