Refugee Women's Access and Navigation of Healthcare Services in Philadelphia

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I. Background

The literature shows that refugees often have difficulty accessing and utilizing healthcare services, which has critical implications for health outcomes. This pilot study, conducted under Temple University's Department of Public Health (Sylvia Twersky, PI) and the Intergenerational Center (IGC) (Hitomi Yoshida, PI) in collaboration with two resettlement agencies (Lutheran Children and Family Service and Nationalities Service Center), aims to understand the ongoing health service navigation and access needs of Burmese[1] and Bhutanese Refugee women in Philadelphia. The pilot study attempts to understand the gap in resettlement service provision and the capacity building needs within the refugee community through four specific aims: 1) To identify specific cultural communication barriers to utilization of healthcare services among Burmese and Bhutanese women refugees in Philadelphia; 2) to identify the key health literacy challenges in the process of accessing and utilizing health services among Burmese and Bhutanese women refugees in Philadelphia; 3) to characterize specific structural barriers to utilization of healthcare services among Burmese and Bhutanese women refugees in Philadelphia; and 4) to evaluate barriers to access and utilization of healthcare services in this population based on data from refugees and healthcare service providers in order to develop programmatic and policy recommendations.

II. Methodology

The study was conducted through the use of focus groups with the targeted communities and an online survey with refugee clinics associated with the Philadelphia Refugee Collaborative. Participants for the focus groups were recruited through the Temple University's Intergenerational Center's refugee women's program operated at the Southeast by Southeast community center. Two focus groups were held, one with each linguistic group, and translation was provided by a community interpreter.

[1] The female refugees who participated in this study are Karen, the largest ethno-linguistic refugee group from Burma, who has resettled in Philadelphia, PA in the past eight years.

The provider survey was developed following the focus groups in order to ensure that survey questions for providers paralleled the issues brought up in both focus groups. The online survey on utilization and access from the provider perspective was sent out to healthcare providers on the Philadelphia Refugee Health Collaborative (PRHC) list serve. A total of 10 health providers participated.

The results from both the focus groups and the survey were presented back to the refugee women's groups at the Southeast by Southeast community center. Two workshops were held by the researchers with the women using community interpreters in order to share the data and discuss implications of the information for both the lives of the women who participated and further program development. In addition, English and communication skills were practiced with the women based on issues identified in the focus group. The skills were requesting an interpreter over the phone in English, understanding automated instructions and making an appointment over the phone.

III. Summary of Main Findings

Focus Group Results:

Two separate focus groups were held. The Bhutanese focus group consisted of 12 women, ages 40-64. All participants have children, ranging from 1 child to 6 children, ages 13 to older than 18. Bhutanese participants have been in the United States for at least 8 months up to as long as 4 years. Only one of these participants have had any formal schooling, and it was from outside of the U.S. The Burmese focus group consisted of 11 women, ages 26-65+. All participants have children, ranging from 2 children to as many as 6 children, ages 1 to 18. Burmese participants have been in the United States for at least 1 up to as long as 6 years. Seven of these participants have had formal school outside of the U.S., ranging from 1 year to 9 years (see Appendix C for detailed demographics).

The focus group discussions with Burmese and Bhutanese refugee women illuminated the layers of linguistic and cultural barriers that exist in accessing and navigating the healthcare system in Philadelphia. The major barriers discussed in the focus groups include language, transportation,

interactions with providers and/or administrators, navigation and cost (see Appendix A for detailed findings).

Both groups experienced several issues due to **language barriers** prior to the medical appointment with the provider. For example, the Burmese group encountered problems almost immediately when attempting to make appointments due to the lack of bilingual family assistance. On the other hand, the Bhutanese group had family support and was comfortable with making appointments. Nevertheless, they experienced issues when attempting to get to the hospital (a combination of language and transportation barriers) or clinic and/or at the reception area. The Burmese group also pointed out the providers' lack of understanding about the language diversity within the refugees from Burma. There are more than 100 languages that exist in Burma.

