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# Health Seeking Behaviors among Displaced Populations/Refugees

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## Abstract

The United States resettles refugees every year. Their population in south-central Kentucky (KY) is diverse and fitting to research into culture-dependent healthcare utilization patterns. A mixed study was conducted with one hundred and ten semi-structured questionnaires and three individual interviews. Significant differences were observed between the use of healthcare services and refugees' nationality ( $F(5, 98) = 4.29, p < 0.001$ ), acculturation ( $t = -2.03, p < 0.04$ ), and interpreters ( $t = 1.92, p < 0.05$ ). Beliefs affect use through the level of cultural competency of the healthcare provider. These findings contribute to the health policy debates surrounding this culturally diverse population.

**Keywords:** refugees, cultural competency, health delivery, acculturation, utilization, immigrants

## 1. Introduction

The immigrant population in the United States (U.S.) is on the rise; refugees and resident aliens are not excluded. Southcentral Kentucky, with its substantial refugee population is an exemplar of an idealized community that the world is a global village. The process of migration involves varying degrees of economic, social, and environmental dislocation, all of which affect the health and well-being of migrants in the period following migration [1]. Refugee migration, access to healthcare, and physical health are related in complex ways that work to the disadvantage of these immigrants [1]. Once in the host country, refugees more likely live-in poverty and face substantial economic barriers relative to access and utilization of medical care.

Differences in healthcare utilization among refugees from developing countries occur due to the strong impact of culture on health. Hence, immigrant culture poses a challenge in seeking help [2]. To understand cultural underpinnings of health and the use of health services among immigrants especially refugees, it is essential to note that decisions relating to healthcare use are bound by a social context [2]. The use of formal healthcare is constrained by the lack of knowledge, limited resources, and access to care, as well as cultural differences in illness and help-seeking behavior [2]. Despite the increased interest in refugees' use of welfare and social services, and in the future of the American healthcare system, surprisingly little is known, especially on a national level, about the healthcare utilization patterns of migrants or their participation in government funded insurance programs [2]. Some researchers are aware that statistics may mask differences in health service use and reasons people seek professional care; therefore, it is important to combine qualitative and quantitative approaches to broaden our understanding of the study.

## **2. Background**

The 1965 amendments to the Immigration and Nationality Act, which changed the pace and composition of immigration to the United States, will have continuing ramifications for many years. Refugees are individuals who have been forced to flee their country of origin due to fear of persecution caused by racial, religious, or social group identification and those who have refugee status in the U.S. [3]. Unlike other immigrants, for example, foreign workers, tourists and students, refugees do not leave their home country by choice and cannot or will not return to that country.

The United States is a melting pot, one that retains cultural richness from various populations [4]. Considering the extent of ethnic diversity in the American society, surprisingly few empirical investigations exist on health service use among refugees. Researchers also know little about the extent to which the healthcare system addresses the needs of these individuals. However, as the U.S. immigration quotas increase, more research is needed on specific immigrant populations to learn about their unique cultural patterns of healthcare utilization. The importance of understanding the concept is evident by the less than sufficient scholarly work about this group [2]. Various studies have shown that limited information exists on refugees' knowledge of healthy behaviors, how much they engage in such behaviors, or whether they have the desire to learn healthier habits when needed. Researchers have identified a growing body of knowledge surrounding the influence of culture on health behavior and healthcare utilization practices [4]. Obvious reasons exist to expect differences in healthcare utilization among refugees' due to the impact of culture on health [5].

This study helps to better understand the role of culture in health service use. In addition, it provides insight and data about the refugee community in south-central, Kentucky, and similar rural areas [2]. The study examines useful information about the expectations or needs of refugees as being consumers in the healthcare system of the U.S. and highlights cultural patterns in their knowledge of preventive health and health-seeking behaviors [2]. Furthermore, to serve more appropriately this category of immigrants i.e., refugees, it is essential to understand the unique cultural beliefs and values that influence their utilization of healthcare services, their health status and health outcomes [2]. Recognizing the dynamics between culture and health is essential, thus, culture guides and influences various aspects of life, including health [2].

