FACTORS AFFECTING PRIMARY CARE PROVIDERS’ ABILITY TO PROVIDE HEALTH CARE TO REFUGEES IN PIMA COUNTY

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Justin John Egoville

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SIGNED: Justin John Egoville

APPROVAL BY MASTER’S REPORT DIRECTOR

This Master’s Report has been approved on the date shown below:

Kathleen M. May, DNSc, PHCNS-BC, RN     Date:
Clinical Associate Professor
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ABSTRACT

Refugees face numerous barriers to primary health care: language and cultural differences, financial limitations, knowledge gaps, and fear. Although these barriers are familiar to refugees, primary care providers, and agencies that support refugees, little research has been done to assess the problem. The United States, and Tucson, Arizona, have been experiencing a continuous increase in the number of refugees accepted over the past decade. Thus, providing adequate primary care to refugees is becoming more important because to the extent that their most basic needs such as health care are met, they will be able to integrate into a new society and become productive, actualized citizens.

This report describes the methods and results of a descriptive, participatory research study that assessed refugees’ access to primary care in Tucson, Arizona. A multidisciplinary work group sent mail-in surveys to 99 providers who offer primary care to refugees in Tucson. Twelve providers completed the survey. Researchers used content analysis to characterize responses and then ranked them in order of frequency. The results demonstrated that language posed the greatest barrier to primary care, followed by cultural differences and transportation. There was also general consensus that the best way to improve access to care for refugees was to make quality translator service more readily available. A review of current literature demonstrated the salient need for translators who are knowledgeable about both the health care system in the United States and the refugees’ culture, to act as both translator and advocate for the patient. The author found no studies that addressed the issues of refugees in Tucson, Arizona specifically. One limitation of this study was that the opinions of refugees were not obtained.
However, in January, 2010, there will be six focus groups conducted to ascertain the opinions of refugees regarding primary care.
CHAPTER ONE: INTRODUCTION

Refugees face a number of barriers to accessing primary healthcare: language and cultural differences, knowledge gaps, and financial limitations (Murray & Skull, 2005). In 2007, 11.4 million refugees, forcibly displaced from their own countries, were under the responsibility of the United Nations High Commission on Refugees (UNHCR). The United States hosted a total of 281,200 of them, the tenth most worldwide (UNHCR, 2007). In that same year, the United States became the largest recipient of new asylum claims, receiving 50,700, or ten percent of the 548,000 new claims lodged worldwide (UNHCR, 2007, p. 14). An asylum seeker is a person on United States soil who has not been granted refugee status, but is seeking it. According to the Immigration and Nationality Act (1952) a refugee is:

A. Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, or;

B. In such circumstances as the President after appropriate consultation (as defined in section 207(e) of this Act) may specify, any person who is within the country of such person's nationality or, in the case of a person having no nationality, within the country in which such person is habitually residing, and who is persecuted or who has a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The term "refugee" does not include any
person who ordered, incited, assisted, or otherwise participated in the persecution of any
person on account of race, religion, nationality, membership in a particular social group,
or political opinion. For purposes of determinations under this Act, a person who has
been forced to abort a pregnancy or to undergo involuntary sterilization, or who has been
persecuted for failure or refusal to undergo such a procedure or for other resistance to a
coercive population control program, shall be deemed to have been persecuted on
account of political opinion, and a person who has a well founded fear that he or she will
be forced to undergo such a procedure or subject to persecution for such failure, refusal,
or resistance shall be deemed to have a well founded fear of persecution on account of
political opinion.

In 2008 the number of people seeking refugee status increased by 12% worldwide, and
the United States received 13% of all new asylum claims, more than any other country, making it
the largest recipient for the third year in a row (UNHCR, 2009). From 2004 to 2008, the United
States was the largest recipient of asylum seeking claims, receiving a total of 253,000. Asylum
seekers cannot return to their country of origin due to serious threat of persecution; therefore, a
durable solution whereby they integrate into a host country is needed. Normally nearly 90% of
refugees can safely remain within their region of origin; however the rest must relocate to
regions often far and very different from their own (UNHCR, 2007). Part of creating a durable
solution for refugees who are forcefully relocated entails accessible primary care. Refugees often
arrive with serious health deficits due to the effects of war or poor living conditions in refugee
camps, thus they may need special care, particularly in the first few months of resettlement
(Miedema, Hamilton, & Easley, 2008). Surveys conducted in the United Kingdom reveal that
about two thirds of refugees have mental problems and one in six have serious physical disorders including tuberculosis, viral hepatitis, sexually transmitted infections, malaria, and various intestinal parasites (François, Hambach, van Sprundel, & Devillé, 2008). A host country must adequately address these serious physical diseases and mental health issues in order for refugees to successfully integrate into the host country, and for a mutually beneficial relationship between refugees and host countries.

Background

Globalization and conflict are creating more refugees at a faster rate than ever before (Tsai, 2005, p. 153). In 2007, there were an estimated 33 million refugees worldwide, nearly half of them 18 years of age or younger (Lamberg, 2007). Recently, warring parties have begun primarily targeting civilian populations. Systematic atrocities, including deliberate massacres, ethnic cleansing, and indiscriminate bombings, are often carried out as rational strategies (Neuner et al., 2008). In addition to suffering numerous and profound losses and traumatic experiences from the immediate exposure to war, refugees also face great uncertainty about the future and receive marginal healthcare in refugee camps. The asylum seeking process itself causes major stress due to frequent delays in processing applications, negotiations with immigration authorities, and most significantly, the uncertainty of asylum status (Ehntholt & Yule, 2006). Inadequate housing, language barriers, obstacles to employment, racial discrimination, and social isolation all contribute to even more psychological stress on refugees (Ehntholt & Yule). These unique and numerous factors make refugees a particularly vulnerable population and account for some of the potential challenges refugees face in accessing primary care. Refugees come to the United States from diverse cultures with distinct health practices,
often speak little or no English, and have significant knowledge deficits regarding the healthcare system in the United States.

Problem Statement

Refugees present to primary care providers with unique and significant needs, yet there are numerous barriers to having those needs met. Furthermore, Tucson, Arizona has been experiencing an increase in the number of new refugees being settled, and this increase will continue into the near future. The number of newly arrived refugees in Pima County from 2004, 2005, 2006, 2007, and 2008 were respectively 571, 621, 445, 408, and 886, with well over 900 anticipated in 2009. In 2008, refugees resettled from 24 different countries, with Iraq, Bhutan, Somalia, Burma, and Burundi settling the most refugees at 340, 167, 105, 59, and 58 respectively (Arizona Department of Economic Security, Refugee Resettlement Program, 2009). These figures reflect the diversity of refugees. Many of them arrive with little or no family, friends, or any other social network and depend heavily on a resettlement agency to assist them in navigating health and community resources.