In terms of the refugee's perceptions of **provider-patient interactions**, both groups appreciated a provider or administrator with respectful manners but the Burmese stressed these mannerisms much more than the Bhutanese. Some Burmese reported that they would not return to a hospital/clinic due to the lack of respect that they felt, especially from clinic staff such as receptionists.

The Burmese focus group often defined the quality of a visit by the personality, communication style, and mannerism of the provider and/or administrator; that is, politeness, warm approach, attentiveness, etc. For the Bhutanese women, the quality of a visit was often defined by the effectiveness of the service; that is, a concrete outcome such as receiving medication and a doctor's personal follow up calls.

Navigation of the city's complex health care system is identified as a major challenge faced by both groups. System navigation issues described in the focus groups included understanding and securing medical appointments, utilizing the referral system, understanding insurance eligibility and coverage, the billing procedures, and interacting with multiple systems such as education, welfare, employment and health. Both groups identified resettlement agency case aids, ethnic-based community organizations, family and friends as their support for healthcare navigation. A

few participants shared a positive experience of their doctor proactively coordinating support beyond his/her primary responsibilities and helping them navigate the system. For example, one person talked about her doctor arranging a volunteer escort from a refugee resettlement agency for her follow-up visit to a specialist**.**

Another major barrier that prevented these two groups from seeking care was **cost**. The majority of the focus group participants reported that they lost their insurance coverage for themselves after 8 months of arrival when their Refugee Medical Assistance (RMA)[2] coverage expired. Lack of coverage often deterred refugees from seeking care due to fear of being unable to pay. Although aware of the city's health clinics for the uninsured, this option is only reluctantly utilized due to extremely long wait times and need to sometimes come back multiple times to be seen.

Provider Survey Results:

All providers have had contact with one or both of the refugee groups in the study. 30% of survey respondents have seen Bhutanese patients but not Burmese patients. The other 70% of respondents have seen both Bhutanese and Burmese patients. On average, the respondents have been practicing primary care medicine for 10 years (ranges from 1-30 years). Only one respondent has not had any contact with refugee service or community organizations see Appendix B, Table 7). The majority have had contact with one or more of these organizations. The Nationalities Services Center was the organization they were most likely to have had contact with, closely followed by the Philadelphia Refugee Health Collaborative. This survey was sent out to providers through the Philadelphia Refugee Health Collaborative list serve so it was expected that all or most of the providers would be familiar with this organization. 90% of respondents had regular contact with and/or participate professionally with Nationalities Services Center and 10% of respondents have heard of the organization. 80% of respondents had regular contact with and/or participate professionally with Philadelphia Refugee Health Collaborative and 20% of respondents have heard of the organization. 70% of respondents had regular contact with and/or participate professionally with Lutheran Children and Family Services, 10% have

[2] Refugee Medical Assistance (RMA) is a 100% federally funded program that provides up to eight months of health care coverage to certain noncitizens who are considered refugees under the Immigration and Naturalization Act.

had contact with the organization as part of their professional duties, 10% have heard of the organization and 10% are unfamiliar with the organization. 60% of respondents had regular contact with and/or participate professionally with Hebrew Immigrant Aid Society, 10% have heard of the organization and 30% are unfamiliar with the organization. 60% of respondents had regular contact with and/or participate professionally with Philadelphia Refugee Mental Health Collaborative, 10% have had contact with the organization due to their professional duties and 30% have heard of the organization. 40% of respondents had regular contact with and/or participate professionally with The Bhutanese American Organization and 60% have heard of the organization. There does not seem to be large differences in knowledge (e.g., recognizing differences between refugee and immigrant health care access barriers) between the providers that work with the PRHC and those who do not. However, only 2 of the 10 providers that participated do not work with the PRHC.

All of the providers that participated received training on cultural competency with patients. 90% of the providers that participated received training on refugee health issues. 90% of the providers that participated also received training on working with interpreters. 67% of these providers received this training within the past year, 11% received this training within the past few years and 22% received this training in medical school or residency.

