

Perceptions of Health Practices and Interactions with the US Healthcare System among Bhutanese Refugees: A Qualitative Approach

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Abstract

Purpose: The aim of this pilot study was to explore health practices of Bhutanese refugees and their interactions with the US healthcare system and providers.

Methodology: Researchers conducted 12 in-depth interviews and 7 patient-provider observation units as part of this descriptive qualitative study.

Results: Participants identified individual definitions of health and behaviors they value to maintain health. They identified significant trust and faith in their healthcare provider and valued provider-directed suggestions. Participants cited concerns with patient-provider communication resulting from limited English proficiency and frequent changes in primary care providers.

Discussion: This study is useful to inform further research and potential interventions aimed at improving health outcomes in Bhutanese refugees.

DOI: 10.18297/rgh/vol2/iss2/3

Submitted Date: December 18, 2018

Accepted Date: May 8, 2019

Website: <https://ir.library.louisville.edu/rgh>

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Recommended Citation:

Szajna, Amy E. (2019) "Perceptions of Health Practices and Interactions with the US Healthcare System among Bhutanese Refugees: A Qualitative Approach," *Journal of Refugee & Global Health*: Vol. 2 : Iss. 2 , Article 3.

Introduction

The United Nations High Commissioner for Refugees (UNHCR) identifies refugees as individuals who flee from their home country due to persecution related to gender, ethnicity, religion, or other individual characteristics, and cannot return to their country of origin due to well-founded fears of persecution (1951). Generally, refugees resettle from areas of conflict with inadequate access to healthcare, experiencing high incidences of chronic illness including diabetes, hypertension, and symptoms of psychological distress related to anxiety and depression (Asgary & Segar, 2011). These conditions often go undiagnosed or are mismanaged prior to resettlement (Eckstein, 2011). From 2016 to 2017, nearly 8,200 Bhutanese refugees resettled to the United States (MPI, 2018). Studies focusing specifically on the Bhutanese refugee population suggest substantial burdens of chronic disease, nutrient deficiencies and depression (Kumar et al., 2013). Bhutanese refugees living in the US are typically at the lower end of the socioeconomic spectrum with high rates of unemployment, low educational attainment, and limited English language proficiency. Bhutanese refugees are at risk for poor health outcomes (Bhatta, Shakya, Assad, & Zullo, 2014).

Research exploring the health practices of resettled Bhutanese refugees or their interactions with the US healthcare system

is limited, focusing primarily on gynecological health among Bhutanese refugee women (Lor et al., 2018; Poudel & Dyer, 2013; Haworth, Margalit, Ross, Nepal & Soliman, 2014; Kingsbury 2017; Davey & Vallianatos, 2018), health practices and perceptions specific to mental health (Mirza et al., 2018; Subedi, Li, Gurung Bizune, Dogbey, Johnson, Yun, 2015; Im & Rosenberg, 2015). Research exploring health practices and interactions with the healthcare system is more prevalent in other refugee populations. Though a heterogeneous group, identifying research exploring health issues in refugee populations was important for our current research with Bhutanese refugees since previous studies provided insight into potential issues encountered. Studies exploring preventive screening in refugee women suggest low screening rates (Redwood-Campbell et al., 2008; Barnes & Harrison, 2004). Somali women reported unmet healthcare needs related to health beliefs differing from the Western medical model (Pavlish, Noor & Brandt, 2004), perceived discrimination by healthcare providers, and questionable competence of medical interpreters (Herrel et al, 2004). Based upon a current review of the literature, the scarcity of studies exploring health in Bhutanese refugees necessitates the need for further research.

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Study Objectives and Theoretical Framework

The research question guiding this pilot study was: “How do Bhutanese refugees, resettled in the US, manage their health and experience interactions with the health system?” This is the first step of a trajectory to promote healthcare providers’ delivery of individualized, culturally relevant care to Bhutanese refugees. Using methodological qualitative triangulation (Guion, 2002), this descriptive study was designed to explore adult, Bhutanese refugees’ experiences and perceptions of “health” and interactions with the health system to determine health practices within this population for hypothesis generation for future studies. The overall study purpose was to describe Bhutanese refugees’ health practices and perceptions of interactions with the US healthcare system through in-depth interviews and observations of encounters with healthcare providers through convergence of research findings using qualitative triangulation.