A major need for refugees is primary care, which according to The American Academy of Family Physicians (AAFP) is:

‘That care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.’ (AAFP, 2009)
Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

Language differences and social isolation are major potential barriers to refugees accessing primary care programs that are available to them in Tucson, Arizona (Catholic Community Services of Southern Arizona, 2009). Additionally, the mental health of refugees is a particularly prominent concern that can be first addressed in primary care (Brouwer, 2007).

Purpose

The purpose of the study addressed in this report was to assess primary care providers’ service and training needs as they relate to working with refugees in Tucson, Arizona. As part of a larger project, in August 2009, a multi-disciplinary team—called the Refugee Primary Care Work Group, or informally as the “work group”—led by Jean McClelland, principle investigator from The University of Arizona College of Public Health, aimed to create a comprehensive profile of service providers’ perspectives and experiences serving refugees. Graduate students from the College of Public Health, College of Nursing, and College of Information Resources and Library Science as well as the Pima County Community Health Task Force (PCCHTF) and the Refugee and Immigrant Service Provider Network of Tucson (RISP-Net) and its member
agencies—Pima County Health Department, Pima County Public Library, The University of Arizona College of Nursing, The University of Arizona Health Sciences Library, and International Rescue Committee—participated in planning and conducting the study. The overarching question guiding the study was: What are primary care providers’ perspectives on access to primary care for refugees?

Definition of Terms

This section provides definitions of the major terms used in the overarching questions for this study.

*Primary Care*

According to the AAFP (2009), primary care is provided by physicians, nurse practitioners, or physicians assistants. Primary care includes comprehensive first contact with a patient, as well as ongoing health promotion, disease prevention, health maintenance, diagnosis and treatment of acute and chronic illnesses, and patient education.

*Refugee*

A person who has been forced from his or her country of origin due to well-founded fear of persecution due to ethnicity, religion, nationality, or political association (Immigration and Nationality Act, 1952).

Significance to Nursing

The study of primary care providers’ perceptions of refugees’ access to primary care is significant to nursing in its relevance to nurses’ work in assuring adequate healthcare for refugees. Nursing is a profession particularly concerned about vulnerable groups, and refugees are a vulnerable population. The results from the study can inform nursing practice such that it
will be more understanding of both providers’ and refugees’ needs as they relate to primary care. Understanding their needs better will help nurses coordinate care and plan interventions that are sensitive to their needs. Public health nurses and nurse practitioners who provide primary care to refugees will be able to use the results from this study to improve access to care for refugees. Finally, this study provides documentation of the barriers to primary care faced by refugees, and the documentation could ultimately be the basis for applying for funding for needed and effective interventions.

Summary

Due to extended time spent in unhealthy refugee camps, refugees are more likely than the general population to have compromised physical and mental health. Current trends suggest that the number of refugees worldwide will continue to increase, with the United States emerging as the recipient of the largest number of refugees. Tucson, Arizona, is presently experiencing a sharp increase in the number of refugees being resettled. Refugees present for primary care with considerable needs, yet there are numerous barriers to having those needs met. The purpose of the study addressed in this report was to complete an assessment of primary care providers’ service and training needs as they relate to working with refugees. The results from the study can inform nursing practice coordinating and providing care between primary care providers and refugees.
CHAPTER TWO: REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Introduction

Chapter Two presents a review of literature on refugees’ access to primary care in the United States and the conceptual framework that guided the study. The conceptual framework is Martha Roger’s Science of Unitary and Irreducible Human Beings (SUHB).

Review of Literature

Combining the terms “refugees,” “access,” and “healthcare” in a computerized literature search yielded 89 articles in Medline OVID, published between 2000 and 2009. The majority of the articles were published in European and Australian journals. Only six of the articles pertained to refugees’ experiences with primary care in the United States. These studies involved Somali refugees in Rochester, New York; Cambodians in Lowell, Massachusetts; Bosnian and former Soviet Union (FSU) refugees in Northern California; Africans in St. Paul Minnesota, and various other groups of refugees throughout Minnesota. The search produced no studies involving refugees in Arizona.

Carroll et al. (2007) conducted in-depth interviews with 34 female Somali refugees in Rochester New York to identify factors associated with both positive and negative experiences with primary care. Only half of the women (n = 17) stated that they had no problems getting needed healthcare. Of those who stated they had no problems, many qualified their responses with one or more stipulations: the assumption that an interpreter was available (n = 12), available transportation (n = 4), understanding how to make an appointment (n = 4), and having insurance (n = 2). Availability of a female interpreter emerged as the primary factor for improving this group of refugees’ access to healthcare. Many women expressed the importance of having a
trusting relationship with the interpreter so that they would be able to express their concerns without reservation. Additionally, 62% of the women expressed that they would be more comfortable fully revealing their concerns to a female clinician. Privacy regarding gynecological issues raised particular concern. Some of those women however did suggest that as they acculturated, they might become more comfortable with a male clinician. Many women, specifically more recently arrived refugees, demonstrated health seeking behavior by expressing a desire to learn more about available preventive health measures. But they generally felt more comfortable receiving health education from a knowledgeable Somali. Thus the key barriers to access to healthcare for this group were communication issues, which could apparently be addressed by having educated, female, Somali interpreters. Their primary concerns were privacy, being listened to, and treated with respect. Health insurance was not an issue with this group.

Cambodian refugees living in Lowell, Massachusetts, home to the second largest Cambodian community in the United States, also experienced challenges regarding communication (Koch-Weser, Liang, & Grigg-Saito, 2006). Southeast Asians as a whole generally exhibit good health; however Cambodian refugees in the United States demonstrate a marked disparity in health from the general population (Koch-Weser et al.). In an effort to address this issue, Koch-Weser et al. surveyed 381 adult Cambodian refugees. Participants self-reported their health as “poor,” “fair,” “good,” “very good,” or “excellent.” Forty four percent reported poor or fair health, with the majority of them older, disabled, and unable to see a doctor in the past year in spite of having wanted to do so. Ninety four percent of the participants had health insurance. Twenty three percent of the participants stated that they wanted to see a doctor within the past year but could not. The primary reason given (45%) was lack of transportation
and the second most common reason (24%) was that they forgot. Eighteen percent stated that they needed an interpreter within the past year in their primary care setting but none was available. Thus again, similar to the Somali women, cost and insurance coverage were not problematic. This study also revealed that Cambodians who arrived in the United States at a younger age and who had spent a greater percentage of their life in the United States were more likely to report better health. This seems to contradict the view of Fennelly (2006, p. 190) that there exists a “healthy immigrant effect” whereby refugees have a health advantage initially but that it diminishes dramatically over time. Just as the Somali women conjectured that, after spending more time in the United States they may eventually feel comfortable seeing a male practitioner, the thus better integrated into the healthcare culture. Indeed, this and the study by Carroll et al. Cambodians who had been in the United States longer might have been more acculturated and (2007) suggest that culture and language appear to be significant barriers. Until acculturation occurs, health promotion and outreach, provided in a linguistically and culturally sensitive manner, can help overcome barriers to care (Koch-Weser et al.).