To address the healthcare needs of these refugees', this study reports on the culturally associated patterns in healthcare service use. Hence, the influence of culture was viewed as refugee cultural characteristics, perceived barriers, and perceptions on health status with regards to utilization of healthcare services. The research questions were as follows [6]:

1. What is the extent of relationship between Frequency of Use of Healthcare Services and the refugee cultural markers?
2. What is the extent of relationship between Frequency of Use of Healthcare Services and barriers as identified by refugees?
3. What is the extent of relationship between Frequency of Use of Healthcare Services and refugees' perceived needs?
4. To what extent does a relationship exist between services available at a healthcare facility and the Frequency of Use of Healthcare Services, i.e., Cultural Competency of Services?

3. Method

3.1 Study design

This study was conducted in 2016 and employed a mixed-study research design. Statistics alone may mask differences in actual health service use and the reason people seek professional care; therefore, it is important to combine both qualitative and quantitative approaches. This approach not only allowed the researcher to collect thoughts on culturally diverse health-seeking behaviors via questionnaires, but helped to integrate further in-depth understanding, feelings, reflections, and clarity on the research questions and the topic during interviews.

3.2 Study population and sample

The target population was identified as refugees who reside in the city of Bowling Green, Kentucky (in the United States), from 2012 to 2016, are registered with the International Center, and fit one or more of the following criteria [2]: (a). Have been forcibly displaced outside their native countries with a history of hardship, including war, famine, and violence, (b). Have spent a part of their lives in refugee camps, (c). Have resettled in Bowling Green over the past 5 years (i.e., 2012 to 2016), (d). Have used a healthcare facility (urgent care clinic, ER, hospital, health department) at least once. Based on these criteria the actual target population was 3,371 refugees. As identified in **Table 1**, refugees meeting this criterion include: Afghans, Burmese, Burundians, Congolese, Cubans, Iraqis, Nepalese (Bhutanese), and Somalians. A convenience sample of 110 refugees was gathered from the target population because of the non-static nature of the refugee population and challenges in assembling individuals within each refugee group [2]. Nations represented in the study sample as exemplified by **Table 1** below were, Burma (which are one of the largest refugee group in Bowling Green), Burundi, Democratic Republic of Congo, Cuba, Iraq, Nepal (Bhutan), Somalia and Others (Bosnia, Pakistan, and Saudi Arabia). A purposeful sample of four individuals fluent in English were selected for the individual audio-recorded interviews. They included one Burmese, two Congolese and one Iraqi who had given prior consent. See **Table 1** (*here*).

Country	Target Population	Study (n)	Sample (%)	% of Target Population
Afghanistan	62	—	—	—
Burma	2122	38	(34.50)	1.79
Burundi	37	3	(2.70)	8.10
DRC	141	19	(17.20)	4.63
Cuba	170	12	(11.00)	1.71
Iraq	362	9	(8.20)	2.48
Nepal	155	8	(7.30)	5.16
Somalia	322	7	(6.40)	2.17
Others	—	14	(12.70)	—
Total	3371	110	110	3.26

*Note. DRC – Democratic Republic of Congo.*

**Table 1.**  
*Population and sample percentages per refugee group, 2010–2015.*

### 3.3 Study instrument

A questionnaire was developed after an extensive literature search. The questionnaire was based on the Andersen-Newman theoretical framework and centered on factors that influence health service utilization. Participants completed informed consent forms. The final instrument consisted of 27 Likert-type questions, five open ended, 10 yes or no, and 15 demographic or background questions.

A pilot study was conducted to test the validity and reliability of the survey instrument. The participants for the pilot study were non-targeted refugees from two main refugee groups in southcentral Kentucky: the Burmese and Congolese populations. The participants in the pilot study were precise in their feedback of the instrument [2]. The researcher then reviewed the information provided, conducted an exploratory factor analysis to validate the instrument.

