

BHUTANESE REFUGEES' HEALTH BEHAVIORS AND PERCEPTIONS:  
A QUALITATIVE APPROACH TO UNDERSTANDING BHUTANESE REFUGEES'  
POST-RESETTLEMENT EXPERIENCES WITH HEALTH CARE SERVICES IN  
MIDDLE TENNESSEE

by

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A Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy in Human Performance

Middle Tennessee State University  
August 2014

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I dedicate this research to my son, Braxton Dakari-Na'im Oliver.

I love you unconditionally.

## ACKNOWLEDGEMENTS

I would like to express my sincerest thanks to my committee for their continued guidance and support: Dr. Andrew Owusu, my dissertation chair; Dr. Denise Bates; Dr. Gloria Hamilton. This experience has offered opportunities for continued growth on both professional and personal levels.

Completion of this project would not have been possible without the support and assistance of various contacts in the refugee community: Gatluak, Damber, Frances, Amy, and women of the Bhutanese community. Your dedication to the interests, success, and health of refugees is unparalleled. Such willingness to share your experiences was courageous and admirable.

Finally, thank you to both family and friends who served as sources of encouragement during challenging times and celebratory partners at each milestone. Braxton, know that my commitment to this work was driven by my undying commitment to you and your future successes.

## ABSTRACT

Extant research investigating the health perceptions and behaviors of Bhutanese refugees is limited, especially in resettled populations. The purpose of the current research was to explore Bhutanese refugees' perceived experiences with health services received post-resettlement as well as their post-resettlement health care practices and continued use of pre-resettlement health behaviors. A qualitative approach was utilized in the current study. Three audio-recorded focus groups were conducted with Nepali-speaking women in the Bhutanese refugee community. Participants were also asked to complete a demographic questionnaire. English transcripts were coded and analyzed using a grounded theory, constant comparison approach.

A total of 32 Bhutanese women participated in the three focus groups. Eight categories emerged from focus group data: difficulties in accessing transportation to receive health services, language barriers in communicating with health professionals, challenges in paying for health services, positive and negative perceptions of post-resettlement health treatments, positive and negative perceptions of post-resettlement health professionals, limited engagement in preventive health behaviors, challenges with the post-resettlement health care system, and use of conventional medicine as the primary health option. These categories were later refined into three categories: barriers to accessing post-resettlement health services, perceptions of post-resettlement health services, and limited health literacy. The three categories contribute to an understanding of how Bhutanese women manage their health post-resettlement and, furthermore, how post-resettlement health management serves as a component of taking care of oneself and one's community during resettlement.

These factors parallel the barriers experienced by other refugee populations. Health educators and health professionals should consider such barriers when designing and implementing health programs and offering health services to individuals in the Bhutanese refugee community. Future research is warranted to better understand health management in other subgroups of the Bhutanese refugee community and ways in which community resources may be modified and established to increase positive health outcomes within this community.

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## CHAPTER I

### INTRODUCTION

Refugees resettling in the United States are faced with a variety of challenges, including developing new communication skills (Asgary & Segar, 2011; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009), finding sufficient employment (Asgary & Segar, 2011; Maxym, 2010), transportation (Maxym, 2010), and housing (Asgary & Segar, 2008, and coping with psychological stressors related to pre- and post-resettlement experiences) (Maxym, 2010; Morris et al., 2009). These factors, though varied, often contribute to difficulties in accessing health care services and, subsequently, the underutilization of such services. Delays in receipt of health services may prove particularly detrimental to refugee populations as they sometimes enter the United States with pre-existing physical and/or psychological conditions serious enough to warrant the attention of medical professionals (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, & National Center for Emerging and Zoonotic Infectious Diseases, 2013).

Government resettlement agency personnel have established programs to assist refugees in navigating the United States health care system (Office of Refugee Resettlement, U.S. Department of Health and Human Services, 2013). Researchers have further examined issues related to refugee health through systematic reviews and meta-analyses and offered information and suggestions for health care practitioners working with refugee populations in hopes to lead to improved patient care and health outcomes (Eckstein, 2011; Segal & Mayadas, 2005; Smith, 2003). Specifically, researchers' efforts have focused on educating health professionals on the most common health needs

presented by refugees and factors affecting refugees' access to health services (e.g., language barriers, transportation, insurance). Consumer programs and provider education as it relates to refugee health serve as steps toward achieving health equity. Health equity is a goal of public health and remains a challenge among refugee populations who may lack consistent health care access and confront more obstacles in communicating their health concerns and needs than their non-refugee counterparts (Asgary & Segar, 2011; Maxym, 2010). Educating practitioners does not completely address the issues of health equity and quality; refugees' perceptions of and encounters with the health care system and received health services may influence their use of health services.

Cultural health practices may influence refugees' perceptions and utilization of Western health services (Maxym, 2010). Additionally, health-related values impact refugees' expectations about Western health services and health professionals (Maxym, 2010). In some instances, refugees' unmet expectations may negatively impact their perceptions and utilization of Western medical services (Maxym, 2010). Unfortunately, limited research exist describing refugees' perceptions of post-resettlement health care services, current health behaviors, and values regarding pre- and post-resettlement health care approaches. The limited extant research in refugee health presents a gap in knowledge that is especially present among Bhutanese refugees resettled in the United States.

### ***Relevance of the Research***

In recent years, 2010-2012, United States resettlement efforts focused primarily on the Near East/South Asia region (Martin & Yankay, 2013). Approximately 107,000 Bhutanese refugees, a target population in this region, have lived in refugee camps in

Nepal since the 1990s (Ranard, 2007). Their relocation to nearby Nepal came as a result of governmental implementation of “Bhutanization,” a unification strategy prohibiting the cultural and religious expression of the Lhotsampas, “Southerners” of Bhutan, who maintained unique cultural and religious beliefs, practices, and traditions separate from other Bhutanese citizens. Despite desires of and efforts toward repatriation to Bhutan or integration into Nepal, third-party resettlement served as the only solution.

The United States and other countries began resettling Bhutanese refugees in 2007. In 2012, Bhutanese refugees (15,070) accounted for more than a quarter of total refugee arrivals (58,179), increasing their total United States population to nearly 49,000. This increase in the number of Bhutanese refugees in the United States presents challenges to professionals lacking competency in refugee health matters. Bhutanese refugees’ noted difficulties with acculturation into United States society (Maxym, 2010) paired with vulnerability to various physical and psychological health conditions acquired and developed during pre- and post-resettlement in the United States (Maxym, 2010; Morris et al., 2009) highlights the importance of detailing Bhutanese refugees’ encounters with Western health care services.

### ***Statement of Purpose***

This investigation explored several topics among women within Bhutanese refugee communities: (1) perceptions of health care services received since their arrival in middle Tennessee, (2) circumstances under which Western and traditional and/or culturally appropriate health behaviors continue to be utilized in middle Tennessee, and (3) value attributed to both Western and traditional medical approaches used for their current health conditions and concerns. While women’s health topics did not serve as the

focus of the research and were not explicitly included as a topic of interest, conducting this research among women offered participants the opportunity to express health concerns that they may not otherwise disclose (e.g., in the presence of men).

Investigations into health care experiences and behaviors prior to and following resettlement in middle Tennessee may shed light on factors influential in perceived satisfaction with health care professionals and current health practices within the Bhutanese refugee community. Insight into these topics has potential to better inform health care professionals working with Bhutanese refugee communities—enabling them to incorporate culturally appropriate approaches during patient-provider interactions and possibly increase service utilization and treatment.

### ***Theoretical Approach***

Qualitative methods with a grounded theory approach were employed in this study. The qualitative format and use of focus groups allowed participants to openly respond to questions posed—a needed element in this research as base information required for the construction of a structured, selected-response questionnaire was limited, if at all present. Furthermore, the grounded theory approach enabled the collection of information focused on issues requiring a complex, detailed level of understanding (Creswell, 2007).

Different research methods are typically less capable of providing the flexibility characteristic of the grounded theory approach (Charmaz, 2006). Flexibility enables the researcher to develop ideas, concepts, and, eventually, theories during and following the data collection process through the pursuit of leads that emerge during interviews and focus groups. Grounded theory as a process emphasizes the importance of allowing the

data, not preconceived assumptions, to direct the study and its findings (Glaser & Strauss, 1967). The generation of a theoretical framework that describes and explains phenomena is the overall goal of grounded theory methods. This goal coincided with the aims of the current study as development of a theory capable of predicting behavior was decidedly premature from the principle investigator's perspective given little extant literature in the substantive area. Qualitative, grounded theory methods were collectively beneficial for the current study because the investigation aimed to understand how women in Bhutanese refugee communities 1) perceive their experiences with health services received in middle Tennessee, 2) reasons for using Western and/or traditional medical approaches, and 3) the value ascribed to both Western and traditional medical approaches.

## CHAPTER II

### REVIEW OF LITERATURE

The current study aimed to investigate the experiences, practices, and perceptions of women in Bhutanese refugee communities of middle Tennessee with the intention of better understanding specific elements of Western and cultural health practices that are valued within this community. To further emphasize the importance of this study, the review of the literature provides an overview of relevant existing research on refugee health and the need for additional studies pertaining to the health of Bhutanese refugees.

#### *Refugees in the United States*

The Immigration and Nationality Act (2010) defines a refugee as:

*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 ... (section 42a)*

As indicated in the above definition, refugees experience a multitude of circumstances that threaten civil and/or human rights, resulting in their migration to other countries. Efforts are made by refugee-oriented agencies to address conflicts and establish agreements with refugees' countries of origin to repatriate individuals. Unfortunately, efforts toward repatriation are not always successful and third party countries, including the United States, may become involved in resettlement of refugees.

Recent reports indicate that in 2012, 58,179 persons were admitted into the United States as refugees (U.S. Department of Homeland Security, Office of Immigration Statistics, 2013). Prior to arriving in the United States, these individuals resided in countries across the globe, though most recent refugees reported nationality from Bhutan, Burma, and Iraq. Despite their varying locations, refugees entering the United States face similar resettlement obstacles (Asgary & Segar, 2011).

Challenges faced by refugees coming to the United States relate primarily to socioeconomic and psychosocial factors (Segal & Mayadas, 2005). Socially, refugees may struggle to cope with new social roles in the host country that differ from the well-understood social roles and relationships of their culture (Stewart, Anderson, Beiser, Mwakarimba, Neufeld, Simich, & Spitzer, 2008). Such changes in social dynamics may lead to interpersonal conflicts within families. Economically, refugees may experience hardships due to limited access to quality education and language barriers which may in turn negatively impact their ability to secure employment (Maxym, 2010). Isolation within their communities and the social and health services is also reported among refugees as some may experience psychological stress as a result of migration, prejudices and discrimination, and acculturation (Asgary & Segar, 2011). Along with these obstacles, refugees may experience difficulties with their health due to pre-existing conditions and health concerns that emerge post-resettlement (Morris et al., 2009).

### ***Health of Refugees in the United States***

Refugees, regardless of origin, are likely to experience a range of health concerns stemming from experienced assault, trauma, and torture in their country of origin or acquired conditions from their duration in refugee camps (Morris et al., 2009). Prior to

resettlement in the United States, refugees undergo a series of health assessments to identify any physical or mental health conditions, especially those considered ‘inadmissible’ health-related conditions (e.g., tuberculosis, leprosy, HIV) (Adams, Gardiner, & Assefi, 2004; Centers for Disease Control and Prevention, 2012b). Despite undergoing the required health screenings, refugees may present a range of physical (e.g., hypertension, diabetes, obesity) and psychological (e.g., PTSD, depression, anxiety) health concerns to medical professionals upon arrival in the United States (Morris et al., 2009).