Though the work by Koch-Weser et al. (2006) seems to, albeit inadvertently, challenge the healthy immigrant effect; a study by Lipson, Weinstein, Gladstone, and Sarnoff (2003) does so more explicitly. The authors took issue with using fewer sick days and having fewer physician visits to be indicative of better health of newer refugees. Instead, they suggest that these measures indicate barriers to accessing care, and customs that differ from American health practices. In order to develop a comprehensive picture of refugee health beyond statistics, the authors assessed health care use patterns of Bosnian and FSU refugees in Northern California using ethnographic studies in addition to database analyses. Many participants expressed
frustration about long lines, long waits for appointments, brief consultations, and inconsistency in primary care providers at county hospitals and clinics. However, they were willing to engage the government funded healthcare system, as opposed to private clinics or no care, because of the trained interpreters on staff who also acted as patient advocates and demonstrated caring and knowledge.

Trained interpreters acting as patient advocates appear to be what the Somali refugees explicitly and Cambodian refugees implicitly needed. “The U.S. health care system remains confusing, largely because of cultural and language differences. Lack of interpreters in most facilities is a major problem in securing satisfactory health care” (Lipson et al., p. 869). The study also revealed that only six percent of Bosnian women and eight percent of women from the FSU had ever had a gynecological exam. One participant reasoned that such testing is not done in their home country; therefore it is not sought here. This example demonstrates the need for education, linguistically and culturally sensitive, regarding the primary care and preventive care options available to refugees. This teaching as well as an orientation to the United States’ healthcare system should be done within their first eight months in the country which is when initial Medicaid coverage ends, although refugees may renew their coverage if they still qualify after 8 months (Lipson et al.).

The three previous studies indicate that from the refugees’ perspective, language and culture appear to be the most important barriers to primary care. Fennelly (2006) approached the issue of providing adequate care to refugees by asking 62 health and social service providers in Minnesota what recommendations they would make to the Governor or the legislature to better serve immigrants and refugees and the communities in which they live. Most responses
identified the need for outreach to help refugees navigate the health care system. Respondents said that the process of finding a provider, making an appointment, and processing insurance could be overwhelming to many refugees. Many respondents specifically mentioned the need for interpreter services. According to Fennelly (2006), even though the U. S. Department of Health and Human Services does require agencies receiving federal funds to provide language assistance to persons with limited English proficiency, the policy is not uniformly implemented. The perception of cultural barriers was also very common. Many participants emphasized the need for bicultural providers or education to providers by foreign-born co-workers to decrease misunderstanding and build confidence between refugees and providers.

An assessment of community members’ attitudes towards health needs of refugees in San Diego found mental health to be the most common health concern affecting refugees in San Diego, and cultural and structural barriers were viewed as the greatest barriers to treatment (Brouwer, 2007). However that same assessment found that language, followed by logistics and transportation, were the overall greatest barriers to primary care for refugees in San Diego.

A study by Othieno (2007) that sought to identify barriers to care for African refugee and immigrant people living with HIV (PLWH) in St. Paul, Minnesota, uncovered additional barriers to care for refugees. Participants volunteered to be in this study and consisted of: 14 community members from nine different African countries, seven religious leaders from six different African countries, eight cultural experts from seven different countries, six young adults from four different African countries, and five PLWH. The PLWH refused to give their country of origin due to fear of being identified. Two of them were out of care, two had recently entered care, and one was in and out of care. The primary barriers to care in this group were fear-based as opposed
to communication-based as in the previously mentioned studies, although communication did present problems to some. Interviews with cultural experts—African-born people who know their communities and are well-informed about HIV—and PLWH revealed the existence of intense stigma against PLWH. From that stigmatization has grown a number of fears that significantly affect refugee PLWH’s decisions regarding seeking care. Engaging in treatment could reveal their HIV status to their family and community and ultimately lead to social isolation. Interviews with cultural experts and PLWH also revealed that PLWH feared termination from employment or deportation due to rumors that Immigration and Naturalization Services will deport refugees if they have HIV. In addition to their fears, many PLWH, though aware of HIV clinics, were not aware of the full range of services available. The reasons given by PLWH for lack of knowledge ranged from not understanding the system and services to making a conscious choice to avoid the clinics due to fear of the consequences of seeking services, e.g., social isolation. Religious leaders further feed the fear of isolation because although some of them advocated for compassion for PLWH, the majority of those interviewed believed that isolation or quarantine was the correct action to prevent further infection. Cultural experts verified that religious leaders’ beliefs were known in the community.

In addition to all of the fears that create barriers to care, many cultural experts indicated that the actual doctor visits posed challenges. According to the cultural experts, Africans generally felt uncomfortable at the outset due to unfamiliarity with the Western style of health services. Being asked explicit questions about their sexuality within the course of a very brief appointment made many feel quite uncomfortable since their culture handles those types of questions differently. Additionally, the use of technical terminology and how fast the provider
spoke created confusion for some Africans. An interview with a PLWH who was in and out of care revealed that distrust emerged due to differences in communication style between himself and the provider and the PLWH’s unfamiliarity with the system (Othieno, 2007).

The cultural experts agreed that religious leaders in the community can best reach out to refugee PLWH because the refugees have great confidence and trust in them. There was general consensus among the cultural experts that health providers could link with religious leaders, if they were willing, to have religious leaders speak up and encourage PLWH to engage in treatment. Yet as Othieno (2007) points out, in spite of the cultural experts’ and PLWH’s belief that religious leaders should play a prominent role in reaching out to PLWH and getting them into treatment, religious leaders had strong and conflicting views about engaging PLWH. Still, once a PLWH presented in a doctor’s office, the issue of communication presented a challenge. Some interpreters who normally lived within or near the same communities as patients had breached confidentiality and thus affirmed the fears of PLWH (Othieno, 2007). Therefore, the cultural experts proposed having an anonymous phone interpreter service rather than interpreters from the community (Othieno, 2007).

