



Navigating healthcare systems before and after resettlement: Exploring experiences and recommendations for improvement from the perspectives of a Bhutanese refugee community



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ABSTRACT

Background: Though refugees often survive in refugee camps for many years, little is known about the impact of their interactions within the healthcare system during that time and how it may affect current concerns with the healthcare system after resettlement. Guiding our analysis was the Community Health Development model, which emphasizes the importance of understanding the impact of historical experiences on a community's health to identify specific current health needs, and plan solutions alongside the community to address and improve health concerns.

Objective: To better understand the healthcare system related experiences of Bhutanese refugees before and after resettlement, and describe potential solutions based on their perspectives to improve their health status.

Methods: This study used an explorative qualitative research design. Four focus group discussions were conducted with 40 female participants to examine their experiences within the healthcare system in Nepal (e.g. before resettlement) and the US (after resettlement). Focus group data were audio-recorded, translated, coded, and reported based on qualitative thematic analysis.

Results: Findings revealed that Bhutanese refugees were mistreated in the Nepalese healthcare system, often neglected from healthcare access and services because of their refugee status. Upon arrival to the United States after resettlement, study participants also reported experiencing challenges within the US health care system including cultural and linguistic barriers when interacting with medical interpreters during visits with their providers, as well as having inadequate time during the visit to fully express their concerns. Respondents' recommendations to improve their overall health centered on their experiences with the US health care system including initiatives developing leadership skills for building community capacity towards advocating for the refugees, while increasing access to external resources.

Conclusion: The result of this study outlines an account of Bhutanese refugees' experiences and recommendations for improving their community's health based on such past experiences and their current needs. These findings provide a starting point for future research with underserved refugee migrant groups and indicate a need for health programs to be historically and culturally sensitive in order to be more effective. Further, the understanding of refugees' collective history should inform the development of collaborative interventions with community members in order to be effective.

1. Introduction

The global population of individuals forcibly displaced from their countries of origin has reached a record high of over 70 million, with

almost 26 million being refugees (United Nations High Commissioner for Refugees [UNHCR] 2018). Close to 3 million new refugees worldwide became displaced and lost their homes in 2018 alone (United Nations High Commissioner for Refugees [UNHCR], 2018). The circumstances leading to refugee displacement from their home country to a

Abbreviations: CHD, community health development; UNCHR, United Nations high commissioner for refugees.

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“host country” can include war, persecution, violence, and political or ethnic conflict (Im and Rosenberg, 2016; Ott and Montgomery, 2011). If the host country is rendered unsafe, the United Nations High Commissioner for Refugees (UNHCR) is the primary agency which refers and assists the most vulnerable refugees to be transferred to another country in a process called resettlement. Resettlement grants access to lawful admission into a new country where refugees are given the opportunity to reside long-term or permanently in a safer environment (United Nations High Commissioner for Refugees [UNHCR], 2018; Ott and Montgomery, 2011). The health of resettled refugees has become a significant public health concern, as refugees often face hardship before and after the resettlement process, which is likely to have a significant impact on their community’s health status (Wachter et al., 2016).

Often, the resettlement process begins with mobilizing refugees to camps, while they are found countries of relocation. Refugees eligible for resettlement may face tremendous hardship in camps prior to relocation, such as inadequate healthcare access, mental trauma, and high rates of chronic and communicable disease (Vergara et al., 2003; Yun et al., 2016; Giulia et al., 2018). After resettlement, refugees tend to continue to live in low socioeconomic conditions, they can experience mental and emotional distress from adjusting to a new country, and can encounter significant language and cultural barriers, all of which exacerbate poor physical and mental health outcomes (Kohrt et al., 2012; Mitschke et al., 2013; Ellis et al., 2015; Hagaman et al., 2016).

Despite the multitude of burdens resettled refugees face, there is limited research analyzing health experiences among these groups to determine the impact of their experiences within the healthcare system on current health behaviors within the community (Matlin et al., 2018) and define immediate health-related priorities and strategies.

The focus of this study is on resettled Bhutanese refugees in the United States. After living for generations as an ethnic minority group in Bhutan, Nepali-origin Bhutanese became targets of institutional discrimination that resulted in being stripped of their citizenship and basic rights in Bhutan. These groups were subsequently exiled into refugee camps in Nepal, where families survived and struggled for almost 20 years, longer than many other refugee groups remain in camps (Hutt, 2003; Evans, 2020).