Factor analysis was conducted on the pilot data. Data checks confirmed that the distribution closely met assumptions relevant to factor analysis, i.e., the sample size ( $N = 158$ ) was sufficient to support the maximum number of items (27 items). Cronbach's alpha for each scale demonstrated adequate to strong reliability. Seven factors emerged with two to five items, which produced a high Cronbach's alpha with values ranging from 0.742 to 0.913. Four items on the initial draft of the survey instrument overlapped other items during factor loading: I live near (within 3 miles/5 km) to a healthcare facility (loading as 0.578); I understand all the instructions given by the medical professional (loading as 0.469); I feel frustrated going to a healthcare facility because nobody understands my language (loading as 0.547); There are interpreters in my language at the healthcare facility (loading as 0.460). As these items were deleted from the final questionnaire, the number of items on the final survey instrument was reduced from an initial 31 to 27 [2]. Descriptive statistics for individual items are provided in **Table 2**.

The questionnaire was translated to various immigrant languages for example, Arabic, French, Spanish and Swahili for those who did not understand English. Questionnaires and informed consent forms were distributed at the International Center, the Community Action of Bowling Green, the Neighborhood Community Services, and the Bowling Green Housing Authority.

### 3.4 Variables

The rationale for including four independent variables (Predisposing Factors, Enabling Factors, Need-Related Factors, and Cultural Competency of Services) and the dependent variable (Frequency of Use of Healthcare Services scale) was grounded in theoretical and conceptual considerations derived from the Andersen-Newman framework. Three of the four sets of items under the Predisposing Factors were chosen because of their relevance to the cultural identity of refugees: Native Language, Nationality, and Religion are fundamental to any group [2]. The items within Enabling Factors (Number of Years in the U.S., Have Health Insurance, Educational Level, Available Transportation, Make an Appointment, and Friendly Environment) can be expected to influence refugees' attitudes about using available healthcare services. Need-Related Factors (Gender and Age) affect refugees' health status or their individual perceptions on health. Finally, the level of Cultural Competency of Services (Interpreters and Health professionals understand patient's condition) items are related to whether a given healthcare facility was tailored toward meeting refugee health needs [2].

The dependent variable for this study was the Frequency of Use of Healthcare Services scale as defined by the number of times in the past year participants used available healthcare services, such as the emergency room, family planning



services, visiting friends and family that were hospitalized, and urgent care centers [2]. The Frequency of Use of Healthcare Services scale consists of 5 items: (a). In the past year, I have visited the emergency room for a life-threatening medical condition “x” number of times, (b). In the past year, I have received family planning services at a healthcare facility (e.g., Contraceptives) “x” number of times, (c). In the past year when sick, I have visited/scheduled an appointment at a healthcare facility “x” number of times, (d). In the past year, I have visited a sick family member or friend at a healthcare facility “x” number of times and (e). In the past year, I have been sick or injured “x” number of times [2].

### **3.5 Data collection—interview**

Individual interviews were conducted with a subset of the participants who opted to participate in this format of the study. The informal interview involved the researcher recruiting refugees who were fluent in English to prevent translation errors that could introduce study bias and issues with response delays [2]. Four participants one Burmese, two Congolese and one Iraqi consented to be interviewed via audio recordings lasting on average 50 minutes using a set of 13 semi-structured, open-ended questions to explore the various perspectives on culture and health-seeking behaviors among refugees. These questions were 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. Although all participants were asked about general community issues, some participants were asked to describe their personal experiences as follow-up.

#### *3.5.1 Data quality control*

The information culled from the questionnaires were reviewed and checked for completeness. The questionnaire was initially prepared in English and later translated into four different languages. It was also pre-tested prior to the actual data collection. Changes to the interview questions included (1) modification of words and sentences used, and (2) reduction in the number of questions asked to avoid redundancy.

#### *3.5.2 Ethics—institutional review board*

Formal letter of approval was obtained from Western Kentucky University Institutional Review Board committee. The respondents were informed about the objective and purpose of the study. Verbal and written consent were obtained from each respondent during data collection.

#### *3.5.3 Data analysis*

Data was analyzed using the Statistical Package for Social Sciences (SPSS) 23 software. Variables which found to be statistically significant at  $p < 0.05$  were identified as independent cultural predictors of health care service use. Audio-recordings and notes taken during the interviews were transcribed. After listening to the interviews many times, the transcripts were reduced, coded, and categorized into themes, and finally triangulated with the quantitative results.

