Examining Health Care Access for Refugee Children and Families in the North Carolina Triangle Area

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BACKGROUND Resettled refugees are at increased risk of poor health outcomes due to acculturation challenges, logistical barriers, experiences of trauma, and other barriers to care that are poorly understood. Refugee children may be particularly vulnerable due to disruptions in health, well-being, education, and nutrition during the resettlement process.

METHOD To describe the health care barriers facing refugees in the North Carolina Triangle area (comprised of Durham, Chapel Hill, Raleigh, and their surrounding areas), we conducted three focus group interviews (in Arabic, French, and Swahili) with 25 refugee parents from Syria, Iraq, Central African Republic, the Democratic Republic of the Congo, and Chad. We also administered a survey to nine organizations that provide services for refugees.

RESULTS Focus group responses highlighted the multidimensional nature of health care barriers for refugee families and children, encompassing challenges with acculturation, communication, transportation, finances, and health literacy. Organizations emphasized similar challenges and described their efforts to improve access to services through increased communication, coordination, and seeking new financial support for programs.

LIMITATIONS Given the geographic focus of the study, results may not be generalizable to other populations and settings. Men spoke more than women in some focus groups, and participants may have been influenced by more vocal contributors. Furthermore, this study is limited by a lack of health outcomes data.

CONCLUSIONS This study suggests that the health care needs of refugees living in the North Carolina Triangle area can be better met by providing comprehensive, coordinated, and culturally relevant care. This could include minimizing the number of visits by integrating multiple services under one roof, providing trauma-informed interpreters, and offering accessible transportation services.

Refugees in the United States face multiple unique challenges related to acculturation, meeting basic needs, and accessing vital services such as health care [1]. Structural and contextual factors, such as “othering” and discrimination, are potential pathways through which acculturation can erode the health of refugees and their descendants [2]. Although experiences of trauma, displacement, and disruptions in health care are not unique to refugees, the experience of real or threatened danger is a defining characteristic of this population, and traumatic experiences may directly contribute to suboptimal acculturation, health care access, and health outcomes [3].

Difficulties in health care access upon arrival in the United States include barriers to navigating complex medical and insurance systems, overcoming language and cultural barriers, institutional mistrust, and the residual impacts of trauma and challenging experiences prior to and during migration [1, 4]. These challenges exacerbate health inequities and place families and individuals with refugee status at undue risk for numerous health issues.

The barriers to health care faced by newly arrived refugees may be particularly challenging for children, who may fail to receive preventive care, lack proper nutrition, and experience developmental delays, all of which may be due to the often chaotic resettlement process and delayed access to care upon arrival in the United States [5]. Mental health issues are especially prevalent among refugee children, who are exposed to trauma before, during, and after the resettlement process [6, 7].

The North Carolina Triangle area (comprised of Durham, Chapel Hill, Raleigh, and their surrounding areas) has long been an important center for refugee resettlement in the state and in the southern United States. In recent years, refugees settling in North Carolina have come from diverse locations including Afghanistan, Central African Republic, the Congo, Iraq, Myanmar, Syria, Somalia, and Sudan. Four agencies assist the resettlement of new arrivals to the North
Methods

In order to consider both patient and service provider perspectives, a two-fold qualitative evaluation was conducted: 1) focus groups with refugee parents and caregivers; and 2) surveys of agencies and local organizations that provide services for refugee clients and their children. Focus groups with refugees were held in December 2017 and surveys of health service providers were collected in March 2018. The study design, data collection, and analysis were led by a team of undergraduate students representing diverse disciplines who were enrolled in an experiential learning course in refugee health offered at Duke University in Durham, North Carolina. The study received ethical approval from the institutional review board of Duke University.

Focus Groups

Participants in the focus groups were recruited through the posting of flyers at local refugee service organizations and outreach of study team members to their professional networks. Interested participants were then invited to attend a focus group held in their first language, which took place in a campus building at Duke University. Each participant received remuneration of $25 for their time and transportation costs. Child care was available during the focus group for those who requested it. Participants included refugees who were parents and/or responsible for the care of a child, and who spoke one of three languages: French, Swahili, or Arabic. Separate focus groups were conducted in each of the three languages. These languages were chosen due to the large number of refugees from Arabic, Swahili, and French speaking countries in the area [8].