In 2007, the United Nations began one of their largest resettlement programs to assist Bhutanese refugees and transferred over 100,000 refugees out of the camps in Nepal into countries including Australia, Canada, Denmark, the Netherlands, New Zealand, Norway, the United Kingdom, and the United States (United Nations High Commissioner for Refugees [UNHCR], 2018). The largest number of Bhutanese refugees were resettled in the US, where over 80,000 currently reside (United Nations High Commissioner for Refugees [UNHCR], 2018). After relocating to the US, Bhutanese refugees continue to face economic and social challenges, experience low socioeconomic status, and have lower rates of education and English proficiency compared to most other refugee groups (Griffiths and Loy, 2019). Recent studies have found Bhutanese refugees face significant disadvantages in the integration process, have difficulty navigating the US healthcare system, and experience high cultural stigma attached to mental illness and seeking mental health care (Griffiths and Loy, 2019; Szajna, 2019; Poudel-Tandukar et al., 2019; MacDowell et al., 2020; Meyerhoff et al., 2018).

While there is a growing body of research addressing various Bhutanese refugee concerns such as mental health, language barriers, and acculturation stress (Griffiths and Loy, 2019; Szajna, 2019; Poudel-Tandukar et al., 2019), there remains a critical need to understand how their shared cultural history and collective experiences within the healthcare systems of Nepal, and later in the US, impact their current health needs and inform practical, specific solutions to improve their

health. To address this gap, it was necessary to gain deeper insight into resettled Bhutanese refugees’ experiences that were currently residing in the US, after navigating various healthcare systems pre- and post-resettlement, as well as understand their perspectives on effective strategies to improve US healthcare practices based on their current needs. This study aimed to address the following research questions:

- 1 What are the experiences of the resettled Bhutanese refugees with the healthcare system prior to moving to the US?
- 2 How do the resettled Bhutanese refugees perceive current challenges in the US healthcare system?
- 3 What are recommendations the resettled Bhutanese refugees believe will improve their health?

1.1. Framework for analysis

Our research questions and analysis were guided by the Community Health Development (CHD) framework, which integrates the experiences of diverse groups to determine priorities and shape future health promotion programs (Felix et al., 2010; Burdine et al., 2007). The CHD framework largely aims to (1) contextualize the historical experiences of a community in order to (2) prioritize current health concerns and (3) provide a foundation to implement future culturally appropriate practices through community supported recommendations (Burdine et al., 2010; Garney et al., 2017). Previous studies have utilized CHD principles to address mental health, health service utilization, and physical activity (Garney et al., 2017; McCord et al., 2020; Chaskin, 2001). While the CHD has not previously been used to address health of refugees, utilizing this framework provides a roadmap to strategize the current health needs of a community and develop solutions which are conceptualized and eventually implemented by the community. The focus of this study involves the initial phase of a CHD process, which includes in-depth discussions with a community to build relationships, as well as learn their histories, concerns, and priorities in order to ultimately plan the most effective strategies to achieve positive health outcomes (Burdine et al., 2007).

1.1.1. Historical experiences of a community

Communities are bound by their historical context, so it is increasingly important to take into consideration the various experiences within the healthcare system that a community has encountered. These historical experiences shape their interactions in the healthcare system.

1.1.2. Identification and prioritization of current concerns

Next, identifying and prioritizing current health concerns calls for addressing specific problems which the community feels are most significantly impacting their health. This is recommended to happen in a group environment, where community members are able to address concerns and hear others’ input on health problems which are affecting the well-being of the community. Together, community members can then determine which health problems should be prioritized and develop solutions to address these needs.

1.1.3. Recommendations to improve health

The recommendations to improve the community’s health begins with a process of collaborative problem-solving, aimed to engage community members as shared stakeholders in improving the health of the community and evenly distributing power so that community members have a voice in improving their overall health status (Felix et al., 2010; Garney et al., 2017). Collaborative problem-solving also lays a foundation towards increasing health knowledge, improving health behaviors,

and finding pragmatic solutions to their health problems which is appropriate to the context of their community (Garney et al., 2017).

The selected CHD framework guided the design and analysis of the focus group discussions conducted in this study to assess the narratives of the resettled Bhutanese refugees' experiences in the healthcare system prior to resettlement and within the US, as well as their recommendations for improvement. Gaining a deeper understanding of these issues can serve as the initial steps towards increasing capacity and building on existing strengths to mobilize community members towards obtaining a long-term positive health status (Garney et al., 2017).