Preliminary research exploring health practices in other refugee populations supports the notion that Bhutanese health practices and interactions with the healthcare system are influenced by a variety of individual, interpersonal, and environmental factors. A social ecological lens guided the narrative approach to interview questions. The Social Ecological Model (SEM) describes the interaction between individuals and their environment and interactions among environmental factors. Levels of the SEM include the following: individual, interpersonal, organization, community, and policy (McLeroy, 1988). To ensure a culturally accurate study continuum, we collaborated with a designated community partner (DCP) who is a Bhutanese refugee and now serves as a community leader. Through this collaboration, researchers incorporated the tenets of community engagement. Community engagement exists as a continuum of varying levels of community involvement to facilitate health research and improve health outcomes. The continuum begins with establishing relationships and collaborating with community members, and eventually, ideally leads to shared leadership with the community through dissemination of findings and inclusion during study-driven initiatives (ATSDR, 2011).

Methodology

Study Design

The researchers employed a qualitative descriptive design influenced by a phenomenological stance for the interviews. Qualitative descriptive studies describe the who, what, and where of experiences using semi-structured interviews or observations of targeted events (Sandelowski, 2000). We selected this approach since specific information was sought to address our research question. A purely phenomenological approach would require exploring much broader patient experiences; forgoing pre-determined interview questions aimed at addressing specific priority topics, which were formed based on previous key informant interviews with representatives from our local Bhutanese community.

Sample and Setting

To achieve our study aims, we recruited adult, Bhutanese refugees for study participation. Inclusion criteria included: legal refugee status in the US defined by the UNHCR (1951), 18-65 years of age, self-identified Bhutan as the country of origin, and current residence in Philadelphia, Pennsylvania.

Refugees who resided in the US for more than eight months were included in the study. During the first eight months post resettlement to the US, all refugees qualify for federally funded Refugee Medical Assistance (RMA) and cash assistance (ORR, 2012b). Previous literature exploring health practices in refugee populations identify cost and lack of insurance as a significant barrier to healthcare utilization (Szajna & Ward, 2015); thus, it is important to focus on Bhutanese refugees after the initial resettlement benefits end. We excluded refugees living in the US for greater than five years since greater likelihood that familiarity with mainstream health practices in the US increases with time spent in the US. We did not consider enrollment of refugees arriving at the clinic with an emergent health issue or exhibiting signs of acute distress.

Sample size selection was consistent with recommendations for qualitative sampling suggested in Morse (1994). Further, as a pilot study, we recognized that future research informed by our pilot would warrant a larger sample size. We recruited participants by posting printed fliers in the lobby of the Bhutanese American Organization Community Center. We also verbally recruited participants in the waiting room during clinic hours. Our DCP translated recruitment material into Nepali and served as the point of contact for interested participants. This collaboration proved crucial, as an exclusion of non-English speakers would clearly result in difficulty achieving a sample that was representative of the Bhutanese refugee community in Philadelphia. Researchers obtained approval from the affiliated academic institutional review board (IRB) prior to study initiation. Procedures for informed consent put forth by the IRB were followed.

Data Collection

Data collection methods included semi-structured interviews and direct observation of interaction between refugees and their healthcare providers during clinic appointments.

Interviews. Individual interviews were guided by an exploratory, descriptive qualitative approach to elicit data on Bhutanese refugees’ experiences and perceptions of health and healthcare since resettling in the US. Interviews occurred at the Bhutanese Community Center (BCC) on weekends when the center was closed. The BCC’s proximity and familiarity to the local Bhutanese community, as well as being a private, quiet environment for interviewing proved an ideal setting for data collection. To maintain confidentiality, only the PI, the DCP, and the participant were present during the interview. We provided a printed statement of the study purpose, in both Nepali and English, to each participant prior to each interview in lieu of obtaining a signed informed consent to avoid collection of any information that would identify our participants. The DCP verbally translated the information and provided clarification to any potential participant questions. Interviews were audio-recorded and subsequently transcribed. We conducted 12 interviews over a one-month period. Interviews lasted between 30 – 90 minutes each. Nearly all interviews were conducted in Nepali. The PI asked the participant each question and the interpreter translated the question to Nepali. Answers given in Nepali were then translated back to English by the interpreter.