The preceding studies demonstrate the importance of good communication and how language and cultural differences apparently pose the greatest barriers to refugees accessing primary care. Being deficient in English places immigrants and refugees at greater risk for poor health outcomes and is even linked with lower rates of screening for cervical cancer (Jacobs, Karavolos, Rathouz, Ferria, & Powell, 2005). The finding by Lipson et al. (2003) that only 6% of Bosnian and 8% FSU women respectively have ever had gynecological exams supports this because if these health practices are not part of those women’s culture and they do not
understand English, they will be excluded from education on this topic unless there is an effort to provide education in their language. In some Spanish speaking communities, deficiency in English is associated with fewer physician visits (Derose & Baker, 2000). A literate person can become better informed about healthcare issues and options and could better communicate with providers regarding his care. Short of refugees speaking English and being their own advocate, a third party translator who is well-informed regarding their healthcare options would be an ideal partner in health.

**Conceptual Framework**

The conceptual framework, Martha Roger’s Science of Unitary and Irreducible Human Beings (SUHB), provided a holistic framework that guided this study. Following an explanation of each major concept in the SUHB is the application of the concept to this study of refugees.

Martha Roger’s SUHB model is an abstract philosophical framework that “provides a worldview from which nurses may derive theories and hypotheses and propose relationships specific to different situations” (McEwen & Wills, 2007, p. 205). Rogers was strongly influenced by the history of science and humanity. In her seminal work, *An Introduction to the Theoretical Basis of Nursing* (1970), she describes how the early Greeks perceived man as a unified being; however this perception has over time become shrouded by the collection of physical details. “Man came to be explained, not as a human being, but as an operating collection of systems, organs, and cells…. Efforts to explore man’s mind led to further separation between man’s physicophysiological behavior and the phenomenon of consciousness” (Rogers, 1970, p. 43). Roger’s theory appears to be a synthesis of philosophy, humanities, metaphysics, and the basic sciences. According to Tomey and Alligood (1998, p. 208) there is a direct connection between
SUHB and nonlinear dynamics of quantum physics and Bertalanffy’s general system theory. In general system theory, a science of wholeness, the study of isolated parts will not reveal knowledge about behavior or order, and thus there is an assumption of wholeness (George, 1980, p. 167).

This corresponds with Rogers’ first major concept in the SUHB, which is that human beings and the environment are irreducible energy fields. Furthermore, they “are more than and different from the sum of their parts” (Rogers, 1970, p. 46) and they cannot be explained by an understanding of their parts. This concept was utilized in this study as a framework with which to view refugees, primary care providers, and the environment in which they interact. Refugees cannot be understood through a summation of the facts that brought them here, their nationality, their physical characteristics, or some other assortment of details with which they present. Similarly, the environment in which refugees receive primary care was not fully known to the researchers, and what the researchers did know about that environment were discrete bundles of facts. Thus refugees and the primary care environment are each irreducible energy fields that are different from the sum of their parts and cannot be understood through an understanding of their parts. In conducting the study of the relationship between refugees and the primary care environment, the researchers would reflect on the overall interaction of the two energy fields, refugees’ entire being and the entirety of the primary care environment.

The second concept is open systems, which is that humans are inseparable from their environment because both are open systems in constant interaction, thus continually affecting and being affected by each other (Rogers, 1970, p. 50). This concept lies at the root of this study, which makes the assumption that refugees and the primary care environment in which they
receive care are inseparable and dynamically affect one and other. Therefore they must be considered together as one in order to gain knowledge of their unified nature.

Fawcett (2003) interviewed the founders of the Society of Rogerian Scholars, Elizabeth Barrett, Violet Malinski, and John Phillips, for an update on how Rogers’ science of unitary beings continues to influence nursing research and practice. In reference to a question by Fawcett regarding how SUHB should guide research, Phillips responded:

“The physical, while crucially important, doesn’t tell the entire story. At times, understanding the spiritual nature of the person may be more important in identifying what is going on and what to do about it than simply focusing on the physical manifestations of illness.” (Fawcett, 2003, p. 47-48).

Phillips’ response underscores the importance of looking beyond the face value of data retrieved in a study by reflecting collectively on the findings. Rogers had called upon the practicing nurse and nurse researcher, to look beyond discrete pieces of physical reality and to observe and identify patterns as they emerge as a whole, unifying concept, not a particular piece of reality (Alligood & Fawcett, 2004).

Roger’s third concept is patterning, whereby the discernable feature of an energy field is manifested in a single wave. The pattern changes constantly because it is an expression of the integration of human and environment energy fields (Tomey and Alligood, 1998). Once the nurse identifies a person’s pattern as it emerges in the interdependent human-environment dynamic, care can be given, or interventions planned, that meet the person where they are in their life process in relationship to their environment.
Refugees accessing primary care, practitioners providing primary care, and the dynamic between refugees and providers in the primary care environment, all manifest patterns. By identifying those patterns and other patterns that contribute to barriers to the provision of primary care to refugees, a nurse researcher is able to plan interventions that address those barriers while integrating into the pattern.

Consideration of an individual’s life process as one with the environment provides a suitable framework to address the barriers to primary care for a vulnerable population such as refugees. According to SUHB, a person’s energy field is inseparable from its immediate and distant environment. The interaction of the human and environmental field processes may be harmonious or dissonant. A person who is unable to participate in an informed and purposeful way in the change will experience disharmony in their human-environment field. This dissonance is an expression of vulnerable groups (Gueldner & Britton, 2005, p. 112) such as refugees. According to the study by Lipson et al. (2003) and Fennelly (2006), many refugees face serious knowledge deficits about how to receive appropriate primary care in their new environment, thus making participation in the change between themselves and this environment challenging. By implementing the SUHB model, we acknowledge that the life process has its own unity and is inseparable from the environment, and we are able to recognize patterns as they emerge and reflect the whole. Once we recognize the patterns, we can implement interventions that strive to create a “symphonic interaction between human and environment” (Erci, 2005, p. 54).
Chapter Two began with a review of current literature regarding the experiences of refugees seeking primary care in the United States. Though not many studies have been done concerning refugees’ access to primary care in the United States, the studies that have been done encompass diverse regions of the United States and diverse cultures. All of the studies reviewed indicated that language and then culture, or language in tandem with cultural differences, were the primary barrier to primary care for refugees. And, from both the refugees’ and providers’ perspectives, the most appropriate intervention to overcome this barrier, was utilization of a cultural broker—someone who could translate both language and culture for refugees and providers. The only study that did not support the use of a cultural broker was the case of PLWH. In that study, cultural brokers had violated the trust of patients by sharing sensitive medical information with the community. Therefore that study found that an anonymous translator service located outside the community would be more appropriate. Although each of the studies related similar barriers to primary care for refugees, there exists a gap in research regarding access to primary care for refugees in Tucson, Arizona specifically.