To address some of these concerns, refugees are offered up to eight months of assistance and health services (U.S. Department of State, Bureau of Population, Refugees, and Migration, 2013b). As part of resettlement assistance, the Office of Refugee Resettlement helps refugees navigate the healthcare system and receive health services appropriate to their needs (Office of Refugee Resettlement, U.S. Department of Health and Human Services, 2013). Aid offered by the Division of Refugee Health is beneficial but does not eliminate all barriers to healthcare that refugees may confront.

### ***Refugees’ Barriers to Health Care***

As with other vulnerable populations, refugees experience challenges to accessing health care in the United States (Asgary & Segar, 2011; Morris et al., 2009). Resettlement issues relating to employment, affordability of medical services, transportation, language, and migration stress resulting from the acculturation process may present additional obstacles to utilization of health services and subsequently exacerbate the problems they experience with their health conditions.

### Employment

Options for employment for refugees appear to do little to alleviate them of resettlement and transitional stress (Asgary & Segar, 2011). Resettlement agencies and refugees alike highly prioritize employment as a key step towards self-sufficiency. Securing employment poses its own challenges for refugees who are not always fluent in English, may lack job skills desired in the United States labor market, or have yet to obtain reliable transportation (Maxym, 2010). Characteristics of attained employment such as long work hours with limited flexibility and little financial support often hinder refugees' ability to seek medical attention.

The emphasis placed on employment and self-sufficiency may lead to personal health becoming less of a priority when compared to maintaining an employment status that allows an individual to pay for his/her and his/her family's shelter and food. Delays in seeking medical care may result from prioritization differences in employment and health. Employment is a top priority for many refugees, yet its attainment does not guarantee open or ready access to health services as employment opportunities may fail to offer employer-sponsored health insurance (Maxym, 2010).

### Affordability of health services

The expense of medical care is well-known among both patients and providers in refugee and asylum seeking communities (Asgary & Segar, 2011). Patients must constantly consider the financial implications for addressing health concerns and identify ways in which to access affordable insurance coverage. As previously mentioned, refugees may be eligible for a maximum of eight months of medical assistance from government agencies. However, refugees may be unable to purchase health insurance

plans following the assistance period (Maxym, 2010). Alternatives to more expensive insurance plans are sometimes available via sliding scale systems; unfortunately, awareness of these alternatives or methods of accessing medical coverage is not always widespread.

### Transportation

Transportation barriers may leave refugees isolated from services as well. Obtaining a drivers' license may pose problems for refugees with limited or no English proficiency and individuals with limited driving experience (Maxym, 2010). Beyond obtaining the driver's license itself, refugees may have difficulties purchasing insurance and decide to drive illegally. Purchasing a vehicle is not without its own challenges, and as a result, relatively few refugees own vehicles (Asgary & Segar, 2011). Refugees may experience difficulties in understanding the United States' financial system, establishing credit (U.S. Committee for Refugees and Immigrants, 2014), or be by-wage jobs—all of which may contribute to an inability to secure transportation.

When refugees are able to purchase vehicles, the vehicles are shared among several family members. Sharing transportation among several individuals forces some refugees to experience periods of isolation and little transportation-related independence. Public transportation does not resolve these issues as it is not always available in communities and may be time-constrained when it is available. Lack of reliable transportation in refugee communities further hinders refugees' abilities to access adequate health services.

## Language

Language barriers pose one of the greatest challenges to the health of refugees (Asgary & Segar, 2011; Morris et al., 2009). Language skills impact the extent to which refugees can communicate their concerns to health professionals and understand questions asked and feedback offered by doctors, nurses, and social service workers (Asgary & Segar, 2011; Morris et al., 2009). When paired with minority status, language barriers may increase the likelihood of poor communication between patients and their providers (Yeo, 2004). Additional patient characteristics including age, educational attainment, income, and length of residency in the United States have been negatively associated with effective communication in patient-provider interactions. As a result of communication barriers, refugees often fail to get preventive services and/or treatment to address existing conditions (Maxym, 2010; Morris et al., 2009).

To overcome the language barrier, refugees may use friends or relatives more fluent in English to serve as interpreters during interactions with medical personnel (Morris et al., 2009). Unfortunately, this does not guarantee that patients' medical concerns are accurately and completely conveyed. For instance, refugees may not feel comfortable disclosing specific health concerns through family members or friends (Asgary & Segar, 2011; Morris et al., 2009). Patients' family members and friends are not always familiar with medical terminology and may miscommunicate information (Asgary & Segar, 2011). For such reasons professional interpreters may be employed by health organizations.

Interpretation services, offered in an effort to more effectively address language barriers, sometimes fall short of this goal due to limited and inconsistent availability in

health care settings including hospitals but especially, private doctors' offices (Chang & Fortier, 1998). To further complicate matters, policies mandating the availability of language services in these facilities do not uniformly define adequate language services—leaving enforcement of language policies to the discretion of individual organizations and facilities. This lack of standard practice is particularly harmful as it may negatively impact the individual's health care experience at several points throughout the health care encounter (i.e., scheduling of appointments, examination, patient consultation with provider, and follow-up visits) (Chang & Fortier, 2004; Morris et al., 2009) and contribute to limited understanding of the host country's health care system (Morris et al, 2009). Even with the establishment of appropriate interpreter services, additional issues such as cultural beliefs and practices not communicated between patients and providers could potentially serve as health care barriers (Yeo, 2004).

#### Acculturation and culture

Refugees' cultural values and experiences, somewhat less salient, potentially hinder refugees' utilization of health services (Asgary & Segar, 2011; Morris et al., 2009). Refugees endure an acculturation process, a transition not limited to geographic location but entailing their psychological and social acclimation to new surroundings and a new social system, which may prove challenging to migrants entering the United States (Asgary & Segar, 2011). Culture, the unique beliefs, practices, and knowledge of a given group of individuals, may be impacted by this transition resulting in assimilation or separation--complete adoption or rejection of the host country's culture (Berry, 1997).

Migrants may express experiences of such challenges as an overall sense of being ill-equipped to navigate systems and resources established for refugees, asylees, etc.

Feelings of confusion can also be more narrowly focused on understanding the health care system, specifically. The circumstances under which individuals enter the United States may affect the extent to which they interact with the health care system and health professionals. Refugees may display a general mistrust of authority figures in the host country (Maxym, 2010) or more situational dispositions such as refugees' perceived mistrust and discrimination from medical professional originating from refugees' fear of deportation (Asgary & Sefgar, 2011). Although medical professionals are not universally viewed as suspicious or threatening, providers appear to bear influence on refugees' decisions to utilize health services.

Understanding the impact of culture on utilization of health services emphasizes the significance of cultural competency in the health care setting—a component to health care that appears to be lacking in some health facilities (Asgary & Segar, 2011). Researchers have presented suggestions for health care professionals to increase their knowledge of cultural appropriateness in working with diverse refugee populations (Eckstein, 2011; Segal & Mayadas, 2005; Smith, 2003). A key step to better educating health professionals is consulting with the members of refugee populations to better understand how they perceive their experiences with health services and identify their health-related values. Gaining insight into the role of culture in Bhutanese refugees' health practices may prove particularly helpful in ensuring that culturally appropriate techniques are employed in patient-physician interactions.

### *Historical Context of Bhutanese Refugees*

Between China and India, in the Himalayan Mountains of southeastern Asia is Bhutan. The earliest record of the presence of people of Nepalese origin in Bhutan dates back to the 1620s, following a request by Shamdrung Ngawang Namgyal, a leader influential in the unification of Bhutan, to construct a monument for his father, Tempa Nima (Maxym, 2010). Subsequent reports of Nepalese-originating residents in Bhutan did not appear again until the late 1800s. During this time, individuals of Nepalese origin were welcomed to inhabit the southern regions of Bhutan leading to their recognition as *Lhotsampas* or “People of the South” (Maxym, 2010; Ranard, 2007).

As migrants in Nepal, the Nepali-speaking Bhutanese continued to populate southern Bhutan and were considered a minority group with distinct Nepali language and the Hindu religious affiliation and culture which they maintained for five decades (Maxym, 2010, Ranard, 2007). The Lhotsampas maintained close-knit, family-oriented communities in which women and men equally shared responsibilities outside of the household in terms of farming and other hard labor. However, as a patriarchal culture, women bore sole responsibility in maintaining the household (i.e., cooking and household chores) and caring for immediate and extended family members and friends who oftentimes co-occupied living quarters. General exceptions to a woman’s responsibilities within the home were only practiced during her menstrual cycle when she was considered “unclean” and forbidden to engage in any food or drink preparation or housework. During the woman’s menstrual cycle, another woman in the household or community undertakes the household responsibilities until duties can be resumed by the woman to which they were originally designated.

A caste system, employed among the Nepalese to delineate societal roles and responsibilities, was also practiced among the Lhotsampas (Maxym, 2010). This complex, hierarchical caste system, in many ways, dictated a Lhotsampa's life course—determining his/her occupation, spouse, and other interpersonal relationships and responsibilities. Though members of higher and lower castes were not entirely segregated in society, specific guidelines were enforced to limit interactions. Hinduism, also retained from their Nepalese origins, served as the predominant religious affiliation among the Lhotsampas and influenced everyday life and social roles.

Unique social and religious characteristics of the Lhotsampas, though different from those of the Druk Buddhist majority who were primarily Buddhist, did not lead to conflict until the 1980s when Druk rulers perceived the growing Lhotsampa minority as a threat to their reign and tradition (Maxym, 2010; Ranard, 2007). Bhutanization,” a government-led campaign known as “One country, one people,” was soon initiated, forcing residents of all Bhutan to adhere to the Druk dress code, language, and religious practices. While these laws were presented as a collective effort to unify Bhutan and its citizens, they simultaneously suppressed the cultural expression of the Lhotsampas by prohibiting their use of the Nepali language and traditional and religious practices. As a result, during the early 1990s major conflicts were occurring (Maxym, 2010; U.S. DOS, U.S. DHS, and U.S. HHS, 2011) and by 1992 more than 100,000 Lhotsampas, unable to verify citizenship due to unreasonable criteria, were forced out of Bhutan or fled Bhutan fearing torture, detention, and imprisonment.

### *Bhutanese Refugees in Nepal*

Many Lhotsampas relocated to Nepal and lived in seven refugee camps in southeast region of the country: Beldangi I, Beldangi II, Beldangi II extension, Goldhap, Khudanabari, Timai, and Sanischare (Maxym, 2010). Within these refugee camps, everyday living remained challenging. Refugees lived in poverty with limited access to resources including education and electricity—a stark contrast from their pre-refugee lives. Refugee camps did, however, offer dietary and health services.

Bhutanese refugees were able to receive rice and lentils as food staples (Maxym, 2010) as well as “chickpeas, vegetable oil, sugar, salt, fresh vegetables,” and “Unilito,” a “locally made, fortified, blended food containing micronutrients, from the World Food Programme and United Nations High Commissioner for Refugees (UNHCR) (Brennan, Bilukha, Bosmans, Dahal, & Jha, 2005). Although these rations adhered to their primarily vegetarian diet and avoidance of beef and pork in respect of religious beliefs, it was a departure from their previous diet consisting of various self-harvested seasonal fruits they were responsible for harvesting. Under specific health conditions (i.e., malnutrition, pregnancy and lactation, and infectious tuberculosis), refugees received additional supplements and rations.

Bhutanese refugees had access to traditional medical approaches and Western medicine prior to and during their time in Nepal’s refugee camps (Maxym, 2010). Western treatments, though limited, were preferred by most Bhutanese refugees. Despite this preference, it was commonplace for Bhutanese refugees to initially utilize traditional home remedies and only seek Western medical treatment if home remedy efforts were not successful. Continued engagement in traditional health practices may have been

associated with their beliefs regarding the origin of illness and disease. Traditional medical practices would take these beliefs into consideration and enable treatment-seekers to participate in rituals of a spiritual nature not found in Western medicine.

The Association of Medical Doctors of Asia provided medical services including immunizations, pediatric care, reproductive health services, emergency medical services, referrals and screenings (U.S. HHS, 2013). However, these options were limited in comparison to the Bhutanese government's healthcare system and services were not consistently available (Maxym, 2010).