Observations. Observations during medical visits at the Bhutanese Clinic provided the opportunity to gather data on interactions between refugee patients and providers. The Bhutanese Clinic, located at the Bhutanese Community Center, is open once a month during the evening for Bhutanese refugees

who no longer have medical insurance through the RMA program. The clinic operates on a walk-in basis and is staffed by volunteer allied health students and physicians from a local university. While monthly patient volume fluctuates, the clinic typically provides primary care services to about 5-15 patients per month. We observed seven patient-provider interactions over the course of three clinic sessions (3 months). The researchers intended to recruit the same number of patients for observations as interviews and have equal representation of genders; however, we attained a smaller sample. Due to low clinic volume, there were challenges with participant recruitment, yet we are confident that future research extended beyond the duration of this pilot study will yield a larger sample.

The PI's role was strictly as participant-observer during each observation unit, meaning that the participant knew the identity of the researcher, but the researcher did not interact with the participant in order to maintain a normal, routine patient visit. Observations lasted between 10 minutes to an hour, consistent with the variability of normal clinic visits. Limited provider demographic characteristics were recorded; however, observation units included five different providers. Of the five providers included for observation, all were either third or fourth year medical students with oversight by a family practice physician. There was near equal representation of both genders for all providers and Nepali interpreters. Provider gender can significantly influence the patient-provider interaction among Bhutanese refugee patients, particularly when the patient is female. Bhutanese women report a greater hesitancy to share sensitive health information in the presence of a male healthcare provider or medical interpreter (Lor et al., 2018). In fact, various refugee advocacy organizations have suggested asking female Bhutanese refugees if they would prefer to interact exclusively with female providers. We witnessed an interaction where a female patient laughed and hesitated when the male provider asked permission to perform a breast exam before ultimately consenting. Regrettably, clinics serving refugee patients often rely on volunteer providers; thus, options for patient-provider gender matching may not be feasible. We used an adaptation of the Four Habits Model (Frankel & Stein, 2001) as the framework for patient-provider interactions to establish rapport and build trust with the healthcare provider. The Four Habits Model provides a communication skills framework for patient interviewing and follows the following four habits: invest in the beginning, elicit patient's perspective, demonstrate empathy, and invest in the end. Specific skills include eliciting the patient's concerns, asking the patient for ideas, respond in a culturally appropriate manner, and encourage patient questions (Frankel & Stein, 2001). We applied these concepts during the observations but revised each concept to be patient-centered, rather than provider-centered. For an example, rather than recording if the provider elicited the patient's concerns or involved the patient in decision-making (Frankel & Stein, 2001), we recorded if the patient voiced concerns or included his or her own opinions regarding a treatment plan. We also recorded nonverbal cues through field notes describing patient actions such as eye contact with the provider and common signs of emotion including laughter, facial expressions, and hand movements such as wringing of hands, or fidgeting with an object.

Data Analysis

We employed thematic content analysis to gain a preliminary understanding of the health practices of Bhutanese refugees and their interactions with providers in the US healthcare system.

The PI entered verbatim transcriptions of interviews and observation field notes into NVIVO-11 (QSR, 2015). The software provided a structured method for organizing and identifying data with corresponding codes. The research team incorporated the components outlined in Lincoln and Guba (1985) to ensure analytical rigor. The PI verified codes with a qualitative expert serving as a peer-debriefer to confirm credibility. The PI maintained detailed field notes during both data collection and the analysis process to facilitate transferability. External audits, by co-investigators, verified accurate interpretation of the data for dependability. We maintained confirmability of data interpretation through audit trails to minimize biases and triangulation of the two data collection methods.

Following analysis, the two data sources were merged to determine the presence of corresponding themes. We conducted data triangulation using the Triangulation Protocol (Farmer, Robinson, Elliot, & Eyles, 2006). The six-step process includes sorting, convergence coding, convergence assessment, completeness assessment, researcher comparison, and feedback. For research comparison, the co-investigator served as the second researcher to assist with clarification of data interpretations. For the final phase of the protocol, the feedback phase, the co-investigator, as well as the DCP, reviewed findings for clarifications.