All focus group participants provided written informed consent prior to study enrollment. Each focus group was led by 1-2 faculty from the experiential learning course and assisted by 1-2 students from the course. Focus groups were organized around a predetermined set of questions using a semi-structured interview guide. Questions explored when and how participants sought formal health care for their children and obstacles faced in doing so. Participants were asked to speak about the role of communication and language in the care of their children, how they navigated medical bills and prescriptions, access to transportation, and the mental well-being of their children (for the full interview guide, see Appendix A). Focus group sessions lasted approximately one hour and were audio recorded with the permission of the participants.

Analysis

For the focus groups, audio recordings of the group sessions were simultaneously translated into English and transcribed. Next, transcribed data were organized onto a priori domains derived from the interview guide using a qualitative memo writing process [10]. The memo writing process serves to summarize large amounts of data and to reorganize transcripts around key domains for ease of analysis. Memos representing each domain were then analyzed using an inductive, iterative approach informed by grounded theory and the constant comparative method [11]. Memos were reviewed individually by multiple coders, themes of responses were identified by each coder, and the themes were then combined into a single codebook in consensus-building sessions.

For the organization survey, each open-ended question was similarly labeled as an a priori domain and data were
analyzed by multiple coders until team consensus was reached. Multiple choice questions are reported using simple frequencies and descriptive statistics.

Results

Focus Groups

The focus groups included 25 refugees (17 female, 8 male) originating from Syria (n = 13), Iraq (n = 1), Central African Republic (n = 6), the Democratic Republic of the Congo (n = 4), and Chad (n = 1). The average age of participants was 38. The average time participants had spent in refugee camps was four years (range = 0-13 years). All had arrived in the United States within the past three years.

Quality of health care. When asked about the overall quality of the health care they receive for their children, participants generally shared positive feedback about their health care providers but frustration with perceived challenges in navigating the health care system (Table 1). Providers were described as respectful, kind, caring, professional, and knowledgeable. One participant shared, “The doctors are very good, but the system is frustrating.” Another participant felt frustrated with the amount of paperwork required before they could receive services: “Before they see you, they ask you for your father’s name, what he suffered from, what illnesses your sister had, how many times you smoke; it’s so much paperwork.”

Despite several reported frustrations, many participants felt that their children’s health had benefited from being in the United States and that they were receiving high-quality care. This was particularly emphasized with regard to their children’s emotional well-being. As one participant shared, “Our kids are psychologically happier here.” However, in the Swahili group, there was a substantial conversation about the cultural challenges of resettlement, including concern that their children had adopted Western values that were “not respectful” of their culture of origin. Swahili parents perceived this change as a negative impact to their children’s well-being (Table 1).

Table 1: Refugee Perspectives on the Quality of Health Care for Children (N = 25)

| Category                  | Focus Group | Illustrative Quote                                                                 |
|---------------------------|-------------|------------------------------------------------------------------------------------|
| Quality of Services       | Arabic      | “We feel comfortable with the credibility and knowledge of our doctors.”           |
|                           | Swahili     | “There’s a doctor at [name of local institution] who is very friendly and really cares about my child’s overall health and well-being.” |
|                           | French      | “The emergency response is really great, 911 gets you to the hospital very quickly from wherever you are, whenever.” |
| Children’s Well-being     | Arabic      | “It can be difficult to understand children’s medical needs or know what to give them so we might be quicker to take them to the hospital than if it were ourselves.” |
|                           | Swahili     | “We feel there’s an erosion of cultural values. Our children talk back to us and are not respectful.” |
|                           | French      | “The kids are doing well – they have friends at school and in the neighborhood”    |

Wait times were another common issue, particularly among participants who had to take time off work or had to find child care for other children while they attended appointments. When navigating a system that seems complex, many saw the emergency department as a gateway to the health care system despite problematic wait times. “When we go the ER, the wait is at least eight hours. Sometimes we simply go back home [without receiving services].”

Most participants reported that the direct cost of medical care for their children was minimal, as their children were enrolled in Medicaid or the Children’s Health Insurance Program (CHIP). However, participants reported that living in poverty influenced children’s health care in other ways. For example, there were many indirect costs related to taking time off work, transportation to clinics, child care costs...
TABLE 2.  
Refugee Perspectives on Barriers to Accessing Health Care (N = 25)