After nearly two decades of failed attempts toward repatriation to Bhutan and integration into Nepal as citizens, Lhotsampas began resettling in third party countries (Maxym, 2010). The International Organization for Migration (IOM) has served as a leader for resettlement of Bhutanese refugees by initiating its own efforts in October 2007 (IOM, n.d.). IOM resettles Bhutanese refugees in eight countries: Australia, Canada, Denmark, New Zealand, Norway, the United Kingdom, and the United States. Preparation for resettlement in most of these countries entails an orientation on the host country's culture and opportunities for education, employment, housing, and social services. The orientation is followed by a health assessment and additional efforts to ensure accuracy of the refugees' appropriate travel information.

Resettlement into the host countries has gradually led to a decrease in number of Bhutanese refugees and refugee camps—from seven original camps to two remaining camps (Maxym, 2010) with approximately 38,100 refugees from the original 108,000 (Gurung, 2013). To date, the United States has taken the lead in resettlement of Bhutanese refugees.

### *Bhutanese Refugees in the United States*

Over the past three years, admissions of refugees of Bhutanese nationality in the United States have increased (Martin and Yankay, 2013). By 2012, more than 49,000 Bhutanese refugees had resettled in the United States with the majority resettling in Pennsylvania (10.0%), Texas (9.9%), New York (8.1%), and Georgia (7.0%). One-quarter of all refugees resettled in the U.S. during fiscal year 2012 were from Bhutan. In 2013, resettlement numbers for Bhutanese refugees in the United States reached over 66,000 (Gurung, 2013). Bhutanese refugees have been resettled throughout the country but remain free to relocate and commonly do so to reunite with family and friends in various Bhutanese communities (U.S. HHS, 2013).

Bhutanese refugees resettling in the United States, similar to other refugee populations, experience transition-related challenges. Daily activities such as grocery shopping may overwhelm refugees who are not familiar with local markets (Maxym, 2010). Low education levels, limited fluency in English, and relatively no exposure to technology, can lead to refugees' frustrations and stress. Social dynamics related to cultural values and practices may alter in favor of Western practices and beliefs and new responsibilities.

Refugees inherit new responsibilities and lose significant aspects of their pre-resettlement lifestyles upon relocation to the United States. For instance, familial and communal practices such as dining collectively may be impacted by work responsibilities. Decreased opportunities to interact with friends and family and pressures to provide oneself and one's community with basic needs are experienced alongside cultural changes affecting caste, gender, and education (Maxym, 2010).

Attempting to cope with these stressors, Bhutanese refugees sometimes engage in substance use behaviors or develop poor mental health deleterious to overall health (Maxym, 2010). It is certainly recommended that Bhutanese refugees seek assistance of social and health workers when faced with negative health behaviors and outcomes; however, refugees experience difficulties with accessing health care due to affordability barriers and cultural factors.

Less is known regarding specific affordability barriers beyond factors commonplace among refugee populations (e.g., limited resources and employment). The prevalence of traditional medicine use is unknown upon refugees' resettlement but may be explained by the significance of spirituality in illness and disease among individuals in the Lhotsampa community. Traditional approaches are diverse ranging from herbal mixtures and organic remedies to medication, prayer, and rituals performed by priests, traditional healers, and shamans. Traditional medicines are not used exclusively among Bhutanese refugee and some may employ traditional and Western medical approaches to treat health conditions.

Bhutanese refugees who use Western approaches hold Western health care providers in high regard (Maxym, 2010). These expectations may impact refugees' perceptions of health professionals when practitioners are impolite, rude, or rush through consultations. Cultural ideas of gender roles may also impact patient-physician interactions and level of disclosure among women in Bhutanese refugee communities. Women have generally been reluctant to discuss their own health concerns—seeing the health issues of spouses and children as higher priorities (Maxym, 2010).

Investigating the health experiences, perceptions, and behaviors of Bhutanese refugee communities has particular relevance in the United States as 26% of new refugee arrivals in 2012 were from Bhutan and resettlement of refugees from the Near East/South Asia region remains a top priority (Martin, 2012). Though Tennessee is not a primary relocation site for individuals from this region, nearly 15% of all refugees resettled in Tennessee during fiscal year 2013 were of Bhutanese nationality (Catholic Charities of Tennessee, Inc., 2012). Additionally, secondary migration, relocation after initial resettlement, among this population is common (U.S. HHS, 2013) and may suggest higher or lower population estimates of Bhutanese refugees in Tennessee. It can be assumed that Bhutanese refugees experience general barriers similar to those of other refugee populations. However, few reports exist depicting the hardships of Bhutanese refugees in addressing health concerns, and even less is known in terms of the specific ways in which they perceive their health services and interactions with medical professionals. Descriptions of their health perceptions and practices may serve a vital role in explaining the nature and extent of their utilization of Western medical services and be influential in decreasing existing health disparities and increasing health-promotion behaviors and positive health outcomes.

## CHAPTER III

### METHODS

#### *Purpose*

The current study utilized qualitative research methods to examine Bhutanese refugees' experiences with post-resettlement health care services received in middle Tennessee. In examining these experiences, particular attention was paid to refugees' perceptions of their encounters with Western health services, Western and traditional health behaviors—both positive and negative, and the value each medical approach holds for Bhutanese refugees post-resettlement. While the aforementioned research foci served as an origin for the investigation, the iterative nature of the qualitative approaches employed allowed for the data to guide the research process. Approval to conduct the current study was granted by the Institutional Review Board of Middle Tennessee State University (Protocol Number 14-135).

#### *Study Design and Theoretical Approach*

Due to the lack of substantial information regarding Bhutanese health practices and perceptions in the extant literature, qualitative research methods with a grounded theory approach were deemed to be the most appropriate for the research. A focus group design was selected to allow the principle investigator to effectively address the research foci with semi-structured, open-ended questions that were concerned with understanding how Bhutanese women managed and understood their interactions with pre- and post-resettlement health encounters. The open questions further allowed the investigator to capture a broader scope of information from study participants that may not have been possible to obtain via quantitative methods that typically conduct assessments with

closed-ended questions offering limited response options. Additionally, the lack of existing literature on Bhutanese refugees and their health post-resettlement curbs the use of a narrower instrument. The openness of focus groups also allowed for similarities and differences among participants' experiences and perspectives to emerge from group discussions (Hennink, 2014) leading to the establishment of a foundation of literature on this population—providing future researchers with valuable insight into this population and, specifically, their health concerns.

The rationale for utilization of classic grounded theory also centers on the lack of existing literature pertaining to Bhutanese refugees' health perceptions and behaviors. While it is often useful to design research investigations with a specific theoretical framework in mind, to the principle investigator's knowledge, no literature was available providing sufficient evidence for the appropriateness of existing health-related theories with the current population. Even if available, the use of health behavior theories and models at the individual-, interpersonal-, or community-levels for this research may have failed to take into consideration participants' unique perspectives as such theories are typically deductive rather than inductive in their application.

Furthermore, use of such theories would not have allowed the principle investigator to comprehensively examine Bhutanese refugees' experiences with and engagement in post-resettlement health behaviors as well as how these experiences were perceived in comparison to pre-resettlement health behaviors. Pre-existing theories and conceptual models consisting of well-established constructs are useful in predicting behaviors. Applying predetermined constructs and concepts may not have coincided with the main points of interest of focus group participants. In considering the current study's

intentions to develop a detailed description and explanation of Bhutanese refugees' health perceptions and behaviors, and in an effort to limit assumptions or impose a theoretical framework on this culturally unique population, grounded theory methods were employed.

Grounded theory as proposed by Glaser and Strauss (1967) intends to describe and explain behavioral patterns that occur within groups. To this aim, concepts presented in grounded theories emerge from the data, yet are reflective of participants' main concerns rather than individual experiences and explicit statements. While a theory constructed from this approach does not intend to prove or predict behaviors, concepts developed through this process may be used describe and explain Bhutanese refugees' behaviors and provide contributions to the literature that can inform future research and be modified in subsequent inquiries. The 'grounded' quality of a data-generated theory furthers its longevity as it continues to be supported by the data from which it was abstracted.

In the grounded theory process of data collection:

*"... one generates conceptual categories or their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept. The evidence may not necessarily be accurate beyond a doubt ... , but the concept is undoubtedly a relevant theoretical abstraction about what is going on in the area studied."* (Glaser & Strauss, 1967, p. 23)

Utilization of qualitative methods and grounded theory processes led to the collection of data, rich in detail, and more reflective of how women in Bhutanese refugee communities perceive their experiences with health services and how these perceptions are valued. The iterative aspect of this research design required data collection and data

analysis to occur concurrently, further enabling the research process to be guided by the data and the yielded findings to be well-grounded in the data generated (Glaser & Strauss, 1967). The themes identified through the research process could then be compared to constructs of existing theories and/or used to develop new, more appropriate theoretical or conceptual frameworks that fit within the specific group.

### ***Gaining Access to the Target Population***

Access to the target population was gained through existing relationships between a refugee assistance organization (RAO) located in a metropolitan area of middle Tennessee and the principle investigator's colleague. The RAO involved in the current study serves a diverse refugee population which represents over thirty countries. The researcher gained access to the target population through the existing relationship between the Bhutanese community and RAO.

The RAO's founder, director of health programs, and volunteers offered access to the population through these pre-existing contacts and relationships. Additionally, representatives from the organization were available for consultation throughout the research process—providing logistical (i.e., meeting locations, participant) and informational resources (i.e., health topics of interest to the organization and Bhutanese refugees, findings from health forums and programs held with Bhutanese refugees) to aid in working within the Bhutanese refugee community.

### ***Role of the Interpreter***

Interpretation services for this research were necessary to enable communication between the English-speaking investigator facilitating the focus groups and participants, the majority of which spoke only Nepali. To address this communication barrier, the

investigator consulted with colleagues and community members who had experience with translation services. Through consultations and recommendations, the investigator identified a local Nepali-speaking woman of Bhutanese descent who was formally trained as a medical interpreter and had served as interpreter in previous research endeavors with Bhutanese refugees. The research aims and design were presented to the recommended woman and an agreement was made to employ the woman for the study's interpretation needs.

Interpretation services remained the primary responsibility of the interpreter. As a well-respected and well-educated member of the community, the interpreter provided additional assistance prior to and following commencement of the study. The interpreter used her role in the community, particularly that of holding mutual trust and familiarity, to recruit participants. She was also helpful in coordinating meeting times and locations for the focus group sessions. Her advice was also taken into consideration when comparing appropriate methods of recruitment and means of compensation for participants. The knowledge she possessed regarding Bhutanese refugees aided in the process of considering and accommodating cultural factors that could influence study outcomes (i.e., caste system and gender).

### ***Navigating the Issue of Caste and Gender***

Cultural factors, specifically, the caste system and beliefs about gender, were considered when designing this study. In the review of literature caste appeared as a prominent component of Bhutanese culture that dictates day-to-day living (Maxym, 2010) and potentially the social dynamics within this population. The principle

investigator discussed the potential of caste as a confounding variable in data collection and research findings with contacts to the Bhutanese refugee community

While many members of the Bhutanese refugee community assimilate to a more Westernized lifestyle, some Bhutanese refugees continue to value and engage in cultural practices that impact their day-to-day interactions. The investigator's primary concern regarding the effect of the caste system was its potential to interfere with the extent to which participants would engage in dialogue, specifically higher caste members' willingness to interact with or communicate about topics in the presence of lower caste members.

The investigator relied on the interpreter to address concerns related to caste. As a member of the community, the interpreter had cultural knowledge regarding Bhutanese refugees. The interpreter could manage caste differences when recruiting for and conducting focus groups. However, the issue of caste did not appear to influence women's level of participation in focus groups, though this issue was not discussed in great detail with the interpreter.