Martha Rogers’ SUHB model provided a holistic framework with which to guide this study of primary care providers who work with refugees. The three major concepts within the SUHB model were elucidated and then applied to refugees and providers in the primary care setting. By applying the model, patterns of behavior between refugees, providers, and the primary care environment become illuminated, and interventions that address barriers to primary care can be developed and integrated into the patterns.
CHAPTER THREE: METHOD

This chapter describes the methods used to conduct the service delivery and training needs assessment survey of primary care providers who serve refugees in Tucson.

Design

The design of this study was descriptive. Data were gathered by a survey of primary care providers who work with refugees. These questionnaires generated new knowledge about a particular phenomenon that has not been studied yet—barriers to access to primary care for refugees in Tucson, Arizona. Representatives of the community being studied and primary care providers played an active role in planning and conducting the study, thus also making this a community based participatory research study (Burns & Grove, 2005, p. 537).

Setting and Sample

The setting for this study was Tucson, in southwest Arizona, a community with refugees from over 10 countries. The setting for data collection was primary care provider clinics and offices, from which providers responded to questionnaires.

Project staff identified 99 primary care providers known for working with refugees in Tucson, Arizona. The sampling was purposive (Polit, & Hungler, 1999, p. 284) in that the team identified specific primary care providers, known to provide care for refugees, who would be knowledgeable about the topic. Twelve of them responded to the survey, giving a sample of 12 and thus a 12% response rate. Seven pediatricians, two family practice doctors, two internal medicine doctors, and one gastroenterologist responded to the survey. These providers have offices primarily in mid-town and east-side locations, with clusters of offices at the UPH clinic, medical suites around Tucson Medical Center, St. Joseph’s Hospital, and Kino Hospital. At these
locations refugees can have all of their primary care needs met. These offices serve the public in general, and refugees only comprise a small proportion of their business.

Protection of Human Subjects

The Institutional Review Board for the University of Arizona approved this study. All investigators and co-investigators who participated in data collection completed human subjects training by completing the Collaborative Institutional Training Initiative program. The principle investigator reinforced with staff the importance of confidentiality in data collection. The primary care providers received a cover letter explaining why they were selected to participate (Appendix A). The principle investigator provided her contact information to respond to any concerns. The cover sheet on the survey disclosed that participation was completely voluntary, that interviews were confidential, and that information would be reported only collectively. Completion of the survey indicated informed consent. A coding system whereby participants were assigned an identification number that was kept in a separate location from their name maintained the anonymity of all respondents’ surveys throughout the data collection and analysis process. At the same time, this allowed investigators to track who had not responded so that follow up contact could be made. After completion of data analysis, staff shredded all personal identifying information of the participants.

Data Collection Procedures

On July 21, 2009, the work group sent postcards to all potential survey participants to notify them that they would be receiving a questionnaire about providing primary care to refugees within a week. The goal of this preliminary mail out was to raise awareness of the coming survey in an effort to increase the response rate. Work group members mailed or hand-
delivered questionnaires to the 99 providers. Respondents mailed back 12 completed questionnaires from the end of July through the middle of August 2009. In the cases of prospective participants who did not respond to the initial mailing, the work group sent postcards offering the opportunity to participate via email, fax, or personal interview. The work group contacted potential participants who did not respond, by phone, fax, mail, or in person, three times to encourage a response before removing them from the participant list. Follow up contact yielded no additional returned questionnaires. The principle investigator secured all submitted questionnaires in a locked location at The University of Arizona, College of Public Health. The information technology department at the College of Public Health created a secure drive to store all electronic records. Only the principle investigator and three graduate students in the primary work group had passwords to access to the electronic records. The principle investigator and graduate students analyzed the survey results between August 3rd and September 4th, 2009.

Instrument

The work group, with the direction of the principle investigator, drafted survey questions addressing barriers to primary care for refugees as well as the needs of providers in terms of caring for refugees in the context of primary care. After the work group revised several drafts, a final survey questionnaire was approved by consensus and called the Provider Service and Training Needs Assessment Survey (Appendix B). The instrument was a researcher-constructed questionnaire consisting of 27 total questions, 9 of which were open-ended. The content of the questionnaire consisted of eight main topics: finances, services, language, understanding of the resettlement process, education, barriers to primary care, factors that facilitate overcoming those barriers, and community resources.
Data Analysis

The principle investigator and three graduate students used descriptive statistics to summarize data and prioritize refugees’ barriers to primary care, challenges providers face when serving refugees, and innovative service strategies that have demonstrated effectiveness. Ms. McClelland and the graduate nursing student developed a coding system whereby numbers represented either yes, no, or other various options in closed ended questions with several possible responses. The work group then aggregated data from the closed-ended questions. To analyze and interpret open-ended questions, the work group used content analysis to characterize responses and then ranked them in order of frequency.

Summary

This chapter described how the Refugee Primary Care Work Group performed a service delivery and training needs assessment survey of primary care providers who work with refugees in Tucson. The work group used a community-based, participatory research approach. Three attempts were made to encourage a response from each provider. The results of the survey were aggregated and analyzed using descriptive statistics and content analysis to identify refugees’ priority and unmet needs as well as challenges to providers in serving resettled refugees.
CHAPTER 4: RESULTS

This chapter describes the results of the Provider Service Delivery and Training Needs Assessment Survey.

Translation Services

Providers ($N = 12$) offered services in a number of different languages: Spanish ($n = 7$), Vietnamese ($n = 3$), any language available through the blue Cyracom Phone ($n = 3$), French ($n = 1$), Italian ($n = 1$), Somali ($n = 1$), and Cantonese ($n = 1$). Eight of the providers had professional translator services available, three had informal translators, and one did not respond to the question. Five providers stated that AHCCCS paid for the translation services, two providers paid out of pocket, and in one instance El Rio Health Center paid. Although the majority ($n = 11$) of providers did provide translation services, many of them expressed the need for support in providing services in the language of their refugee clients: better access to interpreter services ($n = 2$), financial assistance ($n = 2$), translation ($n = 1$), cell phones ($n = 1$), social services ($n = 1$).

Resettlement Process

Four providers reported that they did not understand the refugee resettlement process at all and eight reported being somewhat familiar with it. Seven providers stated that their staff did not understand the refugee resettlement process at all; four stated that their staff was somewhat familiar with it, and one believed that his staff needed to know more. None of them provided training to their staff about refugee resettlement and less than half of the providers ($n = 5$) wanted to receive education on the resettlement process.
Problems with Different Services

Providers’ were asked for their perceptions of difficulties that refugees had using 10 different medical related services. Language, transportation, and culture were the top three reasons listed for every service. Some providers responded “yes,” “no,” or “very much” apparently indicating that their clients did or did not have difficulty with the service, but also indicating that the provider was either not reading the question completely or reading it but not taking the time to answer it appropriately. Four providers skipped this question entirely.