| Category          | Focus Group | Illustrative Quote                                      |
|-------------------|-------------|----------------------------------------------------------|
| Transportation    | Arabic      | “For the first three years, we didn’t have a car and had to rely on the buses; it was hard.” |
|                   | Swahili     | “Usually I call an Uber or ask a neighbor with a car.” |
|                   | French      | “Sometimes we use the Medicaid vans, but you have to call days ahead and still they may not come.” |
| Oral Interpretation| Arabic      | “Sometimes the interpreters come in person in the room with us. They are usually good. The issue is mainly with the interpreters on the phone.” |
|                   | Swahili     | “I like the in-person interpreters better and because I’m learning English, I can tell if my message is coming across.” |
| Wait Times        | Arabic      | “In Lebanon and Syria, there is no wait.”               |
|                   | Swahili     | “In the refugee camps, we didn’t need to book an appointment days in advance but could simply walk into a designated clinic area, register and wait to be served.” |
| Price of Services | Arabic      | “Right now, I cannot afford to pay medical bills, but we are waiting for approval for Obamacare.” |
| Pharmacies        | French      | “I went to get a refill, and showed them the box I had gotten before, but they turned me away saying I needed a new prescription. Then I had to make a new appointment all over again.” |

for other children in the home, and over-the-counter medications (Table 2).

Organization Surveys

The organizations participating in the survey served a range of 50 to 800 (mean = 242) refugee clients in 2017. Six of the nine were nonprofit organizations, and all received or relied on government contracts to carry out their work. Additionally, organizations reported needing strong support from volunteers to provide their services. All organizations noted they provide adult mental health services and five provided primary medical care (Table 3).

Challenges faced. The barriers faced by refugee organizations in providing their services were quite homogeneous and largely reflected the challenges described by the parents of refugee children in the focus groups. These barriers, the work the organizations are doing to overcome them, and their recommendations for further improving services are summarized in Table 4. For example, organizations described that patients frequently were late or missed appointments due to transportation and financial challenges. Language barriers and difficulties with interpretation created issues with service delivery, health communication, and patient education. Additionally, providers perceived cultural differences in health beliefs and low health care literacy as critical challenges impacting treatment adherence. Others highlighted the complexity of the health care system as a key barrier. One organization’s representative shared, “New patients often have challenges in obtaining insurance and providing the necessary documents needed [to receive care].”

Steps being taken to overcome barriers. To address these challenges, organizations are taking practical steps internally but also seeking to form additional collaborations and obtain new resources. Internally, several organizations reported seeking to enhance their interpretation services, either by training their own interpreters or by partnering with interpretation services to meet the needs of refugee families and children. Similar efforts were also being taken to promote health education and communication between providers and patients. Nearly all of the participating organizations described efforts to enhance collaborations with other organizations to encourage communication and cooperation, deliver services efficiently, and minimize duplication of services.

In describing external support needed, nearly half of the organizations shared they were seeking external grant support to fund their improvement efforts. Multiple respondents also noted that current levels of governmental support were insufficient to meet the needs of their patients. Specific examples included the need for increased funding for organizations providing refugee services and lengthening of the window of eligibility for services for newly arrived refugees (Table 4).

Discussion

Findings of this study highlight the multiple challenges refugee families face in accessing health care for children. According to both refugee parents and service organizations, interpretation and communication issues were a key barrier to health care access post-resettlement [12]. Also consistent with existing literature, language barriers contribute to problems in understanding the US health care system and may underlie some refugees’ frustration with navigating health care, including registration paperwork, health insurance, and finding transportation to appointments. Focus group participants generally had positive comments about health care providers.

Study findings should be interpreted in light of the following limitations. The similarity of our observed themes across focus groups is an indication of data saturation. However, given the geographic focus of our study in the North Carolina Triangle area, results may not be generalizable to other populations and settings. Further, discussion threads can depend heavily on the participants present and themes may vary in different population groups or subgroups within our sampled populations. For example, opinions of one person may influence or override the views of others in the group. In some groups, men had the tendency...
to speak over women, despite facilitators attempting to elicit female perspectives. A female-only focus group could address this potential source of information bias. This study was also limited by a lack of outcomes data, as it is unclear if access issues faced by participants have led to poor health outcomes. Future studies may seek to quantify the potential health impact of the issues identified in this formative work. Finally, organizational survey results were limited by the low number of responses received, a common challenge with internet-based surveys. Based on the results of this study, the research team produced two deliverables that seek to address the primary barriers to refugee health care named in this study: an organizational report and an informational brochure. Following the survey’s closure, participating organizations received a report distilling key findings of the survey, informing organizations of services available in the North Carolina Triangle area and different models of care as well as providing recommendations for future efforts. Next, a brochure directing refugees to basic health care services in the area was created and translated into French, with plans to translate into Arabic and Swahili, as well. The research has also been used to support other campus initiatives. For example, a series of videos based on our findings were filmed in a subsequent course on refugee resettlement at Duke University. The videos, which are freely available at dukehello.com, are presented in French, Swahili, and English in both written and oral format. These materials were shared with refugee partners (who were instructed on how to use them) and received enthusiastically by local community organizations supporting refugee resettlement, as well as by the office of the United Nations High Commissioner for Refugees, which recently responded with enthusiasm about the project.