Another factor thought of as a potential barrier to effective communication in the focus group was gender. Based on previous studies of barriers to health care for refugees (Morris et al., 2009), it was believed that both men and women may feel more inclined to disclose personal information when discussing health issues with a same-gendered interviewer and interpreter as well as fellow participants. The female investigator's employment of a female interpreter was helpful in addressing this concern.

Providing women with an opportunity to discuss women's health issues, though not the primary rationale behind the researcher's overall investigation served as an

additional benefit of the study. In discussing inclusion and exclusion criteria for study participants, representatives from the RAO suggested exclusively working with women in the Bhutanese community to increase the feasibility of the study and likelihood of participant ease and comfort. Given the information gathered during the literature review and consultations with refugee assistance colleagues, the principle investigator decided to focus exclusively on women from the target population. In doing so, the researcher aimed to increase the likelihood of participant disclosure by eliminating participant concerns related to gender.

### ***Sampling***

Purposeful, convenience sampling strategies were employed to obtain a sample of women in the Bhutanese refugee community that was diverse in age, education level, and religion. Primary efforts for participant recruitment were conducted by the interpreter who had an established rapport with and significant level of access to the target population as an employee at a local non-profit organization providing resettlement services to many refugees and also as a member of the Bhutanese refugee community. Women contacted for participation in the current study were also encouraged to ask additional women meeting the research inclusion criteria to participate.

These recruitment strategies most effectively avoided potential language/communication barriers present in utilizing traditional recruitment methods (i.e., flyers). The word-of-mouth, one-on-one strategies may have also increased participant response rates by increasing potential participants' trust, comfort, and ease associated with research participation. During participant recruitment efforts Bhutanese women were informed of the anticipated duration of the focus groups, the availability of

refreshments at the meetings, and that they would each be paid ten dollars as compensation for their participation.

The following inclusion and exclusion criteria were selected to ensure that the only members of the target population were allowed to participate in the study. Although refugees of varying cultures and origins may report similar experiences with health services during pre- and post-resettlement encounters, it was important that the current study focused on the experiences of only the Bhutanese community. The criteria for participation were reviewed by the investigator following each participant's completion of the demographic questionnaire. Any concerns regarding participation in the focus groups (e.g., purpose of discussion, intentions of the researcher) were addressed by the investigator and interpreter prior to the start of each focus group session.

Inclusion criteria:

- Participant is 18 years old or older.
- Participant is female.
- Participant is Bhutanese, specifically of Nepali-descent.
- Participant has migrated to the United States as a refugee.
- Participant currently resides in the middle Tennessee area.
- Participant is able to recall experiences with health care services in the middle Tennessee area.

Exclusion criteria:

- Participant was ineligible for participation in the study if they fail to meet any of the above inclusion criteria.

- Participant was ineligible for participation in the study if they refuse to or are unable to provide consent for participation.

### ***Informed Consent***

Each woman recruited for participation was asked to complete an Informed Consent Form prior to participating in the focus group (Appendix B). The consent form provided to each participant described the purpose of the study, potential benefits and risks as a result of participation, the voluntary nature of participating in the study, and measures taken to ensure her privacy and the confidentiality of her responses. Women literate in English were able to sign and date the Informed Consent documentation independently. Individuals not literate in English had the Informed Consent Form read to them in Nepali by the assisting interpreter. Participants were allowed to ask questions and/or discuss concerns they had regarding their participation at any point during the meeting. Women were also provided contact information for community health resources in the event that any questions and/or concerns arose during the focus groups that warranted further attention but could not be addressed by the investigator and/or interpreter.

### ***Instrument Development***

Instruments were constructed to collect demographic information and guide focus group meetings. Questionnaire items were written in English using vocabulary that would readily translate to Nepali and offer the least amount of confusion for the participants. Demographic items included on the questionnaire are listed below:

- Age
- Employment status
- Health insurance coverage
- Importance of religion
- Religious affiliation
- Highest level of education
- Birthplace
- Length of residency in Bhutan
- Length of residency in refugee camps
- Length of residency in United States
- Length of residency in Tennessee

The focus group semi-structured interview guide was constructed by the principal investigator with assistance from co-investigators and contacts at the RAO. The original interview guide consisted of eleven questions but was narrowed to focus on general perceptions, behaviors and values pertaining to Bhutanese refugees' health pre- and post-resettlement that could be assessed in a time period most convenient for participants.

The final semi-structured interview guide was not translated into Nepali but consisted of five open-ended questions worded in such a way to enable the interpreter to communicate the Nepali translation accurately with an appropriate level of understanding for the participants. Prompts accompanied each of the main statements/questions and were used to gain clarification and deeper insight into participant responses. The

questions and prompts pertained to health perceptions and practices yet were broad to elicit responses that allowed the women to provide only information they felt comfortable sharing with the researcher, interpreter, and members of the group.

1. Has anyone been sick since coming to middle Tennessee? Tell me about what happened the last time you were sick/went to the doctor/nurse for another reason.
2. How did you feel after you got the medical treatment?
3. What do you do/have you done to keep yourself from getting sick (again).
4. When you lived in (Bhutan/Nepal/refugee camps), how did you keep yourself from getting sick?
5. When you lived in (Bhutan/Nepal/refugee camps), how did you get better when you were sick?

The demographic questionnaire and semi-structured interview guide were both assessed for face and content validity by experts in the fields of refugee health and Bhutanese refugee resettlement. When assessing face validity, experts were asked to review the extent to which questionnaire items appeared to pertain to the type of information the investigator intended to gather. Reviews for content validity focused on the degree to which instrument items covered the scope of the investigator's research interest for the current study.

### ***Data Collection and Entry***

For each focus group, participants gathered at a selected apartment to participate in the study. The apartments used to hold the focus groups were leased to the RAO. A total of three meetings were held between December 2013 and February 2014. Each meeting lasted between one hour and thirty minutes (the third focus group) and two hours and thirty minutes (first focus group) and was held at a different apartment complex identified by the interpreter and principle investigator as a suitable place in which to conduct data collection based on comfort and convenience of the participants and interpreter. Ten to twelve women participated in each focus group. Women who agreed to participate in the study were only allowed to attend one focus group meeting to avoid duplication of data.

At focus group meetings, participants were first asked to complete the demographic questionnaire. Participants fluent in English and comfortable completing the questionnaires without additional assistance were allowed to complete the questionnaires independently. Participants not fluent in English received individual assistance from the interpreter to complete the demographic questionnaire. All demographic information was collected from participants prior to the beginning of the focus group portion of the meeting.

Collection of demographic information from participants served dual purposes. First, the principal investigator was able to more confidently confirm that participant in the focus groups met the inclusion criteria. Second, the data would further enable the investigator to identify factors associated with various health perceptions and behaviors that emerged from the focus group discussions.

Prior to the start of the focus group, participants were assigned a focus group participant identification letter (e.g., assigned the letter 'A') to wear and be referred to as throughout the duration of the focus group. Participant identification letters were used to maintain confidentiality in the data collection process. During each focus group session the investigator posed questions to the focus group participants. The interpreter offered the Nepali translation of the question to the women in the focus group. Each participant was given the opportunity to respond to the posed question. Participants were asked to clearly state their focus group participant identification letters before responding to the posed questions. Their responses were communicated in English to the researcher. Each focus group meeting was audio recorded using a digital recording device.

During focus group meetings, participants were asked to respond to a series of statements/questions from the semi-structured interview guide (Appendix C) pertaining to their experiences with health care services received in middle Tennessee and health behaviors prior to and following their relocation to middle Tennessee. Though reaching a group consensus was not a goal of each focus group, women were allowed to respond to each other's comments; this feedback was useful in identifying similarities and differences within the greater community.

The taped recordings were then transcribed verbatim using the investigator's questions and the English translations of participants' responses. As a supplement to the recordings, handwritten notes were recorded by the researcher during the focus groups. The questionnaire and focus group questions were not piloted within this community due to the limited participant pool. In lieu of piloting the questionnaire and focus group items, data collection instruments were assessed by experts with experience in refugee health

research, focus groups with Bhutanese refugees, or Bhutanese refugee health programs. The proposed questions were discussed among co-investigators who had experience with international populations and sent to the director of health programs at the resettlement agency and the interpreter both of whom had experience interacting with Bhutanese refugees as it related to health concerns and health education. Clarity, ease of translation, potential bias, and presence of assumptions were the focus of instrument reviews.

Saturation, or the point at which collection of new data no longer provides unique information or insight, served as the basis for the end of data collection (Charmaz, 2006). All collected data were stored in a password-protected file on a password-protected computer maintained by the principle investigator and co-investigators.

### ***Data Analysis***

Demographic data was entered into Microsoft Excel. Statistical analyses were not conducted on demographic data for comparative purposes. However, frequencies were conducted, when appropriate, to provide sample characteristics.

ATLAS.ti7, version 7.1.8 was used to manage codes and build themes during data analysis, though this software was used less so for the latter process. In accordance to literature on grounded theory approaches, data collection and data analysis occurred simultaneously in this study, as (Charmaz, 2006; Glaser & Strauss, 1967). Using the transcript for each focus group, the principle investigator coded through two main processes identified by Charmaz (2006): initial coding and axial coding.

Initial or open coding allowed for comparison of the data as its purpose is to separate the data, enabling the coder to identify distinct codes. To accomplish this goal, the researcher first coded each transcript line-by-line. The line-by-line coding approach

enabled the researcher to “stay close to the data” (Charmaz, 2006, p. 49). Constant comparison of the focus group transcripts was conducted to assure that the data collection process was iterative and guided by leads emerging from the participants rather than researcher assumptions. This involved comparisons of data, codes, and categories. Axial coding followed to reunite the codes identified through the initial, open coding. Connections made between the most dominant codes were categorized.

Memo writing was also incorporated into the analysis process. Memos, or notes taken “to tap into the initial freshness of the analyst’s theoretical notions” (Glaser & Strauss, 1967:107) were taken following coding and when comparing codes and categories. In making memos during the constant comparison process, the investigator attempted to avoid the development of artificial reasoning and further ground themes and emergent categories (Glaser & Strauss, 1967).

An additional reviewer, not affiliated with the study, used the same process to review 33% of each transcript and identify codes and construct themes for validity and reliability purposes (Lincoln & Guba, 1985). This review further ensured that the investigator’s findings were grounded in the data and the generated theory and conclusions followed a logical path that was supported by participants’ responses. Both coders had prior experience in coding and theme construction in research projects with migrant populations. Codes and themes constructed by the outside coder and principle investigator were subjectively assessed (i.e., discussed to provide clarification of interpretation and reach consensus) (Hennink, 2014).

### *Evaluation of Qualitative Studies*

Researchers conducting qualitative work share some of the same responsibilities of quantitative researchers in that issues of validity and reliability should be acknowledged, presented, and discussed throughout various stages of research (Hennink, 2014) In understanding this task, researchers have offered several guidelines to dictate how to accomplish this goal. Unfortunately, a consensus on evaluating qualitative work has yet to be reached due to the many variations in qualitative approaches and the interpretative nature of the work. With this as the current state of qualitative research, the current study was evaluated by criteria that reflect the purpose and aims of grounded theory.

Theories generated from utilization a grounded theory approach are not generally focused on predictive capabilities (Glaser & Strauss, 1967). Furthermore, grounded theory does not seek to generalize findings to outside populations; alternatively, grounded theory aims to understand a specific group of individuals in a specified situation or set of circumstances (Charmaz, 2006) The extent to which findings were credible, transferable, dependable, and could be confirmed (Lincoln & Guba, 1985) were, therefore, central to the study's evaluation. Other characteristics of classic grounded theory such as 'fit' and "work" were also considered in evaluation of research findings (Glaser & Struass, 1967).

Credibility, an alternative to internal validity, refers to a study's ability to reflect a level of intimacy or closeness with the topic and setting, saturation of data, and logical connections between data collected and researchers' findings (Lincoln & Guba, 1985). Credible findings should validate the participants' true responses. Strategies to increase a study's credibility have been presented by Lincoln and Guba (1985).