2. Methods

2.1. Study design

This study is part of a larger study focused on understanding the community health needs of Bhutanese refugee women before and after their resettlement into US society. We used a cross-sectional study design with a qualitative approach. The data collection mechanism used in this study was focus groups since they provide opportunities to better understand and explore certain phenomenon through dynamic interactions and shared accounts of health-related experiences (Tolley et al., 2016). Interactions among participants can illuminate broader community perceptions on health issues and facilitate open dialogue, as well as generate deep insights in an environment of mutual understanding and support (Tolley et al., 2016; Krueger and Casey, 2016). This focus group study adhered to accepted criteria for reporting qualitative research (Tong et al., 2007). The total number of focus groups to be conducted was determined by reaching a point of saturation, defined by data no longer yielding new insights (Tolley et al., 2016).

2.2. Site selection

The study occurred in central Massachusetts in the city of Worcester, which has an estimated population slightly over 185,000. The poverty rate of Worcester is 20%, determined by an income less than \$13,000 for an individual or \$26,000 for a family of four (United States Census Bureau, 2015). This rate is double that of the United States as a whole (10.5%) (United States Census Bureau, 2015) and can impact health and well-being and limit access to necessary health resources and services. This city was selected for several reasons. First, it holds one of the largest numbers of resettled refugees in the state (United States Census Bureau 2015; Fábos et al., 2015). Second, almost 30% (55,628 persons) of Worcester is considered foreign born (United States Census Bureau, 2015), and the refugee population represented 1.2% of the total population of Worcester at the time of this study, or roughly 2,220 persons (Fábos et al., 2015). Finally, there is a large Bhutanese refugee population in Worcester, accounting for almost 600 residents (27%) of refugees in the city.

2.3. Recruitment and participants

The participants for this study were recruited through purposive and convenience sampling, and were approached by two community leaders, who were also Nepali-origin Bhutanese. These leaders were identified through the first author's prior networks and connection with the community. Such leaders were deeply integrated within the community and were knowledgeable of the local culture, customs, and resources. They served as liaisons that assisted with recruitment and provided information about the study to potential participants by word-of-mouth, and by going door-to-door to inquire about interest for participation. Reflecting the larger study this paper is part of, we limited participants to women as the main question revolved around women's health issues. Of the 50 community members approached, 10 declined due to other commitments. For the remaining 40 who agreed to take part in the study, a convenient time during the weekend was secured by the community

leader. As steps to ensure a safe space with open communication, community leaders recommended focus group participants to consist of the same gender, so each of the four focus groups were comprised of individuals identifying as women. Maintaining homogenous group characteristics to ease comfort and facilitate discussion is consistent with previous studies conducted with migrant women (Ruppenthal et al., 2005). Inclusion criteria were adult women (18 years and older) of Nepali ethnicity identifying as Bhutanese refugees, who had previously lived in refugee camps, and were voluntarily willing to participate in the study. This study was approved by the Texas A&M Institutional Review Board (IRB) through the Division of Research.

2.4. Data collection

The four focus groups conducted in this study occurred between June and November 2016, with a total of 40 participants. Each focus group had 8–12 participants. There was a total of 40 female participants in the focus groups; two of the focus groups had 10 participants, the third group had 12, and last focus group had 8 participants. The average age and education of participants were 49 years old with 3 years of formal education, and average length of time living in the US was 4 years. Participants lived in refugee camps for 19 years on average, and 40% reported no English proficiency. Almost half (49%) rated their health as "fair" on a five-point scale (Table 3).

The close ties that existed between participants of the study allowed three of the four focus groups to be held in the home of one of the participants per group, who volunteered to use their space. The fourth focus group was held at a local religious temple. Each location was conveniently accessible for community members, and carpools and rides were provided by community contacts for those who needed assistance.

The focus group guide was developed and tested based on community health assessment questionnaires and modified with input from the community leaders familiar with the culture of the participants. The questions addressed the major components of the CHD framework, including the historical experiences of the community, current health concerns, and recommendations for health improvement (Table 1).