Results

Final sample size was $n = 12$ (interviews) and $n = 7$ (observation units). We aimed to include nearly equal gender representation and variable ages although low clinic volume created difficulties with observation recruitment. **Table 1** details sample demographics for enrolled participants. As this was a preliminary study, we did not correlate our findings to specific participant demographics. We recorded no identifying data.

Interviews

Six primary themes became apparent during analysis of interviews. Specific exemplar quotes corresponding to each theme are included as **Table 2**.

Participants reported definitive responses regarding behaviors valued for health maintenance and promotion. Nearly all participants reported consumption of fresh, clean, fruits and vegetables as health promoting foods. The majority of participants stressed the importance of keeping a clean house and daily bathing, associating a dirty house or poor personal hygiene with becoming ill. Participants readily expressed the value of exercise indicating that physical activities such as stretching, yoga, and neighborhood walks were crucial for health maintenance. Many participants also indicated that doing laundry, cleaning, and other household chores fulfilled physical activity.

Most participants reported learning health behaviors related to diet and exercise from their providers in the US, indicating faith in US providers' recommendations. Behaviors related to individual and home hygiene appeared to relate more to culture, as participants primarily reported that they just knew that hygiene promoted health for as long as they could remember.

Reliance on US healthcare providers was also evident when participants described their thought processes and actions related to concerns about their health. All participants reported that for common ailments not resolving at home, or for any

Table 1 Description of Demographic Characteristics of Participants

Characteristic	Interview (n = 12)	Observation (n=7)
Gender		
Male	6	6
Female	6	1
Age $\mu = 39.5$ (I) / $\mu = 38.3$ (O)		
18-30 years	3	3
31-45 years	6	2
46-64 years	3	2
Length of time in US $\mu = 3$ years (I) / $\mu = 2.3$ years		
1 year	1	0
2 years	2	3
3 years	0	3
4 years	4	1
5 years	5	0
Language Proficiency		
Nepali only	8	6
Nepali and English	4	1
Employment status		
Full-time	2	1
Part-time	3	2
Unemployed	7	4
Home Status		
Rent	12	7
Own	0	0
Number of people in household $\mu = 5.2$ people (I) / $\mu = 6.4$ people		
0-2 people	0	0
3-5 people	5	2
6-8 people	7	4
Primary transportation		
Public	9	12
Car	3	0

Table 2 Interview Analysis Exemplars (n=12)