In establishing credibility of the study's findings, the investigator conducted "member checks" as recommended by Lincoln and Guba (1985). Member checks with key informants were carried out during and following data collection and analysis. During the assessment, key informants were presented with the research findings and asked to provide additional feedback regarding the identified themes. Information obtained from key informant interviews was compared to codes and themes that emerged from the data to assess the extent to which the feedback supported or contradicted research findings. Results from this process are further explored in the discussion section.

Transferability of findings was a more difficult criterion to achieve. Lincoln and Guba (1985) note the near impossibility of obtaining true transferability or external validity of findings in grounded theory work. Researchers can only extend findings to specific groups under well-defined circumstances during a certain period of time. Such information can be provided in research reports to inform other scholars and stakeholders, yet guidelines to dictate the information needed for appropriate generalizability has not been presented. Transferability of results for the current study is discussed in the conclusion.

Towards the issue of internal and external reliability, Lincoln and Guba (1985) introduce dependability and confirmability, respectively. When assessing dependability, researchers focus on the process of conducting the study. Confirmability entails an examination of the study's data and results as well as overall conclusions drawn. Hennink (2014) notes researcher interpretations as one of the major challenges to obtaining reliability in qualitative studies. Researcher interpretations are subjective yet should be linked and grounded to the data. Although outside reviewers may not be able to

produce identical findings, review of data and conduction of similar research procedures should be transparent and enable outsiders to understand how conclusions were reached.

To address the issue of reliability, procedural steps are included—providing the context in which study findings were obtained, analyzed, and conceptualized. Focus groups were conducted in similar settings and participants were asked the same questions to achieve a degree of consistency across groups. The outside coder was also beneficial in assessing reliability by offering an additional review of transcripts using the same procedural techniques to code the data and construct themes.

Glaser and Strauss (1967) emphasize the importance of two additional criteria, fit and work, in their discussion of a theory's purpose and responsibilities. Fit refers to the degree to which constructed categories can be applied to study findings without being forced. The iterative analytic process assisted with reaching this goal by forcing the investigator to constantly review data and abstractions from the data. The categories constructed were frequently compared to the data codes for assurance.

Work, the necessity for a theory to be relevant, meaningful, and useful in explaining behaviors, was initially assessed via prompts utilized in focus group sessions to ensure correct interpretations of collected data. Following each focus group and at the conclusion of data collection, the investigator consulted with key informants to address concerns with and verify interpretations.

## CHAPTER IV

### RESULTS

Results from this investigation into the post-resettlement perceptions and values regarding health and current health behaviors among Bhutanese refugees are presented. This examination led to the construction of a theoretical framework identifying and describing factors influential in how Bhutanese women interact with and make sense of health services to manage their health post-resettlement. Participant characteristics have also been included, providing additional context for purposes of transferability of study findings.

#### *Participants*

Participants for the proposed study consisted of 32 women from the Bhutanese refugee community recruited from a non-profit organization in the middle Tennessee area offering resettlement assistance to refugees and immigrants through social and educational services and programs. Ages ranged from 18 years to 87 years of age, though 53.1% of the women ( $n = 17$ ) were between the ages of 30 to 49 years of age. Twenty-one women (65.6%) reported no formal education, 27 women (84.4%) reported being unemployed, and 11 women (34.4%) reported being uninsured. The majority of women (53.1%) were Hindu, though Christianity and Buddhism were also frequently reported. Data also indicated that most women (78.1%) had spent at least twenty years in refugee camps and lived in the United States two years of less (81.2%). Many women (84.4%) were also new residents to Tennessee having only lived in the area twenty-four months or less, also suggesting that few women were secondary migrants. Additional demographic information can be found in Table 1.

**Table 1. Characteristics of Focus Group Participants.***Characteristics of Focus Group Participants**(n = 32)*

| Characteristic                    | <i>n</i> | %    |
|-----------------------------------|----------|------|
| <b>Age</b>                        |          |      |
| 18-29 years old                   | 5        | 15.6 |
| 30-39 years old                   | 8        | 25.0 |
| 40-49 years old                   | 9        | 28.1 |
| 50-59 years old                   | 4        | 12.5 |
| 60-69 years old                   | 2        | 6.3  |
| 70-79 years old                   | 3        | 9.4  |
| 80 years old or older             | 1        | 3.1  |
| <b>Employment Status</b>          |          |      |
| Employed                          | 5        | 15.6 |
| Unemployed                        | 27       | 84.4 |
| <b>Health Insurance Coverage</b>  |          |      |
| Insured                           | 20       | 62.5 |
| Uninsured                         | 11       | 34.4 |
| <b>View Religion as Important</b> |          |      |
| Important                         | 31       | 96.9 |
| Not Important                     | 1        | 3.1  |
| <b>Religious Affiliation</b>      |          |      |
| Buddhist                          | 6        | 18.8 |
| Christian                         | 8        | 25.0 |
| Hindu                             | 17       | 53.1 |
| Kirat                             | 1        | 3.1  |
| <b>Education</b>                  |          |      |
| No Formal Education               | 21       | 65.6 |
| Middle School Education           | 3        | 9.4  |
| Secondary School Education        | 5        | 15.6 |
| Some College Education            | 1        | 3.1  |

**Table 1. Characteristics of Focus Group Participants. (cont).**

*Characteristics of Focus Group Participants (cont.)*  
(*n* = 32)

| Characteristic                 | <i>n</i> | %    |
|--------------------------------|----------|------|
| <b>Years in Refugee Camps</b>  |          |      |
| 0-14 years                     | 0        | 0    |
| 15-19 years                    | 5        | 15.6 |
| 20 years or more               | 25       | 78.1 |
| <b>Months in United States</b> |          |      |
| Less than 12 months            | 12       | 37.5 |
| 12-24 months                   | 14       | 43.7 |
| 25-36 months                   | 2        | 6.3  |
| 37-48 months                   | 2        | 6.3  |
| 49-60 months                   | 1        | 3.1  |
| 61 months or more              | 1        | 3.1  |
| <b>Months in Tennessee</b>     |          |      |
| Less than 12 months            | 13       | 40.7 |
| 12-24 months                   | 14       | 43.7 |
| 25-36 months                   | 2        | 6.3  |
| 37-48 months                   | 1        | 3.1  |
| 49-60 months                   | 1        | 3.1  |
| 61 months or more              | 1        | 3.1  |

### ***Construction of a Theoretical Framework***

In staying true to iterative, qualitative research, data guided additional data collection and subsequently influenced the construction of themes. The main research topics (i.e., perceptions of post-resettlement health services, current health behaviors, and the value found in pre- and post-resettlement medical approaches) served as an initial guide for the research; however, throughout the data collection process the research became significantly more centered on use of conventional medicine and obstacles

encountered in refugees' efforts to access and utilize such services. Refugees also made several comparisons between pre- and post-resettlement healthcare experiences—providing information about refugees' perceptions and values of both approaches as well as insight into refugees' health literacy.

The departure from the original research foci, though unexpected, was welcomed as it accurately reflected the utilization of grounded theory which emphasizes the necessity of participant-oriented data collection. Using this emic approach, data collected were grounded in the points of interest identified by the participants—legitimizing the findings and aiding in the construction of a theoretical framework that is likely transferable to similar populations in a comparable context. Original themes emerging from the data included transportation difficulties when accessing health services; language barriers in communicating with health care professionals; challenges in paying for health services (out-of-pocket or through insurance); positive and negative perceptions of post-resettlement health care professionals; positive and negative perceptions of post-resettlement health treatments; limited engagement in preventive health behaviors; frustration with post-resettlement health care system; and use of conventional medicine as a health option. Further exploration of relationships between these themes led to the construction of the following themes: positive perception of post-resettlement health services; barriers to post-resettlement health services; and limited health literacy. Each distinct theme or concept identified is a relevant factor in understanding how Bhutanese women understand and manage their health in the United States and understanding health in the United States in general, but it is important to note

the interrelatedness of the concepts from the viewpoint of the researcher, key informants, and, most importantly, the Bhutanese women (Figure 1).

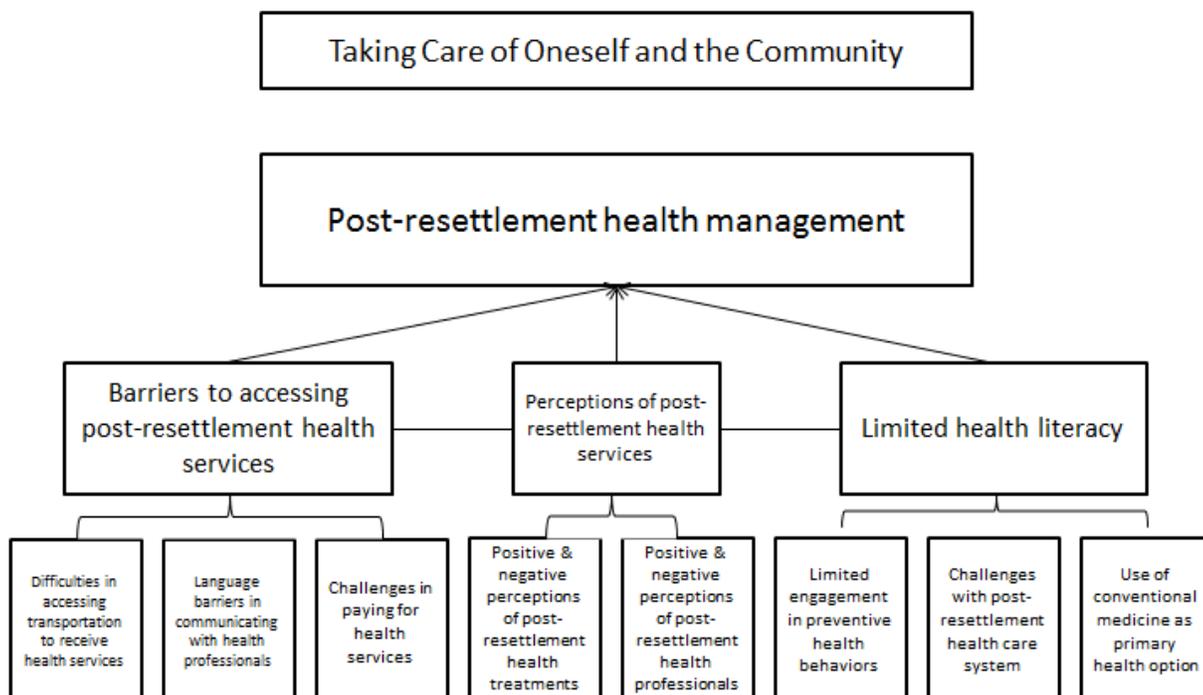


Figure 1. Theoretical Framework for Bhutanese Refugees' Post-resettlement Health Management.

Identification of several concepts and relationships between concepts demonstrate the complexity of Bhutanese refugees' perspectives regarding their health and health experiences. Findings fall short in the development of a grand theoretical framework. However, data collected and analyzed were suitable for the development of a middle-range theoretical framework (Glaser & Strauss, 1967) useful in better understanding the intricacies of post-resettlement health experiences and practices for Bhutanese refugees.

### ***Context of Bhutanese Women's Medical Health Care Perceptions and Utilization***

An understanding of health conditions experienced among Bhutanese women was not included as a general or specific focus of this investigation. However, women volunteered personal health information (i.e., conditions, ailments, and diseases) during each of the focus groups to provide the investigator with a broad view of ailments and diseases more commonly presented among Bhutanese refugees in middle Tennessee. Over the course of the study both acute and chronic conditions were frequently noted among participants. The most common conditions reported among the Bhutanese women included gastritis, headache, back/joint pain, and vision and hearing problems.