All of the focus groups were led by the first author in Nepali. The first author is female, second-generation Nepali-American, bilingual (Nepali and English), knowledgeable of the culture, and a doctoral student trained in qualitative research methods. However, while the first author shared language, culture, and ethnicity with Bhutanese refugee participants, she had a vastly different history of migration in comparison to the study participants. The increased interest by the first author on this topic stems from personal encounters with Bhutanese refugees and stories they shared about their journey. Purposeful effort was made to prioritize the needs of the participants, and to remain cognizant of existing power and privilege differentials in order to provide a safe space for sharing their stories.

At the beginning of the focus group, a community leader helped introduce the study topic and purpose for the research and helped answer questions about the study, which served as an icebreaker and demonstration of support for the study and facilitator. Participants were asked to give verbal informed consent for audio-recording. Focus groups lasted from 1 h and 30 min to 2 h. Reflective notes were made after the focus group and used for the initial coding during the analysis.

2.5. Analysis

Participant responses in all focus groups were audio recorded and transcribed verbatim in Nepali, translated to English, and back-translated to maintain consistency and ensure original meanings by the participants, completed by the first author with the assistance of a Nepali certified medical interpreter. ATLAS.ti (v7) software was used to analyze the data. To maintain anonymity, pseudonyms were used during focus groups, transcription, and analysis. The first and third authors (MS, JS) reviewed and re-read transcripts and field notes to understand

Table 1
Sample questions and structure of focus group guide.

Question Category	Focus Group Question
Opening	1. Please introduce yourselves, what is your name (pseudonym if they do not want to give name)?
Historical experiences	2. How is getting health services here different than in Nepal/refugee camp/Bhutan? 3. How has the process of adjusting to a new life and/or culture gone for you? 4. Where do you, or people you know, go in Worcester for help or advice for health issues?
Current health concerns	5. What are some of the difficulties in going to health-related places (clinics, hospitals, etc.) and getting the services and information you need for a health problem? Does your status or role (as a refugee) change the way you think about or get health care compared to your life in Nepal/refugee camp/Bhutan? 6. What are some organizations that help refugees when they have health concerns? 7. Other than those who work at organizations that you mentioned, are there individuals here (in focus group or in Worcester/ surrounding areas) that help Bhutanese refugees find out about and/or get to health services?
Recommendations to improve health	8. What are the most important health concerns for you and/or your family? 9. Are there any health services that you feel Bhutanese refugees here need but do not have? 10. If you could design a program to help refugees in the Bhutanese community have better health, what would be the top two most important factors to include?
Closing	11. Are there any other things important to you about Bhutanese refugee health that we haven't asked you about?

Table 2
Summary of the Community Health Development (CHD) framework components and the categorization of focus group discussion themes.

CHD Framework Component	Themes	Subthemes
Historical experiences of the community within the healthcare system	Institutional Neglect	· Last in line · Disruptive discrimination
Identification and prioritization current concerns in healthcare system	Cultural disconnect in clinical encounters	· (Mis) interpretation · Constrained clinical conversations
Recommendations to improve the community's health	Collaborative participation in health promotion efforts	· Representation in healthcare system · Leadership in health promotion

Table 3
Average socio-demographic characteristics of Bhutanese refugee participants from four focus group discussions (n = 40).

Background Characteristics	Average for all focus groups participants (n = 40)
Age	49 years (range:32–70)
Years in refugee camps in Nepal	19 years (range:17–21)
Years in the US/ Worcester	4 years (range:1–5)
Years of formal Education	3 years (range:1–4)
Self-reported English proficiency	Fluent (8%)Some (23%)Little (29%)None (40%)
Self-reported health status	Excellent (3%)Very Good (11%)Good (23%)Fair (49%)Poor (14%)

broad issues and create initial codes. A coding schema was developed using principles of thematic content analysis (Vaismoradi et al., 2016; Saldaña, 2015) to guide the analysis of the data, and the transcripts were systematically coded and re-coded by MS and JS, then categorized into subcodes in order to elucidate meanings based on shared patterns that were developed into themes (Saldaña, 2015; Tolley et al., 2016). Themes and subthemes are reported under the broad components of the CHD framework illustrated in Table 2. Major themes, which emerged after analysis of the focus group discussions, are described in the results section, which included institutional neglect, cultural disconnect in clinical encounters, and recommendations for collaborative participation in community health improvement. Results are categorized based on CHD components and address the study's aims in exploring: (1) the historical experiences of the community (2) identifying major concerns within the US healthcare system and (3) recommendations for health improvement.