Most providers perceive that their refugee patients lack skills or knowledge in requesting interpretation, understanding when to seek care, non-compliance with medical recommendations or lack of follow-up on medical issues, and lateness. The providers did not see making appointments, getting to the clinic, and applying for insurance as a problem for the refugee patients (see Appendix B, Tables 5 and 6). One of the reasons financial issues might not have been highlighted with these providers is because most of them see patients with RMA (see Appendix B, Table 2). The refugee participants in our focus groups have been in the United States for more than 8 months and therefore no longer have RMA. Issues with follow-up and lateness are therefore not attributed to difficulty accessing and utilizing the healthcare system. Despite the providers' positive experience with interpreter services (see Appendix B, Figures 1, 3 and 4), 50% believe that refugee patients need improvement in requesting a translator. They however did not see language as a major barrier to communicating with refugee patients (see

Appendix B, Table 5). These findings suggest the providers' perception is that bridging language barriers is primarily the refugee patient's responsibilities.

Providers' understanding of the multiple barriers faced by refugees, especially those experienced prior to and after the medical consultation will be beneficial to lowering the barriers and increasing communication. Likewise, it is suggested that refugees be furthered educated on topics such as the U.S. health care system and understanding what to expect in situations such as the city's health clinics so that their expectations are more realistic. In this manner, a mutual understanding between the refugee and provider can be established. One limitation to drawing comparisons across the provider and refugee data is that the refugee women in the focus groups visit the city health clinics rather than the clinics associated with the Philadelphia Refugee Health Collaborative due to their lack of coverage.

IV. Implications and Recommendations

For Providers

- Healthcare providers should be aware of language and other barriers their refugee clients go through BEFORE they see a doctor in the office. This may help providers understand lateness or lack of follow up. Additionally, administrators, such as receptionists, should be included in language and cultural sensitivity education.

- Language barriers are more complex than it may appear on the surface. Providers should be educated about the language diversity among refugees from Burma.

- Refugee's appreciation for the advanced medical service in the U.S. should be communicated to the providers. At the same time, providers should be aware that how health care service is delivered (communication styles, mannerism, coordination, etc.) matter a great deal in refugees' experience of health care in the U.S.

- Formalized networks that link providers and organization such as PRHC and PRMHC are critical for refugees' access and utilization of medical care services. Providers outside of

the traditional RMA network need to be trained in refugee issues, especially in the free clinics. Volunteer escorts should expand their services for all refugees.

- The challenges of health care access faced by refugees intensify once their Refugee Medical Assistance expires after eight months of arrival. The majority of the focus group participants reported that they utilize city's free health centers for their primary care. To reduce the challenges of health care access for faced by refugees whose RMA have expired, Refugee Health Collaborative should expand its network to include health centers and clinics frequented by refugee patients in order to help them prevent from falling through the cracks after the RMA period.

For Refugee resettlement agencies and community programs

- Health literacy and life-skills education for newly-arrived refugees should encompass practical life-skill building such as making appointments and time management. A broader cultural orientation should include basic health care navigation and self-advocacy skills.

- Volunteer escort service to a large hospital was identified as valuable support by the focus group participants. Resettlement agencies and other organizations which mobilize community volunteers should expand this aspect of health navigation service for refugees.

- Refugee resettlement agencies seem to effectively educate newly arrived refugees about the duration of Refugee Medical Assistance upon arrival. Intense health navigation guidance and support within this RMA period should be provided in order to overcome the refugees' inability to navigate the system on their own which prevents the refugees from taking full advantage of their RMA.

- Refugee resettlement agencies and other social service agencies serving refugees should expand their outreach and cultural sensitivity education to clinics that serve non-insured populations.

- Refugee resettlement agencies should work with Ethnic Community Based Organizations (ECBOs) to assist in identifying insurance opportunities and/or options for refugees whose RMA has expired.