This information became particularly useful in providing a context in which to interpret the data and understanding the extent to which utilization of health services impacted the Bhutanese community. The participants' disclosure of various health conditions led to more targeted conversations about efforts they had taken to address specific health issues (i.e., seeking medical advice, undergoing treatment, attempting to self-treat/medicate). The information provided in these discussions described their utilization of conventional and traditional medical approaches to treat their disclosed health conditions, both successfully and unsuccessfully. It also opened discussions of obstacles encountered in health service interactions and further emphasized the importance of health literacy for Bhutanese women throughout points in health care consumerism—primary, secondary, and tertiary prevention.

### ***Barriers to Accessing Post-resettlement Health Services***

With a range of health conditions, Bhutanese women more frequently reported use of conventional medical intervention than traditional health practices for themselves,

family members, and other members of the post-resettlement community. The reported use of conventional medicine included both outpatient and inpatient procedures such as prescription medication, x-ray, and surgery. Despite reports of such utilization they also cited several barriers to continued use of conventional medicine including transportation, affordability and insurance, and language.

### Transportation

Continued use of conventional medical treatment was sometimes hindered by an individual's ability to access reliable transportation. Transportation in the Bhutanese community is limited and preference is given to those who are employed and need vehicles for their work commutes. Asking friends and neighbors to provide transportation was one way in which refugees attempted to overcome the transportation barrier. However, limited available transportation was reported as a major obstacle and reason for delay in treatment.

A 44-year-old woman who had lived in Tennessee for one year shared her family's difficulties in obtaining transportation:

*“Um, so to go to the doctor, my husband works but he goes, he goes in someone else's car. We don't have a car yet. Umm, so he works, but we don't have enough money to pay yet. So transportation is my biggest problem now ... So, I've been to the hospital for the very initial health screening with the case manager, and then we needed transportation to go to the hospital so we've never been to hospital.”* (FG 2, p. 12, Part. F)

An older woman also notes her difficulties in continuing treatment:

*“So I've not been back to the doctor again because I don't have a car and the kids who are able to drive or who could talk to the doctor are back to, have started working now. So, I've not been back to the doctor after I completed medication.”* (FG 2, p. 11, Part. A)

Transportation as a hindrance to health services was noted by several women. Efforts to address the concern were limited to seeking the assistance of friends and family members. None of the participants reported attempts to use public transportation to reach doctors' offices, clinics, or hospitals. Additionally, compared to issues of affordability and language/communication, transportation seemed to be a lesser obstacle within this community.

#### Insurance and medical expenses

The costs associated with medical treatment were frequently identified as a barrier to use of medical interventions. In discussing the expense of medical treatment, women often expressed disbelief in the high cost of health services—emphasizing the thousands of dollars they were asked to pay for their own treatments or those of family members. Accompanying these comments, women shared ways in which they dealt with the expenses.

The costs of treatment were sometimes covered by insurance. However, as lapses in insurance coverage were reported in this community, addressing medical concerns during the insurance coverage gaps became the predominant issue. In some instances, pain or discomfort from the condition became too unbearable to further delay treatment—leading individuals to undergo treatment and receive bills amounting to thousands of dollars.

*“We feel like we’ve been taken really good care of while we’re at the hospital, but when my husband went to the clinic last time, he stayed there all day and by the time he came back the bill was sent the following week and it was of \$11,000 ... It takes us the whole year to make that much money.” (FG 2. p. 13, Part. B)*

In other cases, women described enduring the pain until insurance was available to cover the expenses:

*“My back hurts bad ... and when I went to the clinic last time they told me that I didn’t have any insurance. So my son didn’t let me take, didn’t let the doctors to take care of me thinking that I would receive a lot of bills. So I’m waiting to get my insurance from my husband’s work ... So I’m just in dilemma whether to go get my treatment done or not, but really my back and my heels, both heels hurt bad. Umm, I need care, but I don’t know whether I will go or not.”* (FG 1, p. 10-11, Part. F)

Employment did not appear to alleviate the stress of paying medical expenses.

*“... I’ve not got time to go to the doctor because of my work schedule. I don’t get the hours when I go to the doctor.”* (FG 2, p. 7, Part. C)

Most women were not employed but offered the experiences of family members.

*“Because he does not have insurance he cannot go and see the doctor. He just works too much, and it doesn’t make enough to pay for his health.”* (FG 3, p. 2. Part. I)

Having medical insurance may have alleviated this particular barrier. However, several women discussed instances in which they were no longer covered by medical insurance.

*“So, we didn’t have any Medicaid. So it was all cut off so we didn’t want to go and take all those bills.”* (FG 3. p. 6, Part. F)

Despite medical expenses that may be incurred, at least every woman in the focus group had seen a medical professional at least once since resettling in the United States—indicating some ability to overcome transportation and financial barriers to receipt of care. Language barriers could, however, remain a significant factor in accessing services.

### Language and communication

When transportation and insurance barriers were overcome, language barriers remained present and interfered with the attainment of health services. Women who reported frustrations in handling language barriers:

*“The doctor would have been able to understand my problems, but here I do have to use a translator, and I’m not sure if the translator tells exactly how I’m feeling. So depending on translator has been a barrier between me and the doctor ... Umm, not all the doctor’s offices have interpreters in one thing. And sometimes even if they have translators, I’m not sure if all the messages are communicated.”*

When asked if family members or friends were helpful in accurately communicating information, the woman added

*“I feel the same way, like interpreters cannot [communicate] ... that’s not my words [unclear].”* (FG 2, p. 4., Part. J)

Interestingly, language also interfered with individuals’ ability to engage in self-care as over-the-counter medications, usually available in English rather than Nepali, were not readily understood. This was the reported cause of further delays in treatment and even worsening conditions:

*“Umm, well there are several families just because of the language barrier, they stay home tolerating all of the pain they have. They don’t even know how to get the medication over-the-counter to feel better. They do not have any idea that we get medication over the counter or there are places over-the-counter to get medication. Umm, even if they know that they could get medication over-the-counter, they do not know how to read the medication, what is for that. So, I’ve seen several people and their families who has got none of the family members to help them to find out the right medication over-the-counter. So they will stay home tolerating all the pains they have, and then the situation gets worse by the time they go to the doctor.”*

### ***Perceptions of Post-resettlement Health Care Services***

Bhutanese refugees mentioned several aspects of conventional health care services during discussions of their health care perceptions. Satisfaction with administered treatment as well as its perceived efficacy was frequently mentioned as were descriptions of the health care setting and interactions with health care professionals, namely doctors and nurses.

#### Health treatments and health care facilities

Bhutanese women generally reported satisfaction with received medical treatments. In one such instance, medical interventions received post-resettlement were perceived as life-saving as the participant made comparisons between possible outcomes under the same health circumstances in the United States versus in Nepal's refugee camp.

*“Umm, I felt like if I was back in Nepal I would not even live so I'm so happy the care and the medication that they gave me here.” (FG 1, p. 2, Part. D)*

Positive perceptions were also associated with the health care setting with many positive comments being made in regard to the cleanliness of the facility as one participant described in the following statement:

*“The hospital environment is super-clean compared to where [I] am from ... cleanliness, very clean.” (FG 1, p. 7, Part. H)*

Overall, participants shared opinions that were complimentary of their health treatments; some women did, however, voice frustrations with medical care. No one expressed feelings indicating a preference for pre-resettlement health services over post-resettlement in terms of efficacy of the treatment. Yet, the short-term effectiveness and

overall ineffectiveness of post-resettlement medications were mentioned by some participants:

*“Umm, I felt pretty good while I was at the hospital, but after I left the hospital, umm, I had the same problem back again.” (FG 1, p. 1, Part. G)*

A woman from a subsequent focus group commented:

*“But, I got, I took medication for gastritis, and I’ve been taking medication for gastritis, but it has not worked. It has not made me feel good ... I told the doctor that the medication didn’t work well, and then the doctor said that the medication only work with time. [I] just have to wait until the medication actually starts working. They tell me, they told me that I have problems with gastritis. That is what it is, but I’ve not felt any better and I’ve not been able to work just because of that problem.” (FG 2, p. 3, Part. J)*

Both statements seem to reflect frustrations that may be experienced when treating health conditions. In some ways, the comments may also expose an underlying issue that relates to refugees’ comprehension of and expectations for post-resettlement health services. Refugees may lack an understanding of health conditions as well as the duration of treatment necessary to alleviate symptoms. Frustration may also result from beliefs in the immediacy of health care interventions—that is, one’s symptoms will cease following short term treatment and care and recurrence of disease or health conditions will not be experienced.

### Health professionals

Responses to questions regarding interactions with health service providers were generally positive with women specifically noting politeness, listening, and caring as qualities of health care professionals in their post-resettlement experiences. A 58-year-old

woman who had lived in Tennessee two and a half years following nineteen years in refugee camps provided the following response:

*“As far as my experience whenever we go to the doctors, they really listen to us and they really take care of us.” (FG 2, p. 13, Part. B)*

Another woman who had lived in refugee camps for twenty years but had only been in the Tennessee for four months added the following comment:

*“So we see the doctor really taking care of us when we go to the doctor and they’re doing well. We don’t know what, what they’re supposed to be doing so they are the experts.” (FG 2, p. 13, Part. E)*

While the latter comment further contributes to the overall positive perception of post-resettlement health services, it also provides insight into the value placed on health care providers by Bhutanese refugees. Doctors, nurses, and other medical professionals are seen as “experts” and highly valued within this community. Bhutanese refugees’ perceptions of health care professionals may contribute to the passive health care consumer role undertaken by Bhutanese refugees and, furthermore, their low level of health literacy.

### ***Limited Health Literacy***

#### Limited engagement in preventive health behaviors

In response to questions asked about health practices used to keep oneself from becoming ill or to treat medical conditions when conventional health services were not accessible, Bhutanese refugees reported use of general self-care and healthy living behaviors as ways to address health concerns and alleviate health symptoms independently. Healthy living behaviors targeted physical health (i.e., physical activity

and diet). Physical activity among Bhutanese women included participation in a local fitness programs and self-directed physical activity (i.e., walking around the apartment complex by oneself or with other residents). Bhutanese women also noted changes that should be made in terms of diet, specifically noting the need to drink water several times each day and limit their intake of fats.

Self-care practices and healthy living behaviors overlapped but the former were characterized by the respondent's reference to engagement in a specific health-related behavior to treat a particular health concern. For example, one woman discussed changing her dietary and hygienic practices (i.e., cleansing oneself more frequently, changing clothing more often) to address feminine health concerns.

Engaging in hygienic practices can have positive effects on an individual's overall health and thus be considered a practice of healthy living. However, the investigator felt it necessary to highlight instances in which efforts were undertaken by participants to treat health conditions independently, and thus, made the distinction.

*“By myself, I’ve been trying to drink as much as I can. Well, I don’t know the reasons, but I feel like I’m not having as much discharge here like I used to have in the country. So to make myself feel better I’ve been drinking as much as I can and then I’ve been trying to eat the healthy food, and I’ve been paying more attention to personal hygiene like changing the undergarments every day to make sure it does smell out and trying to keep myself clean. That is what I’ve been trying to do; that is all.” (FG 1, p. 6, Part. H)*

#### Challenges with post-resettlement health care system

Statements made in regard to post-resettlement health services generally reflected an appreciation for such services. However, Bhutanese women also aired grievances when discussing aspects of the health care system. Most comments pertained to medical

expenses incurred when treatment was sought without insurance coverage as one participant shares:

*“So doctors, I wish though I have insurance now, I have the experience from the past. Though we get good care, I wish they would understand our problems. Also, they are too expensive so I wish they could make it a little cheaper than what they actually charge for the services they provide.” (FG 2, p. 13, Part. J)*

*“Umm, not all the doctor’s offices have interpreters is one thing. And sometimes even if they have translators, I’m not sure if all the messages are communicated.” (FG 2, p. 4, Part. J)*

*Primary use of conventional medicine as post-resettlement health option*

Utilizing conventional medicine was not viewed as a negative health behavior by the Bhutanese women or the researcher. After data analysis it became more apparent to the researcher that such use of conventional medicine was underscored by participants’ dependence on doctors to manage their health—fostering the development or continuation of passivity among Bhutanese refugees as health consumers.