As a result of this study, we recommend making the following efforts to improve access to comprehensive, coordinated, and culturally relevant care of refugee children and families in the North Carolina Triangle area: streamlining referrals and combining appointments to minimize the number of visits needed for clients to address health issues; providing an integrated model of care with multiple services available under one roof in order create comprehensive, holistic health care; and emphasizing face-to-face communication over phone calls. Challenges to these recommendations include gathering necessary funding, aligning key stakeholders, and creating effective monitoring and evaluation protocols.

Additionally, our results point to certain programs that, given adequate funding, could benefit the North Carolina Triangle area refugee population. Comprehensive case management programs, dedicated to assisting refugees with acculturation for 1-5 years after arrival, could provide the support needed to familiarize newcomers with the health system along the continuum of integration [13, 14]. Trauma-informed care and accessible transportation services should also be made more widely available [9, 13]. Trauma-informed care shifts the clinical perspective from “what’s wrong with you” to “what happened to you” by recognizing and accepting symptoms and difficult behaviors as strategies developed to cope with trauma. This approach can create a safe environment for refugees and promote positive health and behavioral health outcomes [15]. In addition, given that both surveys and focus groups revealed language as a principal barrier, trained, trauma-informed interpreters should be made more widely available alongside all appointments [16]. Such efforts should be evidence-based and accompanied

TABLE 3.
Organization Characteristics (N = 9)

| Variable                        | n (%)          |
|---------------------------------|----------------|
| **Organization type**           |                |
| Nonprofit                       | 6 (67%)        |
| Faith-based                     | 2 (22%)        |
| Local government                | 1 (11%)        |
| State government                | 0              |
| Source of budget                | [Max %, Mean % across organizations] |
| Government contracts            | 85%, 27.8%     |
| Foundations                     | 20%, 5.3%      |
| Private donors                  | 25%, 6%        |
| Client fees                     | 8%, 1%         |
| Health insurance payments       | 50%, 10.6%     |
| Other                           | 80%, 16%       |
| **Staff makeup**                | [Mean % across organizations] |
| Full-time volunteer             | 0.6%           |
| Part-time volunteer             | 50.4%          |
| Full-time employee              | 23.6%          |
| Part-time employee              | 4.9%           |
| Independent contractors, partner organizations | 3.4% |
| **Services provided**           |                |
| Housing                         | 3 (33%)        |
| Employment                      | 3 (33%)        |
| Health screenings               | 6 (67%)        |
| Urgent care                     | 4 (44%)        |
| Primary medical care            | 5 (56%)        |
| Preventative health             | 7 (78%)        |
| Care coordination               | 8 (89%)        |
| Mental health                   | 9 (100%)       |
| Education                       | 2 (22%)        |
| Language training               | 5 (56%)        |
| Oral interpretation services    | 7 (78%)        |
| Legal services                  | 4 (44%)        |
| Cash assistance                 | 2 (22%)        |
| Transportation                  | 5 (56%)        |
| Other                           | 3 (33%)        |
| **Expected wait time to receive services** |            |
| 1-3 days                        | 3 (33%)        |
| 4-7 days                        | 0              |
| 1-2 weeks                       | 3 (33%)        |
| 2-4 weeks                       | 1 (11%)        |
| 1-3 months                      | 0              |
| No response                     | 2 (22%)        |
by well-designed monitoring and evaluation protocols to maximize their benefit and increase the potential for future expansion to other population groups and settings [17, 18].

Finally, partnerships among resettlement agencies and health care providers can be strengthened using established exemplar models, such as the Philadelphia Refugee Health Collaborative [19, 20]. The Philadelphia Collaborative links multiple resettlement agencies and health care centers to offer weekly refugee health clinics, mental health screening, and specialty referral. Services are supported by interpretation services and “cultural liaisons” who assist with scheduling, transportation, and other issues. Such collaborations have the potential to greatly enhance the coordination of care among organizations and improve access to and increase retention in quality care, thus providing comprehensive care from which all parties can benefit. In addition, interprofessional partnerships can support the development of community-centered programming such as cultural activities, arts programs, language classes, or parent groups in order to build institutional trust. Furthermore, collaboration across academic disciplines, such as that demonstrated by the team leading this study, is necessary to understanding and addressing the complex needs at hand.