- Refugee patients should be educated more about the American health care system and adjust their expectations, especially for health clinics where there is a high demand and limited time available for each patient. Although current conditions at the city's health centers should be improved, setting realistic expectations for refugees may reduce their frustration and would prepare them to establish a more mutual understanding with providers.

- More capacity building opportunities for refugee-led community organizations and leaders should be promoted. Their capacity building can include organizing community meetings to identify common challenges and to facilitate collaborative advocacy efforts for better health care access.

For Researchers

- Researchers conducting community-based research should incorporate a data sharing mechanism with the community members in their research design, so community members can understand and operationalize the research data collected from the community. The service providers and community members can utilize the data to better understand their community, improve outcomes and advocate for positive change.

Appendix A: EMERGING FINDINGS FROM THE FOCUS GROUPS

I. Language Barrier

Both groups encounter layers of language barriers prior to seeing the actual provider.

Bhutanese often rely on bilingual family members and friends to make an appointment but they expressed difficulties getting to the hospital and at the reception area.

"Yes sometimes we used to take our relatives or friends but all the time they are not available to help us so then we need to miss that appointment."

Karen (Burmese**)** talked about the lack of bilingual assistance on making appointments and expressed anxiety about calling and requesting an interpreter over the phone. They continue to experience anxiety to interact with receptionists. This high anxiety regarding making appointments appears to stem from their lack of confidence in speaking English and self-efficacy. Many of them tend to wait to make an appointment until someone who is bilingual is available to help them.

"I have to wait until someone is free because everybody busy, right? So if I want to make an appointment, I have to wait..."

A key informant of the Karen community indicates that the lack of self-efficacy among Karen women poses as an additional barrier to successful health care access at various points of health care, even if language access service is available to them. She noted that many women are afraid of asking for an interpreter over the phone.

"They get…nervous or scared…you know when you call the number… [you just have to say] 'I speak Karen.' Directly you get it…but they're scared to call…that's the problem…" -Burmese Key Informant

Both groups described that interpretation service is generally available at a hospital but the quality and effectiveness vary based on factors including whether it is in-person or phone. Karen-speaking refugees from Burma particularly pointed out the lack of knowledge and

understanding in the languages used by refugees from Burma. For example, several participants noted the commonly occurring confusion of Karen with Korean due to the latter being more well-known in the United States.

"At the hospital they have interpreter but when I say Karen, they give me Korean…"

One participant explained that even within the Karen speaking community, there are different dialects and some refugees do not understand the version of Karen provided by a hospital interpreter.

"[…] because in Karen there's many dialects…For me, […]I was lucky because I was born in the countryside but I grew up in the city…so I knew both…I came here and can understand either way." – Burmese Key Informant

II. Transportation Barrier

Bhutanese focus group illuminated the challenge of navigating the city transportation system when families are referred to visit a specialist at a hospital.

The Bhutanese group did not express difficulties in making appointments but rather in keeping an appointment due to their inexperience with public transportation and time management, and the lack of a bilingual escort for the appointment.

"I didn't go once to the hospital because I have lost problem. I don't know how to drive, transportation, I need to travel, subway but I don't know. I miss last time. "

"Yes sometimes we used to take our relatives or friends but all the time they are not available to help us so then we need to miss that appointment."

Many participants appreciated the transportation orientation and escort provided initially by their resettlement agency. Bhutanese expressed the need for more practices WITH case workers.

III. Interaction with Providers and Administrators

Both groups appreciate a provider or administrator with respectful manners but the Burmese stressed these mannerisms much more than the Bhutanese. In fact, some Burmese reported that they would not return to a hospital/clinic due to the lack of polite manners presented to them.

Additionally, participants expressed that they feel mistreated by receptionists due to their language barrier. Although both groups highlighted the importance for respectful provider interactions, the Burmese focus group often defined the quality of a visit by the personality, communication style, and mannerism of the provider and/or administrator; that is, politeness, warm approach, attentiveness, etc.