Themes	Exemplar Quotes
Personal meaning of health	<i>"So, it is, I think, without any kind of disease."</i>
	<i>"Where there is no disease or no any kind of medical conditions."</i>
	<i>"It's everything"</i>
Health promotion and maintenance behaviors	<i>"So washing fruits and vegetables before we eat. . ."</i>
	<i>"So it is just my experience that eating healthy, fresh food keeps us healthy."</i>
	<i>"I would keep myself clean and my house clean and then I like fresh fruits and vegetables."</i>
	<i>". . . I would get out of my bed and walk every morning, and then stretching of my legs. . ."</i>
	<i>"Sometimes I have to carry a barrel of water from the laundry which is near the room. That's how I stretch out my muscles and everything."</i>
Actions when experiencing healthcare concerns	<i>"So when I get sick the first thing that comes to my mind is that I have to go to hospital and take medicine so that I will be okay."</i>
Influences when making healthcare decisions	<i>"In many cases my family members would tell me what to do if I'm sick, and even some friends, like my close friends would tell me what to do."</i>
	<i>"All family members sit together and make a decision."</i>
	<i>"When I come here, my friends and relatives, they teach me."</i>
	<i>"The doctor advised me."</i>
	<i>". . . the doctors told me how to stay healthy and I would follow them."</i>
	<i>"When I come here I hear these things from the doctors, they told me and then I realized it was really important for the health. . ."</i>
Experiences with the US healthcare system and providers	<i>"When I am sick and have to go see the doctor, they will do tests and then find out what's wrong with my body, and then they will give me medication for that, and I feel happy on that."</i>
	<i>". . . when I go to see my provider or the doctor, they treat me very well. They want to help me clean my eyes and now I have better vision that what I had before."</i>
	<i>"They will explain everything about the health situation of our body . . . They try to explain us in detail so we can understand what's going on in our body and what's not working."</i>
	<i>". . . the doctors and the hospitals can really make sick people cured, so I feel better."</i>
	<i>"So when I was new here . . . I do not know how to speak English so it was very difficult in the beginning, but now I can go there by myself and I can at least sign in there. . ."</i>
	<i>". . . I'll try to start the conversation myself and then I'll ask for the interpreter. . ."</i>
	<i>"Every time when I have to go to the hospital I won't be able to speak to the doctors and healthcare persons and I feel sad on that. I have to rely on other persons, interpreters."</i>
	<i>". . . it would be nice if we had an in-person interpreter. . . not over the phone or something like that, so that we would be able to express our feelings, how we feel that day to the doctors."</i>
	<i>"So there have been a lot of changes in the primary care provider since I come here. . . So I don't know if they look at my medical record and find out what us the starting point of my disease or sickness. . ."</i>
	<i>". . . and there has been a lot of changes in the provider, like there are four providers so far. . . and I don't even know, we can't keep track of who the doctor is right now, . . ."</i>
	<i>"They will have more than four or five doctors in there, and we can't find out who is the primary doctor."</i>
	Health here versus Nepal
<i>"The healthcare system in the refugee camp, there was kind of, it was available but they only had limited medicines that they gave out and most of the medicine we had to buy them. We had to pay for that. Even the treatment was not better, not good. . ."</i>	
<i>"I think that most of the Bhutanese people, they had at least a kind of medical condition . . . and many of them were cured when they came here. . ."</i>	
<i>"In some way we were doing a lot of physical work back in Nepal. That in some way keeps us healthy."</i>	

Table 3 Observation Analysis Exemplars (n=7)

Theme	Exemplar
Passive role during visit	<i>Responded only yes or no unless asked to elaborate (n = 7)</i>
	<i>Very little eye contact with provider (n = 4)</i>
Expression of opinions related to health and treatment and potential treatment barriers	<i>Less than half provided opinions and suggestion to guide treatment</i>
	<i>Very few expressed treatment barriers. Cited barrier included language and insurance (n = 2)</i>
Nonverbal expressions of emotion	<i>Laughed when asked about substance use and mental illness (n = 3)</i>
	<i>Fidgeted with hands or object during the interaction (n = 4)</i>
	<i>Appeared apprehensive but consented to male provider performing breast exam (n = 1)</i>

serious medical condition, treatment with a healthcare provider is essential. About half of the participants also explained their inclination to use natural remedies during illness. Specific remedies varied but were always described as herbal or organic. Participants explained that these remedies were passed down through generations and were common in their country of origin because expensive, western medical treatments were seldom attainable. All participants emphasized preference to follow the instructions of a healthcare provider for a serious health condition if a traditional remedy proved ineffective.

Similar to actions taken when participants had a healthcare concern, themes related to healthcare decision-making were apparent. Nearly all participants reported reliance on family members and friends to assist with healthcare related decisions, suggesting strong value in the family and community unit. Consistent with previous themes indicating strong value in US healthcare providers, nearly three quarters of participants identified doctors as a primary influence in decision making.

Overall, participants described their interactions with providers and the healthcare system in the US as favorable. Participants expressed faith in their US providers with nearly half of all respondents conveying their perceptions of a positive experience with provider-directed treatment. While participants generally articulated praise for the US healthcare system and providers, the majority did identify language barriers as a significant concern when accessing healthcare in the US. Many participants reported their inability to speak English as a barrier but still attempted communication. Various perceptions of medical interpreters, including availability, were also evident in over half the interviews. Two participants also identified communication barriers with reception personnel as a significant concern. A quarter of the participants reported dissatisfaction with frequent changes in their providers, related to continual clinic and insurance changes. Participants reported confusion and frustration over having to reestablish relationships and identify their most current physician.