*“... we are kind of totally dependent on the doctors and the hospitals.” (FG 1, p. 16, Part. D)*

This notion was further supported by connections they appeared to make between diagnosis and treatments. Both aspects of medical experiences were discussed may or may not be related (i.e., a subsequent treatment may not have been related to a previously mentioned diagnosis).

***Core Conceptual Category: Post-Resettlement Health Management***

The generated theoretical framework incorporates each of the aforementioned concepts as factors influencing the ways in which Bhutanese women, and perhaps their

family members and friends, managed their health. The model consists of concepts that have the potential to both facilitate and hinder Bhutanese refugees' use of conventional health services during post-resettlement in the United States. Each concept possesses the ability to impact health care experiences individually but is most likely accompanied by other factors as illustrated in participants' comments. While the three key concepts of the framework (i.e., perceptions of post-resettlement health services, barriers to health services, and health literacy) share similarities, they do not fully encompass each other.

Positive and negative perceptions of post-resettlement health services may affect Bhutanese refugees' likelihood to seek medical treatment from conventional health service providers. Bhutanese refugees' high regard and trust of their medical providers may be associated with utilization of health services. In contrast, negative experiences with practitioners may be detrimental to refugees' likelihood to seek medical advice and treatment post-resettlement.

While the former, more positive perceptions are desirable, such views may not guarantee Bhutanese refugees' access to health care. Their efforts to consult with medical professionals may be halted by the transportation, insurance/expense, and language barriers they encounter when attempting to access health services. Bhutanese refugees were dependent on transportation from family members and friends and did not report utilizing public transportation as an alternative. When individuals were able to arrive at doctors' offices, clinics, and hospitals, uncertainties arose about the accuracy in communicating health concerns via interpreters, personal and professional, to health care professionals. Bhutanese refugees' diagnosed with health conditions may face the added

dilemma of paying out-of-pocket medical expenses or further delaying treatment and continuing to suffer until insurance coverage can be obtained.

Obstacles to managing health were not limited to barriers to accessing health services. Individual perceptions of health services and ability to understand health diagnoses and prevention as a way to minimize or eliminate negative health outcomes also impacted health management. Women expressed positive and negative perceptions of health professionals and treatments. Positive perceptions were made in conjunction with ability to access services and undergo successful treatment, as would be expected. Negative perceptions tended to relate to challenges in accessing health. Although participants utilized health services and were generally satisfied with interventions, some preferred more traditional methods and feeling dependent on the new medical system.

Barriers to health services may lead to negative perceptions of health professionals who may or may not have the resources to enable refugees to overcome barriers. The perceptions may also be influenced by health literacy as individuals frustrated with health services and policies may attribute perceived shortcomings to individual providers. With all of the potential barriers, it is likely that exposure to health promotion information and opportunities to increase health literacy within this population are limited. In all, the concepts, often overlapping, provide insight into the complexity of the management of health for individuals in the Bhutanese refugee community.

***Central Construct: Taking Care of Oneself and the Community***

Underlying each of the concepts was the common theme and central construct of taking care of oneself and the community. Women appeared to be genuinely concerned with their care in this new setting. Mention of participation in specific behaviors was

limited, and in some ways Bhutanese women appeared to be more passive than active health consumers. A desire to better understand and attain better health in order to be a contributing member of the community was expressed:

*“It is not that we mean to be sick and then stay at home without working. Umm, if I was not sick I would have worked. So it is not my intention to stay at home and get someone else’s money to pay for my bills or everything.”* (FG 1, p. 8, Part. E)

The concepts of the theoretical framework represent some factors that play roles in Bhutanese refugees’ efforts to improve their health and provide for themselves and their community.

## CHAPTER V

### DISCUSSION

#### *Major Findings*

Bhutanese refugees in this study cited several factors influential to their experiences with health services following resettlement in the United States. The theoretical concepts relating to barriers to post-resettlement health services; positive perceptions of post-resettlement health services; and limited health literacy connect to the investigator's original focus on Bhutanese refugees' perceptions, behaviors, and values as they related to pre- and post-resettlement health. Each of the theoretical concepts can additionally be thought of as a factor limiting or facilitating post-resettlement health service interactions. However, the conceptual model constructed is limited in scope—addressing only the most dominant perspectives and, to some degree, underrepresenting outliers in the data that represent individual differences. Results aid in the cultural competency of health providers and practitioners who may be less familiar with health concerns of Bhutanese refugee patients. This information also assists professionals charged with addressing barriers to access and receipt of quality health care.

Despite this shortcoming, findings are transferable to a comparable group of Bhutanese women in a context similar to that of the current sample. This level of transferability to a more narrow and specific group is acceptable in qualitative research which does not seek to generalize results to a larger population but rather speak to the truths identified in a unique setting under certain circumstances. Nevertheless, additional steps were taken to assess the results in an effort to most comprehensively and accurately present the realities of the participants. Key informants working within the Bhutanese

refugee community provided insight into overall findings by confirming the presence of perceptions and behaviors and highlighting inconsistencies. Key informants' roles as health program director, community volunteer, and health case worker as well as interactions with Bhutanese refugees in health settings lent additional credibility to their insights.

Each key informant supported refugees' reports of chronic conditions—not on a case-by-case basis but as reflective of the Bhutanese community. Key informants also agreed that refugees are faced with several obstacles in obtaining adequate health services—most namely language barriers. Established mechanisms to assist in overcoming barriers (e.g., interpreter services in doctors' offices) were mentioned in key informant interviews yet flaws in programs and interventions were also noted (underutilization). Key informants' perspective of health concerns, perceptions, and behaviors within the Bhutanese refugee community were fairly congruent with those identified via focus group discussions; discrepancies in findings did surface during comparisons of key informant feedback, post-study review of the literature, and further review of study findings.

Positive perceptions of post-resettlement health professionals were supported by participants' statements noting the politeness of doctors and nurses and their caring attributes. In response to positive perceptions in medical encounters, one key informant expressed her surprise in hearing such remarks and recounted her experiences accompanying Bhutanese refugees to doctors' visits. During these occasions the informant recalled feeling discomfort and unease as reactions to the manner in which staff and physicians interacted with refugees. Very seldom were Bhutanese refugees

addressed during consultations, leaving the majority of the interaction to take place between the key informant and the office personnel, doctors, and nurses. The employees were “blatantly rude” and disregarded the Bhutanese patients. It is important to note, however, that the negative encounters reported by this key informant may not have been experienced with any of the study participants, and thus, not mentioned during focus groups.

Asgary and Segar (2011) present a possible behavior that may aid in understanding the apparent discrepancy between the participants’ complimentary statements and an informant’s feedback. Patients may indeed identify favorable characteristics in hospital and clinic personnel. However, they simultaneously experience frustrations in other aspects in health setting encounters such as long waits and limited time with physicians. This information was not particularly useful in the current study as negative comments pertaining to similar occurrences were not explicitly stated or suggested by participants.

Additional questioning of key informants about participants’ positive perceptions of health services revealed an alternative explanation. Participants may have made comments in such high regard of post-resettlement health professionals and settings in a comparative context—that is, comparing pre- and post-resettlement health services and interactions. One key informant noted her limited exposure to refugee camps during her time in Nepal but an understanding that even outside of the refugee camps, health services were sub-optimal in comparison to nearby countries. Another informant, a former refugee herself, seconded these remarks, adding that even the longest wait times in United States hospitals, clinics, and doctor’s offices would not compare to the days-

long waits experienced in the refugee camps of Nepal. Therefore, by comparison, few negative feelings about post-resettlement health visits were experienced and no negative remarks were offered by the Bhutanese women participating in focus groups.

### ***Limitations***

The employed study design was limited in that participants were not randomly selected but rather obtained as a result of convenience and feasibility. Women who participated in the focus groups did not serve as a representative sample of the Bhutanese refugee community but reflected an important subgroup of Bhutanese refugees who are responsible for maintaining households and have access to their own personal health information and, in some cases, the health experiences of their family members (i.e., children, siblings, and husbands) and friends pre- and post-resettlement.

It can also be argued that the sample was consisted of an overrepresentation of middle-aged, unemployed women that may not truly represent the Bhutanese refugee community. Despite the lack of complete representativeness, the benefits of conducting research with the acquired sample outweigh the costs or limitations of a more narrow sample in that the data collected are likely more credible than information that may have been gathered in male-only or mixed-gender focus groups. In some respects the focus group was reflective of the community as participants spoke not only on their experiences but also on the experiences of friends and family members; topics arising from this secondary information were often supported by other women in the focus group.

In terms of specific health conditions of Bhutanese refugees, mental health and, more specifically, suicide is arguably one of the most well-researched (CDC, 2012a). In spite of the amount of attention mental health has gained via CDC reports of prevalence

of suicide, women did not mention mental health in the focus groups. This may reflect the ways in which they prioritize mental health in their communities or the negative stigmatization of mental health among Bhutanese refugees as is found in other refugee and asylum seeking populations (Asgary & Segar, 2011). These plausible explanations fail to overshadow the possibility that the researcher's presence may have contributed to women's unwillingness to share mental health concerns.

### ***Reflexivity***

At the onset of this investigation, efforts were made to become familiarized with the study population via a review of the literature and discussions with community contacts. This particular approach was advantageous in minimizing researcher bias and allowing participants to more truly inform the researcher and the findings. Other interpersonal factors may have remained, however, and influenced study results. Such factors include the group setting and interactions between the investigator and participants, the participants and the interpreter, and the participants' relationships with each other.

Challenges in building rapport heightened the researcher's level of self-awareness and led to a deeper need to engage in personal reflexivity throughout the study. As a woman, the researcher felt that participants would be more at ease and comfortable discussing women's health issues if topics in such an area were of particular importance to the women. Participant's willingness to discuss menstrual symptoms experienced by friends, family members, and themselves further supported the researcher's notions.

The community role of the researcher also surfaced as a possible influencing factor when the researcher needed to restate her professional role as a doctoral student

rather than as a medical practitioner during one focus group. It had become apparent that one woman in particular expected her individual health concerns to be addressed during or immediately following the focus group. The researcher clarified her role, the purpose of the researcher, and her limits and ethical standards as a professional (i.e., inability to provide medical advice or administer medical services and obligation to keep confidential information shared by individuals within the groups). This miscommunication led to the researcher's concerns about participants' desire to participate in the study. However, the woman's comments were countered by another participant who expressed appreciation for the opportunity to be involved in research that might lead to positive, long-term outcomes for the health of the community rather than immediate results for individuals.

The effect of other personal attributes of the researcher as a casually-dressed African American who was limited to speaking in English only is less salient and known. It should be noted the language barrier present between the researcher and many of the participants did affect the researcher during and following the focus groups. The researcher, at times, experienced the disadvantages and advantages of inability to communicate with participants freely. The language barrier enhanced the researcher's sense of being an outsider and non-member and inability to fully understand the deeper meaning of participants' experiences—limiting the extent to which those emotions and meanings can be communicated in dissemination of the work. The barrier also enabled the researcher to take a more objective stance and construct concepts from data that incorporated Bhutanese women's concerns and main points without becoming emotionally immersed in individual accounts.

### ***Recommendations for Health Professionals Working with Bhutanese Refugees***

Findings from this research have implications for individuals working with Bhutanese refugees in a health care setting. Health educators and physicians possess the professional skills and responsibility to address factors impacting Bhutanese refugees' ability to address health care concerns and conditions, especially health literacy.

Bhutanese women's references to basic health promotion information provided evidence of some exposure to health education materials—a step in the right direction.