"X hospital nurses…very polite… very nice and very patient and when you don't know where to get to the place, they show directions…like a person like that"

"In my country everything was good…when you are sick and went to see the doctor…walk in…just walk in…the doctor and nurse and everything…like polite and welcome…in here, not like that…when you are lucky...you can see a good nurse…maybe good doctor…I have experience someone yell at me so I was so sad so I had to go home. I'm not happy to see the doctor in here."

For the Bhutanese focus group, the quality of a visit was often defined by the effectiveness of the service; that is, a concrete outcome such as receiving medication and a doctor's personal follow up calls.

"He used to call us all the time, doctor called us for treatment…and the doctor follow(ing) up with us and…he takes care of us."

IV. Navigation Barrier/Support

Besides barriers such as language, transportation and cost, navigating the city's complex health care system is a major challenge faced by both groups. System navigation issues described in the focus groups included understanding and securing medical appointments, referral system, understanding insurance eligibility, coverage, utilization and the billing procedures, and interacting with multiple systems such as education, welfare, employment and health.

For the Burmese, navigation within one system (e.g., hospital) can be challenging, particularly in a large facility. However, it becomes especially difficult when they have to coordinate between two systems. For example, one participant shared her confusion and struggles in obtaining the proper paperwork from her former employer and taking it to the welfare office in order to receive Medicaid.

In terms of insurance eligibility, the focus group participants appeared to be well informed to take advantage of the refugee medical assistance, which covers the first 8 months upon arrival. However, some lack the necessary navigation support to complete tasks such as securing medical appointments for immunizations and obtaining records and arranging preventative care within the given time frame. The reasons they were not able to successfully complete these tasks include negotiating time out of work, taking too long to set up an appointment, etc.

"For me, my caseworker [at the resettlement agency] talked about the insurance, how to use…during 8 months…to see the doctor, to…[get] an eye exam"
"I knew…I have to finish all the shot [Immunizations?] because [in] one year I have to get ready for the green card…so within 8 months I told my caseworker or whoever work for me so[to arrange an appointment for me]. They didn't [make] an appointment because I [was] working so I don't know how to make appointment by myself…"

She eventually got an appointment and received immunizations but did not sign the record at the medical office. She later found that her immunization records were

incomplete. She had to wait for five months to get immunizations again and her Refugee Medical Assistance expired

, *"so I had to take [shots] again…so I had to pay $200…."*

Navigating the insurance system was also identified as a major problem for the Bhutanese. The participants highlighted the confusion around the application and billing process.

Both groups seek support to navigate the healthcare system. Resettlement agency case aids, ethnic-based community organizations, family and friends were identified as their support networks. Bhutanese women especially emphasized navigation support from their young adult children.

"I have children and they can help me. I have three children,…..they help me to ask for appointment, for the hospital visit, for the interpreter, everything they can do for me."

A few participants shared a positive experience of their doctor proactively coordinating support beyond his primary responsibilities to help her navigate the system to see a specialist**.**

"I have [back] problem and when I share the problem with the doctor, he immediately refer me to the center [specialist] and I have good surgery and now I'm fine."

"I used to fall down and had epilepsy and without escort,[I cannot get there] …then the doctor asked for [volunteer] escorts for me [by contacting a resettlement agency] ."

V. Cost Barrier/Support

After 8 months of arrival, the majority of the focus group participants reported not having insurance coverage. Lack of coverage can result in either not seeking health care or relying on the city's health centers for the uninsured. The latter is a solution for low cost healthcare, but it may not always be efficient due to its high demand. Focus group participants talked about the city's health centers as their primary care after their Refugee Medical Assistance

expired. Some of the participants from both ethnic groups reported low medical cost as a positive aspect of the health center.

"Health Center 2 is so cheap if we pay the $5 then we get to see doctor, we get medicine from the Health Center 2 pharmacy, so it's good for me." Bhutanese

"….I use the medicine from the health center, it's free."

Many reported that they and their husband do not seek care due to lack of insurance and fear of high medical expense.