## **4. Results—quantitative findings**

The study participants were predominantly female (65%) and identified as Burmese (34.8%). All of them spoke their native language because none identified

English as their spoken language. Majority identified with Christianity (71%) as their form of religion [6]. An average of two years in the U.S. indicated that most of the participants were new arrivals to the U.S. Almost all participants (80.2%) identified as having received some form of health insurance policy on arrival to the U.S. See **Table 2**. In addition, a little over a third (36.7%) reported having at least an elementary school education from their home country. A smaller proportion (31.2%) identified as either fully employed or working part-time. Most respondents were married (70%) with at least one child living in the home (53.6%). A large majority used Medicaid (83.87%), which is provided a few months after arrival in the U.S. The results also show that most respondents (55.4%) receive some form of assistance, e.g., Supplemental Nutrition Assistance Program (SNAP) from the U.S. government until they find sustainable jobs [6].

Regarding frequency of use of healthcare services, most of the refugees (83%) indicated that they had not visited the emergency room (ER) for a life-threatening illness; 11% had visited the ER once in the past year [2]. Nearly all refugees surveyed (96%) indicated they had never received family planning services or contraceptives from their health department. This could indicate that some aspect of the respondents' culture (e.g., belief or religion) does not advocate the use of contraceptives or that respondents were reluctant to disclose this information. Nearly half (42%) had visited or scheduled an appointment with a healthcare facility during the past year. Of these, some (17%) had done so at least twice and a few (5%) at least five times. Concerning visiting sick friends or family members at the hospital in the past year, the majority (74%) of those surveyed indicated they had not done so. For those who claimed to have been sick or injured in the past year (32%), some (2%) had been sick six times and one person (1%) indicated being sick at least 20 times [2]. See **Table 2** (*here*).

Item	Frequency (N)	Percent (%)
Gender		
Female	69	65.09
Male	37	34.91
Age		
17–28 yrs.	35	32.71
29–38 yrs.	30	28.04
> 39 yrs.	42	39.25
Nationality		
Burmese	38	34.86
Congolese	19	17.43
Cuban	12	11.01
Iraqi	9	8.26
Nepalese/Bhutanese	8	7.34
Others	23	21.10
Language		
Arabic	10	9.80
Burmese	18	17.65
Karen/Karenni	12	11.75
Somali	3	2.94
Spanish	10	9.80
Swahili	18	17.65

Item	Frequency (N)	Percent (%)
Others	31	30.39
Religion		
Buddhism	9	9.00
Christianity	71	71.00
Islam	17	17.00
Other	3	3.00
Number of Years in U.S.		
< 2+ years	67	60.91
> 3+ years	43	39.09
Educational Level		
< High School	51	52.04
> High School	47	47.96
Have Health Insurance		
Yes	81	80.20
No	20	19.80
N = 110.		

**Table 2.**  
*Summary descriptive statistics for predisposing, enabling, and needs-related factors.*

Student t-test, ANOVA, and correlation analyses were used to assess the association between the predisposing factors and frequency of healthcare services use. **Table 3** further explains these results. An  $F(5, 98) = 4.29, p < 0.001$  finding indicates that nationality/ethnicity plays a role in the use of healthcare services within the refugee population in southcentral Kentucky. Religion was not found to significantly influence the use of healthcare services.

The extent of relationship between Frequency of Use of Healthcare Services and identified barriers were assessed. Number of years in the U.S. were categorized into two distinct groups: those living in the U.S. for two years or less and those living in the U.S. three years or more. A significant association was found between those that have lived in the U.S. for over three years and a visiting or scheduling an appointment with a healthcare facility during the past year: and  $t = -2.03, p < 0.04$ , meaning that acculturation plays an important role in service use [6]. More so, a significant association was also observed between the number of years in the U.S. and visiting a friend or family member at a healthcare facility in the past year:  $t = -2.43, p < 0.01$ . There is a measure of familiarity with the units/services of a health facility because of one's level of acculturation [6]. The number of years in the U.S. was also found to be significantly associated with respondents' health status in the past year (whether they have been sick or injured)  $t = -2.22, p < 0.03$ . This result indicate that the longer refugees acculturate with their host country, the more likely they become aware of acceptable ill or health seeking behaviors. Thus, demonstrating an increase in service use, literacy, and awareness of available services due to duration of stay [6].