Unfortunately, this population's report of numerous chronic conditions may also be indicative of a limited understanding of health promoting behaviors and, perhaps, underutilization of prevention techniques and non-compliance with medical advice.

Health care professionals may also address the barriers mentioned by Bhutanese refugees. Offering language services may be the most direct way in which providers can assist refugees in accessing health care. Policies can be implemented to further standardize the availability and quality of language services in both primary and urgent care facilities. While having such services does not eliminate all concerns (e.g., refugees' concern with accuracy of communication and willingness to disclose all information), their availability has potential to facilitate effective patient-provider communication.

Issues pertaining to ability to commute to and from doctor's appointments and affordability of medical treatments may also be addressed by health professionals. Health care workers should familiarize themselves with local and national resources available to refugees. Resettlement agencies have the existing infrastructure and programs to assist refugees in overcoming transitional challenges including those related to transportation and employment—both influential in accessing health services. Information about these

resources should be communicated to refugees who are or may be encountering obstacles related to these factors. Providers and social workers may also conduct further assessments of barriers with their clients to identify their personal obstacles, as those mentioned in this study may be consistent with or vary from specific challenges faced by other refugee populations.

### ***Future Research***

Additional studies are warranted within this population to gain perspectives of Bhutanese men, children, adolescents, and elders who may hold different points-of-view and concerns as it pertains to their individual health needs and those of the community. Qualitative research with health care providers working with Bhutanese refugees may offer invaluable information as they may be capable of elaborating on Bhutanese refugees' health management concerns from the standpoint of a health care professional who understands health sector obstacles (i.e., resources, funding, policies and mandates).

Research with the aforementioned populations may be broad in scope, as in the current study, or delve into areas of interest as noted by key informants: traditional medicine use, negative interactions with health care professionals, effectiveness of established programs and policies. For example, examinations of psychological health, especially among older populations who reported feeling “deaf and mute” in this study should be further investigated as comments appear to reflect a sense of low self-worth experienced among a population of individuals who once considered themselves contributing members of the community.

The specific types of post-resettlement health care services sought should also be further explored. Women discussed utilization of hospitals and visits to physician's

offices. Little effort was made to differentiate urgent care visits and primary care appointments in this or any other known study in this population. Identification of health-care seeking behaviors and patterns for each of these settings will better inform health care workers and enable them to better inform patients of alternatives in the event that under-/over-utilization of urgent care services has become an area of concern (Asgary & Segar, 2011).

### ***Conclusions***

Community-based research endeavors such as the current study allow community members' concerns and behaviors to be more directly communicated and subsequently presented to professionals and stakeholders within the same and similar setting. In this sense, a reciprocal relationship develops between the investigator and the community—the residents provide information and, in return, receive insight that may aid in the establishment of desired outcomes.

Findings from this particular community-based study contribute to a limited body of work pertaining to the general health, health perceptions, and health behaviors of Bhutanese refugees. Bhutanese refugees' management of post-resettlement health services is multi-faceted incorporating their perceptions, values, and behaviors as well as social factors in the form of barriers and health literacy that have the ability to facilitate or hinder the health management process. Identification of concepts involved in Bhutanese refugees' health care management provides a foundation upon which to conduct future research. Future studies should be more concept-specific and narrowly focused among various subgroups in the Bhutanese refugee community to obtain greater

depth of knowledge for individuals with particular interest in the Bhutanese refugee population.

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APPENDICES

Appendix A: Institutional Review Board Approval



November 7, 2013

Brittney Oliver, Denise Bates, Dr.  
Hamilton, Dr. Owusu Health and  
Human Performance  
[bdo2c@mtmail.mtsu.edu](mailto:bdo2c@mtmail.mtsu.edu),  
[andrew.owusu@mtsu.edu](mailto:andrew.owusu@mtsu.edu)

Protocol Title: "Bhutanese Refugees' Health Behaviors and Perceptions: A Qualitative Approach to Understanding Bhutanese Refugees' Post-Resettlement Experiences with Health Care Services in Middle Tennessee"

Protocol

Number: 14-

135 Dear

Investigator(

s),

The MTSU Institutional Review Board, or a representative of the IRB, has reviewed the research proposal identified above. The MTSU IRB or its representative has determined that the study poses minimal risk to participants and qualifies for an expedited review under 45 CFR 46.110 and 21 CFR 56.110, and you have satisfactorily addressed all of the points brought up during the review.

Approval is granted for one (1) year from the date of this letter for 100 participants.

Please note that any unanticipated harms to participants or adverse events must be reported to the Office of Compliance at (615) 494-8918. Any change to the protocol must be submitted to the IRB before implementing this change.

You will need to submit an end-of-project form to the Office of Compliance upon completion of your research located on the IRB website. Complete research means that you have finished collecting and analyzing data. **Should you not finish your research within the one (1) year period, you must submit a Progress Report and request a continuation prior to the expiration date.** Please allow time for review and requested revisions. Failure to submit a Progress Report and request for continuation will automatically result in cancellation of your research study. Therefore, you will not be able to use any data and/or collect any data. Your study expires **November 7, 2014.**

According to MTSU Policy, a researcher is defined as anyone who works with data or

has contact with participants. Anyone meeting this definition needs to be listed on the protocol and needs to complete the required training. **If you add researchers to an approved project, please forward an updated list of researchers to the Office of Compliance before they begin to work on the project.**

All research materials must be retained by the PI or faculty advisor (if the PI is a student) for at least three (3) years after study completion and then destroyed in a manner that maintains confidentiality and anonymity.

Sincerely,

Kellie Hilker  
Compliance Officer/ MTSU Institutional Review Board Member

## Appendix B: Informed Consent

Middle Tennessee State University  
Department of Health and Human Performance  
Informed Consent

**Who are we and why are we here?**

We are educators who would like to ask you and people in your community some questions. We would like to talk with you to find ways to help you and other people who are new to the United States. The questions are important in helping us find ways to give people in your community better health services people in your community need.

**What are we asking you to do?**

You will sit down with other people who are new to this country. You and others will be given pretend names before the meeting begins (for example, A, B, or C). A group leader will ask questions about you and your health. Only a few questions will be asked during the meeting. One question will be asked at a time. Everyone in the group will have time to answer each of the questions. You will need to raise your hand when you want to answer the question. You will be called on by your pretend name (for example “Participant A”). After your pretend name is called, you may answer the question. You do not need to share your real name with people in the group. You may speak as long as you need to speak to give your answer. A tape recorder will be used to record your answers. Your answers are recorded so that they will be understood correctly. The meeting will take 1 hour to 1 ½ hours of your time. Your answers will help us learn more about you and the health needs of people in your community.

**Risks to you**

We do not expect you to be harmed during this work. Your answers during the meeting will be confidential. However, after participants leave the interview, we will not be able to control if other people in the group share information. If you get tired when sharing your words in the group or upset by other people’s answers, you may stop or leave the meeting. We will not be able to take care of harm that you may feel during after the meeting. The tape recordings will be destroyed after we are sure we understand your words. Only the educators will have your answers recorded on tape, written on paper, and on the computer.

**You can choose to do this or not.**

You do not have to participate in the study. Nothing bad will happen to you if you do not want to answer the questions or decide to stop answering questions. You may speak if you have words you want to share. If you want to share your words, you will need to say your answer out loud when no one else is speaking. You may choose to not answer a question or stop speaking at ANY time. You may leave the meeting at ANY time. You will not lose any benefits by participating in this meeting.

**What will we do with your answers?**

We will use the answers from every person to find ways to help people new to the United States with their health needs. Your name will not be used in any reports. Information that may cause danger to a child must be reported.

**CONTACT INFORMATION**

If you have any questions about the study, you may ask the researchers at the meeting or you may contact the researchers Brittney D. Oliver or Andrew Owusu at Middle Tennessee State University, 1301 E. Main St., HHP Box 96, Murfreesboro, TN 37132. If you have questions about your rights as a participant in this study, please contact the Office of Compliance at (615) 494-8918.

**Additional Information:**

If you would like to talk to someone about your feelings from the meeting, you can call any of the agencies below:

United Neighborhood Health Services  
615-620-8647

Siloam Family Health Center  
615-298-5406

I agree to participate in this study. I have received a copy of this form.

---

 Name

Date

---

 Witness (if needed)

Date

Thank you for your time.

## Appendix C: Demographic Questionnaire

**Bhutanese Refugees' Health Behaviors and Perceptions: A Qualitative Approach to  
Understanding Bhutanese Refugees' Post-Resettlement Experiences with Health  
Care Services in Middle Tennessee**

Demographic Questionnaire

1. How old are you in years? \_\_\_\_\_
2. In what year were you born? \_\_\_\_\_
3. Are you currently employed?  
  - 1 Yes
  - 2 No
4. Do you have health insurance?  
  - 1 Yes
  - 2 No
5. Is religion important in your life?  
  - 1 Yes
  - 2 No
6. Which of the following best describes your religious affiliation?  
  - 1 Christian
  - 2 Catholic
  - 3 Muslim
  - 4 Hindu
  - 5 Buddhist
  - 6 Other \_\_\_\_\_
7. What is your highest level of education? \_\_\_\_\_
8. In what country were you born? \_\_\_\_\_
9. In what year did you leave your Bhutan? \_\_\_\_\_
10. How long did you live in refugee camps? \_\_\_\_\_
11. How long have you lived in the United States?  
 \_\_\_\_\_
12. How long have you lived in Tennessee? \_\_\_\_\_

## Appendix D: Semi-Structured Interview Schedule for Focus Groups

**Bhutanese Refugees' Health Behaviors and Perceptions: A Qualitative Approach to Understanding Bhutanese Refugees' Post-Resettlement Experiences with Health Care Services in Middle Tennessee**

Semi-Structured Interview Schedule

1. Has anyone been sick since coming to middle Tennessee? Tell me about what happened the last time you were sick.  
*What did you do? Who did you see? Where did you go (e.g., hospital, clinic, etc.)?*
2. (Has anyone had to seek medical care since coming to middle Tennessee?) How did you feel after you got the medical treatment?  
*How did the doctor/nurse answer your questions? Take care of your concerns? What made visits positive or negative? Satisfaction...efficacy of treatment (if received)?*
3. What do you do to keep yourself from getting sick (again)?  
*Are these similar to things you did before coming to the U.S.? Do you eat certain foods? Take specific treatments? Use religious practices? Exercise? Why?*
4. When you lived in (Bhutan/Nepal/refugee camps), how did you keep yourself from getting sick? Do you do/use any of these now? Why/why not?  
*Did you eat certain foods? Take specific treatments? Use religious practices? Exercise?*
5. When you lived in (Bhutan/Nepal/refugee camps), how did you get better when you were sick? Do you do/use any of these now? Why/why not?  
*Did you eat certain foods? Take specific treatments? Use religious practices? Exercise?*

## Appendix E: List of Original Codes

### **List of Original Codes**

#### Post-resettlement perceptions of health services

Negative perception of traditional medicine--treatment  
Negative perception of traditional medicine--health services  
Negative perception of conventional medicine--health services  
Negative perception of conventional medicine--treatment  
Negative perception of conventional medicine--health professionals  
Positive perception of conventional medicine--health services  
Positive perception of conventional medicine--health professionals  
Positive perception of conventional medicine--health facilities  
Positive perception of conventional medicine--treatment  
Positive perception of traditional medicine--treatment  
Positive perception of self-care

#### Current health behaviors and practices

Use of conventional medicine post-resettlement  
Use of traditional medicine post-resettlement  
Use of self-care post-resettlement

#### Barriers to current health practices

Inability to access traditional medicine  
Insurance and income/expense of conventional medicine  
Language and communication difficulties  
Lack of transportation

#### Health literacy

Frustrations with post-resettlement health care system  
Limited knowledge of health promotion/prevention information

#### Value attributed to medical approaches

Pre-resettlement health services valued over post-resettlement health services  
Post-resettlement health services valued over pre-resettlement health services