3. Results

3.1. Historical experiences of the community

3.1.1. Institutional neglect

Participants described many instances of discrimination and neglect from receiving poor quality of care during their interactions occurring within the healthcare system in Nepal. Outside of basic health services,

most refugees were referred to clinics or hospitals for treatment in Nepal on specific and more serious health concerns, as the camps did not have the technology or resources to deal with more severe health issues. These were located near the camps, but were part of the healthcare system of Nepal, and so refugees would often face institutional neglect based on their lower social status in the broader society. In this study, institutional neglect refers to healthcare systems avoiding giving proper healthcare access and services to Bhutanese refugees. Regardless of the severity of their conditions, participants described being last in line when waiting for services and were often disregarded by medical personnel. Experiencing consistent structural discrimination, a form of unequal treatment from medical institutions, disrupted their access to necessary healthcare services in which many conditions were left untreated or overlooked.

3.1.2. Last in line

Focus groups participants reported consistently feeling they were the least priority, or last in line, within the healthcare system and clinics outside of the camps in Nepal. Once identified as a Bhutanese refugee, they reported immediately noticing differential treatment:

“We would be put in a separate line for refugees, to treat us last, and by the time the sick person's name was finally called they would have died already. Many died like that.” (Sajita, age 40, 3 years in US).

“[The local Nepalese] would call up their own people first to get care, you could not even argue as a refugee... So we would have to stay quiet to save our kids' lives.”

(Anju, age 44, 8 years in US)

Participants described feeling disregarded based on their ethnicity and citizenship status, and reported feeling anxiety and hopelessness while remaining in line to get treated. They also explained that speaking up about their health concerns put their care in jeopardy. Despite the urgency of medical treatment needed, they did not feel the members of their community were prioritized in the healthcare system in Nepal, and perpetually stayed at the end of the line throughout their time as refugees.

3.1.3. Disruptive discrimination

Those who were able to eventually receive treatment continued to face discriminatory practices through careless treatment, and minimizing serious issues which disrupted their potential paths for positive health outcomes. Providers in Nepal were described as mostly inattentive and neglectful, regardless of the severity of the health problem or symptoms being experienced.

“Even if we were very sick or dying, you could not expect help at the hospital... and if we did get treatment, it would be careless.”

(Abani, 50, 7 years in US)

“When I took my sick child to the doctor he said, ‘Why did you bring this little girl here? She’s fine - she’s still breathing.’”

(Anju, age 44, 8 years in US)

Bhutanese refugees in the focus groups empathized with stories like Anju’s, who had spent days in the hospital waiting room, expecting to get timely treatment for her asthmatic daughter, only to be refused care by the doctor. Other participants also described being treated carelessly in Nepal, and recounted instances of verbal and physical abuse by hospital staff towards themselves or others in their community.

A number of participants noted how facing ongoing discrimination as refugees in Nepal disrupted their potential to have good health. The neglect in receiving health services to treat chronic illness, for example, continued to impact their current health status. Additionally, since many of the refugees lived in the camps for almost two decades, the lack of accessible and quality healthcare could increase their overall risk of preventable chronic illnesses, diseases, and serious health conditions.

“We are suffering from the old sicknesses we had in the camp because we didn’t get proper treatment...in my mother’s situation she had COPD [chronic obstructive pulmonary disease] for many years, and did not get proper treatment...so when she came here, it was too late.”

(Jaya, age 40, 8 years in US)

“After staying in Nepal, after living with hardship in the refugee camp, I do not think anyone could have suffered more than that.”

(Radha, 40, 7 years in US)

3.2. Identification and prioritization current concerns in healthcare system

3.2.1. Cultural disconnect in clinical encounters

When compared to the refugee camps in Nepal, participants expressed the dramatic improvement in the infrastructure and quality of medical facilities after resettling to the US. However, their biggest issues stemmed from interactions and communication with medical interpreters and providers. They reported feeling the medical interpreters in the US were inaccurately conveying their specific health-related concerns to physicians and other medical personnel. Additionally, they reported feeling constrained in the time allotted with their doctor, particularly among the older Bhutanese refugee population.

3.2.1.1. (Mis)interpretation. At a number of the local US hospitals, a medical interpreter is required and provided to those with limited or no English proficiency. Though the interpreters spoke Nepali, the primary language used by Bhutanese refugees, their vocabulary and dialect were different due to their background and national origin, which created a linguistic and cultural disconnect.