Greatest Difficulty in Serving Refugees

When asked what is most difficult about serving refugees, all participants (N = 12) responded, some offering more than one response thus giving a total of 17 responses. The most common difficulties reported (n = 17) were: communication (n = 4), cultural differences (n = 3), access to care (n = 3), lack of social services (n = 3), and problems with insurance (n = 3). When asked what is most rewarding about serving refugees, providers said, helping the needy (n = 4), experiencing diversity (n = 4), and appreciation of refugees (n = 2).

Provider Awareness of Services

Providers demonstrated fair awareness of refugee specific services in Tucson, ranging from no awareness (n = 3), through some awareness (n = 8), to wanting to know more (n = 1). The most well known refugee-specific service providers were Jewish Family Services (n = 3), International Rescue Committee (IRC) (n = 2), Catholic Social Services (n = 2), Refugee Medical Assistance Program (RMAP) (n = 2), and the Commitment to Underserved People (CUP) Clinic (n = 2). When asked where they referred clients, responses were (n = 8): “Subspecialties,” “I don’t know,” “Depends on their needs, just as non-refugees,” “Community
Partnership of Southern Arizona,” “University of Arizona,” “CUP Clinic,” “no specific agency,” and “St. Elizabeth’s.” When asked which agencies referred refugees to them, their responses \( (n = 4) \) were: “AHCCCS,” “none,” “Open Inn,” and “IRC.”

Barriers to Primary Care

All \( (N = 12) \) participants responded to the question of what barriers to providing primary health care services to refugees they’ve experienced. Many \( (n = 10) \) different responses were given, and the most common were: language \( (n = 5) \), transportation \( (n = 3) \), and communication \( (n = 2) \). When asked for suggestions to eliminate these barriers, eight providers responded as follows: interpreter services \( (n = 4) \), “Patients and parents need more time in clinic” \( (n = 1) \), “Make appointments for patients before they leave the clinic” \( (n = 1) \), “Educate patients on transportation available through AHHHCS \( (n = 1) \), and “Need help in coordination of care” \( (n = 1) \).

Training

When asked if interested in receiving training in particular areas, the most common areas that participants requested were: existing refugee services in Tucson \( (n = 8) \), web-based patient education materials \( (n = 6) \), and addressing sensitive issues with different cultures \( (n = 6) \).

Summary

This chapter provided the results from the Provider Service Delivery and Training Needs Assessment Survey. Language emerged as the biggest barrier to primary care and all other health services related to primary care. Participants overwhelmingly expressed the need for more and better language services in order to better work with refugees. Culture and transportation were close behind language in terms of barriers to care. Providers and their staff were generally
unaware or only somewhat aware of the refugee resettlement process, but they expressed little
interest learning more about it. They did however express much more interest in learning about
services available to refugees in Tucson, a subject of which they were also unaware or only
somewhat aware of.
CHAPTER FIVE: DISCUSSION

This chapter provides discussion of the results from the Provider Service Delivery and Training Needs Assessment Survey in relation to the Review of Literature (ROL). Also included is assessment of the applicability of the Science of Unitary and Irreducible Human Beings model as a framework with which to conduct the assessment of barriers to primary care for refugees, followed by discussion of limitations of the study, implications for nursing, and recommendations for future research.

Survey Results and Review of Literature

The results from the Provider Service Delivery and Training Needs Assessment Survey bear significant similarities to results of research reported in the ROL. When survey participants were asked about barriers to primary care and ten other health-related services, the top three responses in order of frequency were overwhelmingly language and culture, followed by transportation. The ROL revealed that several researchers (Carroll et al., 2007; Koch-Weser, Liang, & Grigg-Saito, 2006; Lipson, Weinstein, Gladstone, & Sarnoff, 2003; Fennelly, 2006) reached similar conclusions regarding barriers to primary care. Also, just as the survey demonstrated that most primary care providers feel there is a need for something akin to cultural brokers who can translate both the language and culture, the ROL revealed that many refugees feel that need as well (Carroll et al., 2007; Koch-Weser, Liang, & Grigg-Saito, 2006; Lipson, Weinstein, Gladstone, & Sarnoff, 2003).

When asked for suggestions to address the barriers to primary care, half of the providers who responded expressed the need for better translation services. These answers are interesting in light of the fact that eight of the responders claim to have professional translation services
available and three have informal translation services. It is possible that the translation services available do not offer translation of the refugees’ language, or perhaps the responders were referring to primary care in general and not their practices specifically, or they were referring to the element of cultural translation which may have been lost by use of an instrument such as a translator phone. Nonetheless, the point was clearly made by both the survey and the ROL (Carroll et al., 2007; Koch-Weser, Liang, & Grigg-Saito, 2006; Lipson, Weinstein, Gladstone, & Sarnoff, 2003; Fennelly, 2006; Othieno, 2007), that high quality translation services which help mitigate cultural differences and elucidate how the health care system functions, are paramount in reducing barriers to primary care. Also, in both the survey and the ROL (Koch-Weser, Liang, & Grigg-Saito, 2006; Brouwer, 2007), education of refugees in terms of the transportation system emerged as a solution to the barrier of transportation difficulties.

Applicability of SUHB

The SUHB was applicable as a framework with which to assess barriers to primary care for refugees. SUHB’s first concept of energy field, whereby human beings and the environment are irreducible energy fields that cannot be explained by an understanding of their parts, was useful in terms of seeing the whole refugee, existing on a broad life process continuum, rather than just someone who needed a TB screen or immunizations. Also, by looking at the whole picture rather than focusing on a summation of responses within different categories in the survey, we were able to render a more thorough interpretation of the results. No mathematical summation could account for the combination of qualitative and quantitative factors. However by stepping back and considering all of the results as a whole, we were able to make a more comprehensive assessment. For example, the 12% response rate to the survey may indicate that
most providers were either too busy or did not feel strongly enough about the issue to respond. Thus what was not said must be included to develop a picture of barriers to primary care, and this may be missed in a mere summation of responses. Furthermore, many providers who did respond either skipped many questions or jotted brief answers that sometimes did not correspond to the question asked, which indicates that even those who did respond appeared to have been under the pressure of a time constraint. Hence we weighed in the style of the responses as we analyzed data.

The second major concept, open systems, helped account for the reciprocal relationship of refugees and primary care. By viewing both refugees and the primary care environment as open systems, we appreciated the effect that the primary care culture had on refugees and simultaneously the effect of refugees on the primary care milieu. The indivisibility of language and culture, which are two open systems constantly affecting one another, is a good example of how the SUHB’s second concept helped conceptualize the integration of refugees and the primary care environment.