**Conclusion**

This study adds that health care needs of refugee children and families in the North Carolina Triangle area can be better met through improving access to comprehensive, coordinated, and culturally relevant care. Further research is needed to better understand and meet these outstanding needs. NCMJ

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**TABLE 4.**

Organization Responses to Open-Ended Questions (N = 7)

| Domains and Categories                              | Frequency | Illustrative Quote                                                                 |
|-----------------------------------------------------|-----------|------------------------------------------------------------------------------------|
| Challenges facing refugees in accessing health services |           | “Public transportation in Durham is fairly convenient, but many refugees find it daunting to use when going to new places. Community service providers transport refugees when possible, but refugees become reliant on it and miss appointments if an issue arises.” |
| Transportation                                      | 3         | “Some patients have difficulty getting off work to tend to costly medical issues.” |
| Finances                                            | 3         | “Some patients have difficulty getting off work to tend to costly medical issues.” |
| Language                                            | 3         | “Interpreters are not reliably available at primary care providers. Communication of diagnosis, treatment, and prognosis is difficult.” |
| Health care literacy                                 | 5         | “Some need more help to understand medication management.”                         |
| Cultural differences                                | 1         | “Health beliefs and cultural differences play a huge role.”                         |
| Steps being taken at organization to overcome barriers |           |                                                                                     |
| Working with more interpreters                       | 4         | “We are working with partnering agencies to train more interpreters.”                |
| Fostering community partnerships                     | 6         | “We lead a Refugee Health Coalition which brings together the main service and health care providers and resettlement agencies. That has helped us minimize duplication of services, and has increased communication and collaboration.” |
| Applying for grants                                  | 3         | “We have applied for pilot funding to assist patients with transportation expenses.” |
| Teaching health care literacy earlier                | 1         | “This way we can place more emphasis on showing how to organize health appointments and paperwork, and how the health care system actually works.” |
| Dedicated staff for health-related questions and care coordination | 2 | “These providers help track appointments, answer clients’ health-related questions on a walk-in basis, and occasionally monitor medication compliance.” |
| Recommendations for improving health services for refugees |           |                                                                                     |
| Develop partnerships between resettlement agencies and medical providers | 7 | “Medical providers gain expertise and the continuum of care is strengthened through working together.” |
| Increase funding                                     | 2         | “More funding is desperately needed.”                                               |
| Lengthen resettlement period                         | 2         | “We need comprehensive case management programs dedicated to assisting refugees with acculturation for at least 1-5 years after arrival.” |
| Improve interpretation services                      | 3         | “Ensure that interpreters are trained in practice with refugee survivors of war trauma and sexual violence.” |
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APPENDIX A.
Focus Group Interview Questionnaire
Participant Demographics: Obtained by undergraduate student prior to focus group

Interview questions:
1. Health seeking behavior
   1.1 What do you do when you are unwell?
   1.2 If you are sick here in Durham, what would you do that is different from the past? Do you seek care at other places?
2. When child is sick
   2.1 What do you do when your child is unwell? First thing? Second thing?
   2.2 If you seek care from a doctor,
      • 2.2 How do you go about scheduling appointments?
      • 2.3 How do you get to the doctor?
      • 2.4 What conditions will prompt you to take your child to a doctor?
      • 2.5 What do you do in the case of a medical emergency? If your child fell from a tree and you weren't sure if they broke their arm, what would you do?
      • 2.6 Tell me more about how you reach your health care provider for any urgent issue?
   2.7 Which doctor would you take your child and why?
      • 2.8 Tell me more about your experience at that doctor? Would you go back to that doctor?
      • 2.9 What did you like most about that experience?
      • 2.10 What did you like least about that experience?
      • 2.11 What would make your experience better?
      • 2.12 If you had to go to a different doctor, could you tell me about that?
   2.13 What other types of care do you seek when your child is unwell? Where?
3. Communication and influence of language
   3.1 In what language would you prefer to communicate with your provider? Are you able to communicate in this language?
   3.2 Do you feel understood or that your concerns are heard?
   3.3 Do you take someone with you to the doctor? Why?
   3.4 What has been your experience with translators?
4. Financing for healthcare
   4.1 How do you pay for your medical bills?
   4.2 How do you go about getting medication after obtaining a medical prescription?
   4.3 How do you get refills for medication?
5. Childhood mental wellbeing
   5.1 How has your child adjusted to their new home? What do they think about their new school? Have you noted any changes in their behavior?
   5.2 If you child was very sad, anxious, or not doing well emotionally over a period of time, what would you do about it?