“Their words and accents and pronunciations are different, so when the interpreter, even though they are speaking Nepali, it is different from our Nepali.”

(Saru, age 48, 8 years in US).

“I feel only half of what we are trying to say will get through from the interpreter. There are many differences in the language.”

(Rupa, age 50, 6 years in US).

There was a clear distinction between language in the use of “our/their Nepali” throughout the focus groups. Many of the focus group members expressed their frustration with cultural and linguistic miscommunication, and how it impacted their trust and confidence in clinical discussions. For example, in attempts to facilitate conversation, interpreters would ultimately overstep boundaries to impose personal opinions and criticism, rather than directly interpreting concerns during medical visits which puts patients’ health at risk and impacts the autonomy of decision-making for their treatment.

“So many of the Nepali interpreters, they seem to get annoyed, right? They will almost yell at [Bhutanese refugees], saying, ‘No do not say it like that, say it like this!’”

(Radha, 40, 7 years in US)

“For me at the beginning, I didn’t know much for the first few months. When I went to the hospital, I did get an interpreter, he was Nepali, and I told him I was pregnant, and I asked him if he could ask the doctor about what options I have. He said ‘you should not talk about these things [like abortion], you will be in trouble.’ I told him that he should just interpret what I am telling him, rather than telling me what to do. But he did not want to interpret what I wanted to say to the doctor.”

(Anjali, age 39, 7 years in US)

“There was Nepali medical interpreter that was also supposed to help with social services, I begged for help, saying ‘Sir, I need to get my kids in school’ and other important things I did not know how to do. But I felt that because he got an important job after coming from Nepal, he acted as though he was above everyone, and he did not want to talk about my problems.”

(Sajita, age 40, 3 years in US)

The negative dynamics with the Nepali interpreters was, in part, representative of a continuation of discrimination. Refugees felt their concerns were still being diminished by Nepali individuals, mirroring their perceptions of neglect and feelings of inferiority from the interactions with Nepali healthcare personnel and system in Nepal.

3.2.1.2. Constrained conversations. The participants felt their time with their providers in the US was constrained compared to their needs and expectations, as well as cultural norms. This was especially apparent with the older generation, who practice more storytelling to convey information:

“From [the interpreter’s and doctor’s] view, they try to do things based on the time they have. For our parents, it is hard to just answer a question, they like to talk more. You need to give [elders] time, you have to slowly understand what they are saying.”

(Ranju, age 50, 8 years in US).

“There are so many things you want to say that come from your emotions, your own words, but you can’t speak, and there is no time.”

(Nina, 64, 2 years in US).

Most of the older participants spoke limited English and were unable to express their feelings or concerns during their visits. Since they were also experiencing difficulties with the interpreters, they felt their time in the doctor’s office was insufficient and rushed. The culture of speaking slowly and through stories was less compatible with the environment of the medical visits in the US healthcare system, which is often fast-paced and ill-equipped to tailor visits to refugees’ needs (Kotovicz et al., 2018).

3.3. Recommendations to improve community's health

3.3.1. Collaborative participation in health promotion efforts

The third major theme was the idea of collaborative participation in ongoing health promotion efforts. After identifying major barriers, focus group participants contributed ideas and input on planning for solutions to improve health. They discussed specific areas that could be strengthened in order to build a healthier community. This included (1) adequate representation in the healthcare system and (2) participation as equal partners in efforts to improve the community's access to health-related resources and knowledge. This is an important element of sustaining community-supported health programs and enhancing efforts to address priorities identified by community members (Burdine et al., 2010). The shared interest in developing and maintaining community-based health promotional activities can positively impact health status and increase participation in health programs over time (Burdine et al., 2007). Overall, participants were enthusiastic and willing to engage in discussions on strategies for solving health concerns for their community.

3.3.1.3. Representation in the healthcare system. Focus groups participants suggested increasing their community's representation in the healthcare system by training more Bhutanese refugees from the community to become medical interpreters in local hospitals. Employing interpreters with a deep-rooted knowledge of Bhutanese refugee culture would help with translating both the linguistic and cultural interpretations of conversations and interactions. Participants described characteristics of Bhutanese refugee interpreters that would be beneficial for their community.