Health insurance coverage and the use of available healthcare services was examined among refugees. A significant association was observed between health insurance coverage and visits to the emergency room in the past year  $t = -3.35, p < 0.001$ . Also, a significant relation was found between health insurance coverage and visiting a sick family member or friend at the hospital within the last year



$t = -3.00, p < 0.003$ . From these findings it can be deduced that possessing a health insurance card to an extent determines access to a health facility [6].

Student  $t$ -test was used to assess the cultural competency of services. A significant relationship was found between interpreters and the frequency of use of healthcare services (visited the emergency room in the past 1 year),  $t = 1.92, p < 0.05$ . This means that refugees were more likely to visit a healthcare facility where interpreters were available. Many respondents indicated the presence of interpreters at their local health facility, hence the frequent visits to the emergency room [6]. See **Table 3** (*here*).

Frequency of Use of Services	<i>p</i> value	<i>t</i>	Factors
In the past year when sick, I have visited/scheduled an appointment at a healthcare facility	0.04	−2.03	Number of years in the U.S.
In the past year, I have visited a sick family member or friend at a healthcare facility	0.01	−2.43	Number of years in the U.S.
In the past year, I have been sick or injured “x” number of times	0.03	−2.22	Number of years in the U.S.
In the past year, I have visited the emergency room for a life-threatening medical condition	0.001	3.35	Health Insurance
In the past year, I have visited a sick family member or friend at a healthcare facility	0.003	3.00	Health Insurance
In the past year, I have visited the emergency room for a life-threatening medical condition	0.05	−1.92	Interpreters

<sup>\*</sup>  $p < 0.05$  – significant level, <sup>\*</sup>NOYUS – number of years in the U.S.

**Table 3.**  
*Associations between dependent variables (frequency of use of health care services) and independent variables: number of years in the US, health insurance, and interpreters.*

**4.1 Results—interview findings**

Demographically, the four interview participants included one Burmese, two Congolese and one Iraqi, ranging in age from 38 to 75 years with an average age of 56.5. This group did not provide an exact representation of refugees in Bowling Green. Educational attainment on the average was at least a high school degree from their respective countries, and all four subjects were married [2]. Three of the four were gainfully employed; the 75-year-old Burmese immigrant was retired. The sample consisted of three Christians and one Muslim. 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 [2]. 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.

*4.1.1 Importance of taking care of one’s health*

All the 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. Besides, good health provides peace of mind and this, in turn, is necessary to maintain their daily activities [2].

#### 4.1.2 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, but also with 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 [2]:

*"The greatest problem of most refugees from Burma arriving in Bowling Green, is language. Most of them have not 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 cannot 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 [2],

*"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 cannot speak English and has no means of transport that is 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".*

#### 4.1.3 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, ear-aches, 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 [2].

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.

#### 4.1.4 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 current outbreak of the Zika virus. Also noted was the availability of services such as interpreters toward which refugees would naturally gravitate [2].

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 [2]:

*“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 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, encourage others in the community to do the same and make an appeal to the health care system to improve its quality of service to accommodate the increasing influx of refugees.

## 5. Discussions

The study provides a better understanding of the role culture plays in health service use. In addition, the study gives useful information about the expectations or needs of these refugees as consumers in the healthcare system of the U.S. and highlights cultural patterns in their knowledge of preventive health and health-seeking behaviors [2]. The results of the study relate to the literature on behavioral patterns in the use of healthcare services by refugees.

The study results revealed a significant relationship between nationality and the number of times refugees have visited a healthcare facility to visit a friend or family member. The frequency of healthcare service use is essentially independent of refugees’ native language and religion with an exception to refugees’ nationality which was significant. This influence is like other research findings [7]. Findings on language and religion can be viewed from the perspective that ethno-medical approaches, such as the use of spiritual folk healers and folk remedies, affect the health outcomes of refugees [8]. In addition, some immigrants and refugees prefer spiritual healers rather than physicians to treat culture-bound syndromes because it is their belief that the physicians do not possess the knowledge or the understanding to treat foreign disease syndromes. Therefore, a need exists to create more awareness through interpreters, communication experts, and translated health bulletins about the effectiveness of evidence-based clinical practice [2].