SUHB’s third concept, patterning, whereby the discernable feature of an energy field manifests as a single wave, guided the approach to the survey. The purpose of the Provider Service Delivery and Training Needs Assessment Survey was to uncover patterns in access or barriers to primary care for refugees in Tucson. The pattern of primary care providers wanting to provide advanced medical care to refugees, but becoming frustrated by language and cultural barriers as well as the pressure of providing care within very limited time, were patterns that emerged in this study. Identifying these patterns allows us to plan interventions that address the barriers to primary care while simultaneously integrating into the patterns.
Limitations of the Study

It is possible that the providers who took the time to answer this survey are the ones most in tune with the refugees’ situation and perhaps the most interested in issues affecting refugees, which could affect the results. The providers who took the time to complete the survey may possibly demonstrate more caring also by ensuring more adequate translation services than providers who did not take the time to answer the survey. This would limit transferability of the results, or applicability to other sites (Lincoln & Guba, 1985). The percentage of participating providers with translation services may not be representative of the percentage of the larger population of providers who serve refugees in Tucson. Indeed, as the results are considered, it is worth bearing in mind that only 12 percent of the providers who work with refugees responded to the survey, and they may be expressing the views of providers who care about refugees, not the views of providers who work with refugees.

The purpose of this study was to complete an assessment of primary care providers’ service and training needs as they relate to working with refugees in Tucson, Arizona. While the survey obtained the providers’ perspectives on their service and training needs, it did not obtain the refugees’ perspectives. It is logical that the people served would have some insight into how their providers could better work with them.

Implications for Nursing

Findings from the study were reported to PCCHTF and RISP-Net. Both of those groups have public health nurses as members who can take steps to respond to the identified needs and recommendations, including training and program modification. This study also draws attention to how language is enfolded in culture. By being more aware of this, nurses can recognize the
limitations of a simple translator phone or other simple method of translation, and seek out cultural brokers to assist with the provision of primary care to refugees. Mental health nurse practitioners rely heavily on patients’ accounts of their symptoms and their history. Verbal communication is thus of utmost most importance for them, and they can benefit from realizing the need for a cultural brokers’ translation services to put into context their refugee patients’ symptoms and histories. Finally, this assessment may contribute to informing policy makers and providers of care who serve refugees such that they can direct funds and efforts to interventions that will improve access to primary care.

Recommendations for Future Research

In December, 2009, focus groups consisting of six different refugee groups will be conducted to discover health concerns and barriers to accessing primary care. The questions for the focus group interviews will address problems refugee communities have encountered when seeking health care, what can be done to make it easier for refugees to use health care services in Tucson, and when do refugees seek health care services. The results of those discussions will be qualitatively analyzed to identify common themes and then reported to RISP-Net and PCCHTF, who will develop interventions that improve access to primary care for refugees. More research is needed to determine the feasibility of using cultural brokers who can act as translators, patient advocates, and patient educators in terms of navigating the health care system.

Summary

The results from both the Provider Service Delivery and Training Needs Assessment Survey and ROL were compared and indicated that language barriers and culture followed by transportation were the most mentioned barriers to primary care. The SUHB model framework
was applied to conduct the assessment of barriers to primary care for refugees. Limitations of the study were discussed, as were implications for nursing, and recommendations for further research.
APPENDIX A: COVER LETTER TO PRIMARY CARE PROVIDERS
May 31, 2009

Dear Primary Health Care Provider,

The University of Arizona Mel & Enid Zuckerman College of Public Health has received a mini-grant through the Arizona Health Facilities Authority from St. Luke’s Health Initiatives for a project to develop a profile of refugee primary care access and delivery needs in Pima County. The Refugee Primary Care Work Group has been convened to guide this process. The Refugee Primary Care Work Group is an interdisciplinary group of members of the Pima County Community Health Task Force and the Refugee and Immigrant Service Provider Network of Tucson (RISP-Net), representing a broad range of health and human service providers in Tucson.

The primary objective of this project is to identify key primary care service providers and access points for refugees in Tucson, identify training needs of primary care providers regarding serving refugees and their families, and assess providers’ perceptions of their abilities to serve and barriers to providing services to refugees. Enclosed is a confidential survey asking you to share your view of your agency, clinic or program or organization.

You are receiving this survey because members of the Refugee Primary Care Work Group consider your work and your perspective to be very important in assessing primary care access and service delivery needs for refugees and their families. Your response to this survey will contribute valuable information to the field for agencies and organizations serving this vulnerable population.

Please take the time to fill out this survey, and return it in the enclosed reply envelope by June 30, 2009. Information you provide, as well as your name, and the name of your agency, clinic, program or organization, will be kept confidential. If you have any questions about the survey or other activities of the Refugee Primary Care Work Group, the Pima County Community Health Task Force, or RISP-Net, feel free to contact Jean McClelland, principal investigator, at (520) 626 -8228, or at jmcc@u.arizona.edu.

Thank you very much for your time. We look forward to hearing from you soon.

Sincerely,

The Refugee Primary Care Work Group
APPENDIX B: PROVIDER SERVICE DELIVERY AND TRAINING NEEDS ASSESSMENT

SURVEY
Refugee Primary Care Services
Provider Service Delivery and Training Needs Assessment Survey

You are being invited to voluntarily participate in this confidential Refugee Primary Care Services survey because you have been identified by the Refugee Primary Care Work Group, the Pima County Community Health Task Force, or the Refugee and Immigrant Service Provider Network (RISP-Net) as a primary health care provider serving the refugee communities in Tucson. If you have any questions regarding your selection for this survey, you may contact the Principal Investigator, Jean McClelland, at the University of Arizona Mel and Enid Zuckerman College of Public Health (MEZCOPH) at (520) 626-8228, or jmc@rho.arizona.edu.

If you decide to participate, we request that you complete and mail the enclosed questionnaire, which will take about 20 to 30 minutes of your time. You may choose not to answer some or all of the questions. There are no known risks from your participation. You will receive no direct benefit from your participation. There is no cost to you except for your time and you will not be compensated for your participation.

Only the principal investigator and research staff at the University of Arizona Mel & Enid Zuckerman College of Public Health will have access to your name and the information you provide. To maintain your confidentiality, and the confidentiality of your organization, your name and organization’s name will not be revealed in any reports that result from this project. Interview information will be locked in a filing cabinet in a secure place at the University of Arizona MEZCOPH.

You can obtain further information from the Principal Investigator, Jean McClelland at (520) 626-8228. If you have questions concerning your rights as a research subject, you may call the University of Arizona Human Subjects Protection Program office at (520) 626-6721.