"I would like if there was someone that can tell us exactly how to talk to the doctor, what to tell them so that we get what we need. I do not know how to speak [English]. We need one of our own from our community that we can trust is saying the right thing we are trying to say."

(Nina, age 48, 5 years in US)

"A lot of Bhutanese come here and feel anxious and a lot do not know a lot of new things. We can help them to say what they are trying to say, so the doctor understands."

(Asha, late 30 s, 5 years in US)

Culturally relevant interpreters were seen as individuals who would increase the trust in communication with providers. Participants noted that having someone from their community in this position would be relatable and would be an individual who would have an inherent understanding to their way of life. This would lead to strengthened relationships within the healthcare system and more effective care.

3.3.2. Leadership in health promotion

The participants also indicated they would support more involvement in developing programs to make sure their healthcare needs are heard. This would enable them to build community capacity and resources that are culturally tailored through leadership roles. This stemmed from an ongoing concern that their community had limited health resources specific to their needs, as well as an absence of leadership for guidance and support in this area.

"There are some classes at the health center every few months that teach good foods to eat and other things. But nothing from within the community. It would help if we had that." (Chameli, age 34, 6 years in US).

"I think trainings would be helpful. There is not a lot of time with doctors to learn all the information. But there are a lot people that once they understand what [the health problem] is, they will want to make those improvements to their life."

(Mina, age 37, 8 years in US)

Participants felt unseen in healthcare settings and wanted leadership opportunities to give them a stronger presence in these spaces through

access to training and classes to improve health knowledge and behaviors. They discussed the need for community advocates from within their group who would be able to represent their interests in these settings. Respondents described the advantage of internal community advocates that would lead efforts and prioritize the needs of the Bhutanese refugees. Participants noted this would particularly benefit those who were newly arrived, who may have low English proficiency, community members with few ties to friends or relatives and who may have limited transportation to health services.

"We need a leader where it is their job to help with the health problems and give solutions on what to do."

(Reena 40, 4 years in US)

"To make it easier, in our community we would need a type of person who could speak both languages, giving more time and attention [to community members], teaching them to do things, helping to make doctor appointments and taking them to appointments. Someone like that would help everyone."

(Chameli, age 34, 6 years in US)

The limited connections to health knowledge and services outside of the community could be expanded from increased leadership and partnership in health promotion activities. The need for an advocate with shared cultural similarities and goals to improve the community's health was a strategy created and supported within the focus group discussions to find ways to broaden access to resources, develop internal leaders, and provide sustainable support from within the Bhutanese refugee community.

4. Discussion

This study assessed the perspectives of a Bhutanese refugee group to explore their experiences navigating the healthcare system before and after resettlement. The goal of this study was to (1) contextualize the historical experiences of a community in order to (2) prioritize current health concerns and (3) provide recommendations to improve the community's health as a foundation to implement future culturally appropriate practices. For refugees which have been resettled, an in-depth exploration of their stories and experiences provides cultural context to their perceptions of health, acknowledging the multitude of barriers they faced through their lives, and lays a foundation for a desired collaborative health promotional efforts in the community.

There has been growing attention to the importance of contextualizing refugee resettlement experiences and its impact on current health related concerns (Wachter et al., 2016). This study emphasizes that the mistreatment and discrimination of Bhutanese refugees in Nepal disrupts their pathways towards positive health outcomes. The impact of trauma based on discrimination, particularly during the pre-resettlement period among Bhutanese refugees, has been found to be detrimental towards their health and well-being (Poudel-Tandukar et al., 2019; Vonnahme et al., 2015).

Furthermore, Bhutanese refugees can face additional barriers when accessing services in the US, which primarily included cultural tensions with interpreters. While the negative consequences of cultural disconnect of medical interpreters has been demonstrated in other ethnic groups (Flores, 2005; Nápoles et al., 2015), the difficulty experienced by the Bhutanese refugees with Nepali interpreters based on the shared historical background presented an additional layer of complexity. Bhutanese refugees' reliance on a Nepali interpreters and subsequent dissatisfaction with the quality of interpretation paralleled the neglect and feelings of inferiority experiences with the healthcare system in as refugees in Nepal, inadvertently perpetuating the social hierarchy in Nepal into interactions within the US healthcare system. Both cultural and linguistic concordance of interpreters are necessary for effective care and patient engagement in clinical visits (Basu et al., 2017; Tonkin, 2020). Failure to allocate the necessary time and resources towards developing a more robust system that is tailored to refugees specific needs (language, cultural norms, resources to ease transition) can

generate ongoing frustration from the interpreters and providers side (Kotovicz et al., 2018) and can contribute to negative experiences for refugees within the healthcare system (Szajna, 2019; Shannon, 2014).