"…When I get pregnant I had some situation to see emergency but I cannot go…I really scared because I don't have insurance so I cannot go[to the hospital] so I stay home." Burmese

"My husband have problem…he didn't have insurance but last week my husband have 4 days fever around 102, 104 degrees Fahrenheit but because we didn't have insurance…if we go to the hospital then it would be high bill and we're not able to pay that one. He stays at home and we gave him cold water and steam [] he stayed home because of lack of insurance."

Some reported their husband could not seek proper treatment because of the lack of insurance and fear of losing work by taking a time off to visit the health center which requires a day long visit due to a long wait time.

" *my husband...after 8 months, never had insurance, so when he was sick he stayed home and..take some medicine. One time, he had a toothache so he cried, cried, cried…it's too painful….so that's why he went to the dentist and dentist pulled out…because he [didn't] have money to fill out…to treatment…" Burmese*

"So about the health center 2…my husband knew that he cannot go to see the doctor

because when you go see the doctor he can miss the work…and when you miss work you cannot continue […] for the health center 2…knew about the situation but didn't fit with the time…"

VI. Refugee Services

Both groups express caseworkers at the resettlement agency as their main initial source of support upon arrival. For example, caseworkers connect them to the refugee health clinics in addition to escorting them to the clinic for the first visit. They cannot rely heavily on their case workers after a few months because their resettlement services are currently only offered for three to six months.

Duration of insurance appeared to be communicated clearly by their resettlement agency; many reported that they were informed about the time frame of their initial coverage upon arrival. However, they were not well informed on what to do following this time frame in order to ensure that they have coverage.

The majority of respondents vaguely remember obtaining health orientation. If they did, they were confused with some of the information provided as part of cultural orientation such as American housing, etc.

VII. Care seeking decisions

When participants compared their experiences of healthcare in the U.S. to the one in their home country or camp, the following themes emerged.

Burmese women highlighted the differences on how healthcare service is carried out (e.g., interactions, communication, manners, etc.) while the Bhutanese highlighted the effectiveness of medical care and treatment. Burmese focus group participants seem to view US health care more negatively, particularly about the difficulties making appointments and impolite interactions with administrators and providers.

Bhutanese focus group participants also point out the lack of effective communication but more often praise the quality of care (specialization, great treatment) provided by the health service in the U.S.

"Coming from [a refugee camp in] Nepal to America, I find that America is best for treatment in the health service. Some of the doctors are good…majority is good but some of them are not bad, but there's some communication gap." Bhutanese

In responding to a question about when they seek care from a western medical doctor or facility and when they choose to use their traditional way of healing, participants reported as follows;

Burmese utilize traditional medicine because it is readily available through other Asian communities (e.g., Cambodian stores). The Bhutanese use traditional home remedies for mild health problems but appear to utilize western medicine for more serious health problems. It is partially due to the fact that they do not find their traditional medicine as readily available as the Burmese.

In determining whether they seek western medical care at a clinic or at a hospital, factors such as cost and/or the fear of high cost, insurance, time, and conflicts with work influence their decision. In choosing a provider, recommendations/referrals from professionals at a refugee clinic and family and friends influence their decision.

"…we moved from Texas to Philadelphia….and immediately I was ill and sick and was admitted into Thomas Jefferson and everybody advised me to join the Health Center 2 and I take service there."

APPENDIX B: FINDINGS FROM PROVIDER SURVEYS

Table 1.

At your practice which of the following is available-check all that apply:	
Answer Options (n = 10)	**Response Percent**
In-person interpreter for Karen	0.0%
In-person interpreter for Burmese	10.0%
In-person interpreter for Nepali	40.0%
In-person interpreter for Arabic	10.0%
Phone interpreter	90.0%

Table 2.

Refugees in my practice generally pay for health care using: (Rank according to what you most often see: 1: Most often, 5: Least often)					
Answer Options (n = 10)	**1**	**2**	**3**	**4**	**5**
Out of Pocket	10.0%	20.0%	10.0%	10.0%	50.0%
Refugee Medical Assistance	60.0%	20.0%	10.0%	10.0%	0.0%
Medicaid/SCHIP	30.0%	40.0%	20.0%	0.0%	10.0%
Medicare	0.0%	20.0%	20.0%	50.0%	10.0%
Private Health Insurance	0.0%	0.0%	40.0%	30.0%	30.0%

Table 3.