By filling out the survey, you are giving permission for the investigator to use your information for research purposes.

Thank you.
Please provide the following information. The information in this box will be kept confidential, and used by University of Arizona research staff strictly for quality assurance purposes. This page will be detached from your survey and filed separately from your survey responses on the following pages.

<table>
<thead>
<tr>
<th>Agency/Clinic/Program/Organization Name</th>
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<tr>
<td>Address</td>
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<td>phone</td>
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<tr>
<td>Contact Person (Your Name)</td>
<td></td>
</tr>
</tbody>
</table>
Refugee Primary Care Services
Provider Service Delivery and Training Needs Assessment Survey

1. What is your role/specialty in providing primary care services to your clients? (mark all that apply)
   ___ family practice
   ___ internal medicine
   ___ nurse practitioner
   ___ nurse case manager
   ___ ob gyn
   ___ physician’s assistant (PA)
   ___ pediatrics
   ___ other

2. What types of outreach or marketing does your program/clinic/organization use? (mark all that apply)
   ___ one on one / word of mouth
   ___ flyers/brochures
   ___ mailings
   ___ Internet/Websites
   ___ Ads in newspaper/phonebook
   ___ TV/Radio spots
   ___ other

3. Do you charge a fee for services? _____ Yes _____ No (if YES, answer 3a.)
   3a. Which best describes your fee-for-services structure?
      ____ flat fee ____ fee per service ____ hourly rate ____ sliding scale ____ donation ____ other

A refugee is defined as: “a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinions.”

The following questions (4 through 13) are about your agency or organization’s ability to provide services to refugee clients. Even if you do not currently serve this population, please try to answer these questions to the best of your knowledge.

4. Are you able to serve refugees? _____ Yes _____ Sometimes _____ No _____ I don’t know

5. Approximately how many refugees to you provide services for:
   per week ____________? per month ____________? per year ____________?

6. How do you identify a client as a refugee? ________________________________________________
   __________________________________________________________________________________
7. What services do you provide for refugees?

______________________________________________________________________________________

8. In what languages are services provided? (Please list all languages: ____________________________

______________________________________________________________________________________

8a. Are professional interpreter services available for clients? _____ Yes _____ No
If yes, in what languages? (Please list all languages: ____________________________

______________________________________________________________________________________)

8b. How are interpretation services provided? _____ by phone _____ in person

8c. Which agency/company provides the interpretation service? ____________________________

8d. How are the services paid for? (i.e., AHCCCS, other) ____________________________

8e. What kind(s) of support do you need to provide services in the language of your refugee clients?

______________________________________________________________________________________

9. How well do you understand the refugee resettlement process?

_____ Not at all _____ Somewhat _____ Quite well _____ Very well _____ I would like to know more

9a. How well does your staff understand the refugee resettlement process?

_____ Not at all _____ Somewhat _____ Quite well _____ Very well _____ I believe they need to know more

10. Do you provide training to your staff about refugee-specific issues? _____ Yes _____ No
If “Yes,” which issues?

______________________________________________________________________________________

11. What kind of difficulties do your refugee clients have using:

911, ambulance: ?

ER/Urgent Care: ?

Primary care: ?

Insurance cards: ?

Pharmacy: ?

Specialist services: ?

Over the counter medication: ?

AHCCCS: ?

Refugee Medical Assistance Program (RMAP): ?

Behavioral health services: ?

Other medical services: ?
12. What is most (difficult/frustrating/challenging) about serving refugees?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

13. What is most (rewarding/enjoyable/gratifying) about serving refugees?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

14. To what extent are you aware of existing refugee-specific services in Tucson?
   _____ Not at all _____ Somewhat _____ Quite well _____ Very well _____ I would like to know more
   14a. Which ones do you know about? _______________________________________________________
   __________________________________________________________________________________

15. TO WHICH agencies/individuals do YOU REFER your refugee clients for services?
   __________________________________________________________________________________

16. Which agencies/individuals REFER REFUGEES TO YOU for services?
   __________________________________________________________________________________

17. What barriers to providing primary care health services to refugees have you experienced?
   __________________________________________________________________________________
   17a. Do you have any suggestions for eliminating these barriers?
   __________________________________________________________________________________

18. Do your refugee patients use the ER or Urgent Care for issues that you feel would be better addressed by a
    Primary Health Care Practitioner? _____ Yes _____ No
   18a. Do you have suggestions for how to resolve this issue?
   __________________________________________________________________________________
We are very interested in your insights, experience and recommendations regarding provision of services to refugees in Tucson, whether or not your organization is currently able to serve them to the full extent you may desire. With this in mind, please take the time to respond to these final questions.

19. Please rank, in order of importance, any barriers that refugees and their families may experience in accessing your services (with “1” as the greatest barrier):
   1. __________________________________________________________________________________________
   2. __________________________________________________________________________________________
   3. __________________________________________________________________________________________
   4. __________________________________________________________________________________________

20. Please share any refugees’ needs that are currently NOT being met by existing services in the community:
    __________________________________________________________________________________________
    __________________________________________________________________________________________
    __________________________________________________________________________________________

21. What do you consider to be the most important needs of refugees in Tucson?
    __________________________________________________________________________________________

22. What are the biggest gaps in refugee services in Tucson today?
    __________________________________________________________________________________________
    __________________________________________________________________________________________

23. Is there a particular source you utilize for patient education materials?
    __________________________________________________________________________________________

24. What medical information resources do you rely on for specific/unique health issues presented by your refugee patients?
    __________________________________________________________________________________________

25. Would you like training in the following areas?
    _____ refugee resettlement process
    _____ web-based patient education materials/information resources
    _____ existing refugee services in Tucson
    _____ other patient education materials/information sources
______ resources on specific cultural issues for patients from (a) specific country(ies)?

____________________________________________________________________________________________

______ addressing sensitive issues with other cultures/cultural sensitivity (i.e. family planning, family violence, parenting/child development, etc.)
______ other refugee-specific training? (___________________________________________________________)

26. If we were to ask your refugee clients about ways to improve access to your services, or modify your services to better meet their needs, what would you like to know?

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

26. May we contact you in the future for training opportunities? ___yes ___no

27. Do you have any other comments or recommendations for us?

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Thank you very much for your time.

Please return your completed survey in the self-addressed reply envelope provided, or fax it to Jean McClelland at (520) 626-2914.
REFERENCES


Erci, B. (2005). Nursing theories applied to vulnerable populations: Examples from Turkey. In M. de Chesnay (Ed.), *Caring for the vulnerable: Perspectives in nursing theory, practice, and research* (pp. 45-60). Sudbury, MA: Jones and Bartlett.