This study also found that conversations felt constrained during visits with physicians, often feeling rushed and with little exploration of their health concerns. Research has also found that refugees desired physicians to take time to address concerns, understand their backgrounds and stories, and give ample time to discuss symptoms and concerns (Shannon, 2014). It is important for providers to remain cognizant of these types of social norms found in refugee cultures, or they risk further alienating these vulnerable groups in the healthcare system. As a diverse, multicultural society, providers are often managing the needs of various cultural groups daily. Having the support of a skilled interpreter, knowledgeable in both the language and culture of the patient, could also be beneficial in helping both providers understand refugee culture, and patients who are refugees better understand the nuances of the US healthcare system, which could lead to more effective and efficient interactions in visits.

To address barriers in healthcare systems, the participants in this study were supportive of increased leadership from within the community and being connected to external resources demonstrating the potential for effective interorganizational collaboration. A previous study found a key strength in helping develop and implementing health programs is the intrinsic altruism found in Bhutanese refugee communities, which can build a strong foundation for maintaining community-driven health programs long-term (Yun et al., 2016). Partnering with local organizations and elevating leaders from within the community would build on existing strengths and increase local capacity (Matarrita-Cascante and Brennan, 2012; Matarrita-Cascante et al., 2020) in line with CHD framework (Garney et al., 2017). Increasing leadership roles, especially among Bhutanese refugee women, enables feelings of confidence, empowerment, and value within the community, which can further improve community participation, morale, and altogether lead to more resilient communities (Denzongpa and Nichols, 2020; Matarrita-Cascante et al., 2017). In general, community leadership training programs for Bhutanese refugees have been found to be beneficial in increasing knowledge, access, and skills in improving health behaviors (Im and Rosenberg, 2016; Yun et al., 2016; Mitschke et al., 2013).

It is important to initiate dialogue in assessing shared concerns and taking tangible, community-driven steps towards health improvement in the refugee community. Study findings indicate that despite the struggles within the healthcare system, the community was receptive to conversations on their experiences and needs to improve health. For providers and stakeholders, maintaining open communication with the community can help determine the existing strengths of the community, the willingness for participation in programs, as well as the potential for maintaining healthy behaviors (Garney et al., 2017). Localizing power to members of the community involves giving them a voice in expressing their needs, experiences, and recommendations for strengthening their community's health (Garney et al., 2017). This makes it possible to develop culturally appropriate programs that prioritizes current needs and incorporates the context of their cultural history. In line with previous research, this study demonstrated that there is much value in community perspectives on health needs, as their past histories continue to influence the societal structure and perceptions of the health care system of which they are involved (Felix et al., 2010; Shediak-Rizkallah and Bone, 1998).

4.1. Limitations

The limitations of this study included a relatively small sample size of a very specific refugee group. Since this is a study with only one Bhutanese refugee community, results may be less applicable to other Bhutanese refugee groups. The focus groups in this study comprised female participants of mixed age groups, which diversified perspectives, but future research may find shared experiences of similar age groups

and mixed genders may reveal additional in-depth stories on specific events in their lived experiences, such as the process of forced relocation from Bhutan to Nepal. While the focus of this study was the perspectives of the community, future research would also benefit from also obtaining narratives and perspectives from providers, stakeholders, and other relevant health organizations to add to collaborative strategies to improve local health initiatives. Obtaining multiple perspectives on community health needs can help to reduce disparities and increase the likelihood for long-term effectiveness (Urban et al., 2015).

5. Conclusion

Public health approaches should take into consideration a refugee community's history and include them as partners to develop culturally informed practices. This is necessary to establish a deep and empathetic understanding of the volatile history faced by refugee groups. Since each group has its own specific needs, engaging with the community directly and hearing their concerns is an effective way to lay the foundation for health improvement. This study demonstrated that Bhutanese refugees have a multitude of concerns and recommendations to empower their community. Community participation and input is essential in developing health programs and understanding health needs while working collaboratively to implement a solution can produce viable and lasting positive health outcomes (Minkler, 2012).

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Declaration of Competing Interest

None

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jmh.2021.100049.

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