In my experience interpreter services for patient visits are easy to ACCESS. (n=10)				
Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
30.0%	50.0%	20.0%	0.0%	0.0%

Table 4.

In my experience interpreter services for patient visits are easy to USE. (n=10)				
Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
20.0%	70.0%	10.0%	0.0%	0.0%

Table 5.

Indicate whether the following are a problem in your ability to provide high quality care to your refugee patients:			
Answer Options (n = 10)	**Major problem**	**Minor problem**	**Not a problem**
Patient non-compliance	40.0%	50.0%	10.0%
Patient lateness or missing appointment times	30.0%	50.0%	20.0%
Patient inability to pay	20.0%	40.0%	40.0%
Patient not qualifying for government services	30.0%	40.0%	30.0%
Difficulties communicating with patients because of spoken language barriers	20.0%	70.0%	10.0%
Difficulties communicating with patients because of cultural barriers	20.0%	50.0%	30.0%
Difficulties communicating with patients because of low literacy levels	10.0%	60.0%	30.0%

Table 6.

What key information/skills about accessing or utilizing health services are refugees missing? Check all that apply	
Answer Options (n = 10)	**Response Percent**
How to get to clinic	30.0%
How to make an appointment	20.0%
How to request a translator	50.0%
Time management such as keeping appointments on time	40.0%
How to apply for public health insurance	30.0%
Knowing when to seek care from a physician	70.0%
Knowing how to communicate health problems to physician	40.0%
Correctly following care instructions after visit	60.0%

Table 7.

Please indicate your familiarity with the following organizations:				
Answer Options (n = 10)	**Unfamiliar**	**I have heard of this organization**	**I have had contact with this organization as part of my professional duties**	**I have regular contact and/or participate professionally with this organization**
Lutheran Children and Family Services	10.0%	10.0%	10.0%	70.0%
HIAS (Hebrew Immigrant Aid Society)	30.0%	10.0%	0.0%	60.0%
Nationalities Services Center	0.0%	10.0%	0.0%	90.0%
Philadelphia Refugee Health Collaborative	0.0%	20.0%	0.0%	80.0%
Philadelphia Refugee Mental Health Collaborative	0.0%	30.0%	10.0%	60.0%
The Bhutanese American Organization-Philadelphia	0.0%	60.0%	0.0%	40.0%

APPENDIX C: DEMOGRAPHIC SUMMARY OF FOCUS GROUP PARTICIPANTS

Focus Group Participants										
	# of Participants	Age of Participants		# of Children	Age of Children		Length of Stay in US		# with FS*	If YES to FS, how many years?
Bhutanese	12	**Range**	**%**	1-6	**Range**	**%**	**Length**	**%**	1	3-6 years
		18-25	0%		**Under 12 months**	0%	**8-12 months**	8%		
		26-39	0%		**1-5 years**	8%	**12-23 months (1-2 years)**	25%		
		40-64	100%		**6-12 years**	0%	**2 years**	0%		
		65+	0%		**13-18 years**	69%	**3 years**	33%		
					>18 years	23%	**4 years**	33%		
							5 years	0%		
							6 years+	0%		
Burmese (Karen)	11	**Range**	**%**	2-6	**Range**	**%**	**Length**	**%**	7	1-9 years
		18-25	0%		**Under 12 months**	0%	**8-12 months**	0%		
		26-39	64%		**1-5 years**	21%	**12-23 months (1-2 years)**	9%		
		40-64	27%		**6-12 years**	47%	**2 years**	9%		
		65+	9%		**13-18 years**	32%	**3 years**	18%		
					>18 years	0%	**4 years**	55%		
							5 years	0%		
							6 years+	9%		

***FS: Formal Schooling; No participant had FS in US**