Participants expressed strong sentiments regarding their current health status compared to their health prior to resettlement to the US. Participants overwhelmingly reported better health in the US, citing better healthcare resources, better sanitation, and lower healthcare-related costs in the US. Several participants even reported that health conditions experienced in the refugee camp were cured post-resettlement. The individuals acknowledged that they lead more healthy lifestyles prior to resettlement due to physical activity incorporated into daily life.

This however, confirms participants' views on the benefits of physical activity.

Observations

Three primary themes emerged from the seven participant-provider observations. We include exemplars as **Table 3**. Most participants assumed a passive role during the visit and responded to provider questions with yes or no answers until cued to elaborate by the provider yet appeared engaged during the interaction, nodding their head as the provider spoke. This question-answer structure allowed the entire interaction to be provider-directed.

Very few participants suggested treatments or included personal opinions about their illness during the medical visit, voiced concerns, or asked additional questions during the interactions with their provider. Of the two patients verbalizing concerns, one patient identified language as a barrier to scheduling as appointment with a specialist recommended by the provider. The second patient expressed concern regarding lack of insurance required for adherence to provider treatment recommendations.

Several prominent nonverbal cues emerged across several participants that indicated a patient emotion during provider interaction. Three laughed when asked about history of alcohol use and appeared very proud when reporting they had never used alcohol. The laughter appeared to be genuine rather than due to feeling uncomfortable or nervous. Another nonverbal cue included apprehension to allow a male provider to perform a breast exam. This was evidenced by patient hesitation when consenting to the breast exam. We also observed fidgeting of the hands during separate patient-provider interactions that could indicate nervousness during the interaction. Evidence suggests that South Asians cultures may avoid direct eye contact, refrain from emotive responses, and refrain from saying anything that may cause conflict or discomfort when interacting with a healthcare provider, instead electing to show emotional restraint (Kim-Goh, Choi, & Yoon, 2015). Despite fidgeting, these participants did appear engaged during the interaction, nodding their heads and answering questions posed by the provider.

Interview and Observation Triangulation

While observation data yielded fewer themes than interview data, there is questionable evidence of preliminary triangulation between the two data sources. Participants described a sense of trust with providers, citing provider influence over healthcare

decisions. This appeared to be corroborated during the observations; nearly all patients refrained from questioning treatment options dictated by the provider, potentially suggesting faith in the provider. Conversely, this could indicate culturally-influenced perspectives where providers are viewed as a paternalistic figure that should not be questioned. Even when patients voiced concerns related to expensive medication options and limited financial means, they appeared ready to adhere to the prescribed medications despite the provider mentioning the high cost. Patients readily thanked the provider and appeared happy and enthusiastic with the treatment plan. Patient-provider interactions were almost exclusively physician-led, with patients only speaking when prompted by the physician. Further, patients frequently answered with brief, yes or no responses. This interaction characteristic is consistent with participant reports of concerns using a medical interpreter and feeling as though communication is limited when using a translator.

Discussion

The interviews elicited far more themes than the observation units. With the small number of observations units, we cannot report with confidence the presence of data triangulation. Nearly all observations were provider-directed with very few patient-initiated conversations, yet we cannot confirm that this is due to the trust and faith in providers expressed during the interviews. Our DCP reported that when residing in Nepali refugee camps prior to resettlement, this population was unable to take an active role in their healthcare. Further, like many other cultures, Bhutanese refugees regard healthcare providers as figures commanding a high level of respect and authority that should not be questioned. This is consistent with previous research suggesting that Asian cultures view the provider-patient relationship as hierarchical with emphasis on the provider's decisions and expertise through authoritative, provider decision-making (Nitchaikovit, Hill, & Holland, 1993; Claramita, Utarini, Soebono, Van Dalen & Van der Vleuton, 2011). Healthcare consumerism is a learned behavior and this paternalistic patient-provider relationship may not necessarily change once refugees resettle to the US. Future research should likely include questions that would generate more detailed responses related to the patient-provider dyad. Further knowledge related to the patient-provider relationship among Bhutanese refugees could inform future work to facilitate patient empowerment and autonomy among this population.