The length of stay in the host country influence refugees’ use of healthcare services including visiting/scheduling appointments. Besides, possession of health insurance is related to ER visits. This is another similar finding which suggests that trust in Western medicine also appears to be influenced by acculturation level (Number of Years in the U.S.), indicating that greater levels of acculturation are related to greater trust in modern medicine [9]. It has been observed that in the U.S, access often is synonymous with health insurance and to some degree equality in the utilization of healthcare services [10].

Although no age or gender differences were observed in the use of health services, one would expect there to be a significant difference, i.e., more vulnerable populations (women, children, the elderly) would be expected to use services more than others (men, teenagers) in each community [2]. Demographic indicators of health status (i.e., age, gender) are among the strongest predictors of those who use healthcare [11].

Regarding cultural competency of services from the refugees’ perspective, the *t*-test for presence of interpreters at a health facility was only significant ( $p = 0.05$ ) for D1 – *I have visited the emergency room for a life-threatening medical condition.*



However, from the healthcare providers view, identified barriers were reported as, lack of funding, and supports to meet the language and cultural needs of refugee patients, uncertainty about refugees' entitlements to healthcare, uncertainty about continuity of care, and difficulties with making appropriate referrals [12].

The results from the interviews depict what has been echoed 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 challenges with navigating the healthcare system are all reported healthcare barriers from the perspectives of refugees [12]. Language barriers can reduce the quality of care, while the use of trained interpreters can improve access, quality, and patient satisfaction [13]. Moreover, to date, published research has indicated that immigrants face significant challenges regarding healthcare access [14]. It has been suggested that 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 [14].

## **6. Strengths**

The use of a mixed study design helped in gaining an in-depth understanding of health seeking behaviors among refugees. For example, these participants openly shared and expressed their feelings about each interview question. At times, there were laughs, sighs, and long thoughtful pause, before reasonable responses or perspectives were given. Even though some of their thoughts and feelings mirrored responses received from participants who completed items on questionnaires, other opinions or suggestions represented new insights or ideas [2].

## **7. Limitations**

Despite the information provided, the study was not without limitations. The sample of refugees is only representative of the general refugee population in south-central Kentucky. Hence, there is inadequate generalization and transferability with the study. Also, an inability to compare the use of Western healthcare services to informal alternatives to medical care i.e. a case of whether informal alternatives affected the numeric strength that used available services (because they had local alternatives at home). More so, researchers have suggested that refugees use local or herbal remedies (Complementary, Alternative and Integrative Therapies - CAI). Some studies have portrayed the substantial effect of legal status, service use, and interactions with service providers by refugees. This study overlooks the issue of legal status (e.g., refugee versus asylum-seeker; refugee versus resident alien) which could be used to identify to what extent one's duration of stay is due to legal status and how much of this status helps in reducing fear encountered in contacting a physician or utilizing services at their local health facilities [2]. Response bias was also a limitation to the study due to the tendency of a respondent to answer questions on a survey untruthfully or misleadingly.

## **8. Recommendations**

a). Refugees are less likely to access healthcare than citizens, regardless of insurance status; therefore, studies comparing uninsured citizens and uninsured



refugees are needed to further understand differences. b). Healthcare cost is a growing concern within the U.S, the presence of free community clinics is both cost- and resource-saving. Studies are needed to accurately determine the cost-saving benefit of free community clinics or county health departments in the setting of a literacy center, e.g., the International Center. Such studies may help address the pressing issues of health cost and language barriers in healthcare delivery [2]. c). Providing potential access to the healthcare system, however, does not guarantee utilization. Therefore, the relationship between a regular source of healthcare and utilization of healthcare services varies and should be further studied

## **9. Conclusion**

Immigrants and refugees are a growing component of the U.S. population, and their ability to access and utilize healthcare is an increasing public health concern. Healthcare disparities and problems with healthcare access exist among immigrants and refugees [15]. This mixed study explored the relationship between refugee culture and the actual frequency of 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. Despite accessibility of services, without perceived or realized need for services among immigrants, utilization may not occur [16]. Hence, the continued need for awareness and preventive health education.

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