As one of the first studies of its kind with a population of Bhutanese refugees, comparison to findings of other studies is difficult; however, there is utility in comparing findings to similar research employing other refugee populations. In general, Bhutanese refugees appear to view their interactions with the healthcare system (particularly with healthcare providers), as positive. They express faith in their providers and associated services as these relationships have supported relief from illness and maintenance of health, and this may explain why many of their health practices are provider-directed. This finding differs from past studies that identify strong mistrust and perceived discrimination by healthcare providers by other refugee populations (Barnes & Harrison, 2006). Previous research also indicates many refugee populations fear discrimination by other community members if they disclose their health problems (Szajna & Ward, 2015; Subedi et al. 2015), although our sample did not indicate negative views towards specific health conditions.

Culture influences health practices; thus, we expected to find viewpoints from our Bhutanese participants that differed from those presented in the literature, which includes refugees of many other ethnic backgrounds. Previous research with other, non-Bhutanese refugee populations suggests preference of traditional medicine over Western medicine (Pavlish et al., 2010) and decisions related to health practices influenced by culturally-derived family norms (Redwood-Campbell et al., 2008) and religion (Ellis et al., 2010). While Bhutanese refugees acknowledged use of traditional remedies for mild illness, participants in this study overwhelmingly emphasized that serious illness should be treated with Western medicine. Moreover, Bhutanese refugees reported seeking advice from family and neighbors regarding health practices and concerns, but rarely identified specific family members. Future research warrants exploration of the role of specific family members that influence healthcare decisions. Further, establishing factors that influence family members' role in healthcare such as culturally-driven familial structure norms or other factors such as ability to speak English or provide transportation for the household is important. Interestingly, no participants identified religion or spirituality as an influencer of health practices in our study.

Our interview data clearly suggest that participants identified fresh fruit and vegetables as food consumed to promote and maintain health. Considering fresh fruit and vegetables are often costly and difficult to obtain in the urban neighborhoods where most Bhutanese refugees reside, further information is needed related to how and if these food sources are obtained by the community. If a deficit is identified, interventions aimed at improving access to nutritional food sources could be valuable to Bhutanese refugees.

Consistent with previous refugee research (Szajna & Ward, 2015), a theme in our study was problems with limited English proficiency and navigational issues related to the Western medical model. Past research cites barriers with translation services, especially lack of availability of medical translators (Asgary & Segar, 2011). Our interviews identified similar concerns. Difficulty navigating the host country's healthcare system (Asgary & Segar, 2011) was also expressed in our interview data. Despite variability, identification of commonalities across refugee populations, such as linguistic and navigational concerns, is crucial. These similarities are useful when extending potential interventions to other refugee populations.

We highly recommend incorporating the principles of community engagement when working with a foreign-born population or any population who has cultural norms differing from that of the researchers. Working with a DCP proved invaluable during each step of this study and we are optimistic that potential interventions created from our findings will be more successful if leadership is shared among the Bhutanese refugee community.

Limitations, Implications for Practice and Conclusion

A larger sample size will allow researchers to link data with participant demographic characteristics. The research team limited recruitment to one geographic area but acknowledged that specific metropolitan characteristics could influence results. Further, the primary researcher's role as a clinic provider and the DCP'S well-known presence in the community could

have influenced interview responses. We are also aware that investigator biases are always a concern in qualitative research, but careful self-reflection was a mechanism to counteract this limitation.

Conclusion

While current federal policies have drastically reduced refugee arrivals, the need for long-term care of refugees already resettled in the US remains urgent. Health promotion research should subsequently shift to a focus on healthcare topics aimed at improving the long-term health of resettled refugees as we encourage refugees to become active participants in the US healthcare system. Bhutanese refugees' value health and place emphasis on their faith in the US healthcare system and providers. Knowledge of the population's prioritization of health can facilitate potential intervention development for improving health outcomes since these interventions appear welcomed by Bhutanese refugees. Based on the interviews and observations, program development aimed at increasing patient autonomy and self-advocacy during healthcare visits could lead to a trajectory toward improved health outcomes.

Acknowledgements

The author would like to acknowledge the dedication of Dr. Susan Newman, Dr. Mathew Gregoski, Dr. Shannon Hudson, and Dr. David Jack. Their guidance and support made this study possible. Further, many thanks to the Bhutanese American Organization of Philadelphia.

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