

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

Kelly Hunter, Brandon Knettel, Deborah Reisinger, Pranav Ganapathy, Tyler Lian, Jake Wong, Danielle Mayorga-Young, Ailing Zhou, Maram Elnagheeb, Melissa McGovern, Nathan Thielman, Kathryn Whetten, Emily Esmaili

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

Electronically published October 5, 2020.

Address correspondence to Emily Esmaili, Duke Hubert-Yeargan Center for Global Health, 310 Trent Drive, Box 90518, Durham, NC 27708 (bee6@duke.edu).

NC Med J. 2020;81(6):348-354. ©2020 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2020/81601

Carolina Triangle area, where the total number of refugees and their demographic characteristics vary each year. From 2010 to 2017, there was a gradual rise in resettlement arrivals in North Carolina, from 200 to approximately 400 per year [8]. However, recent policy changes by the Trump administration have contributed to a precipitous drop in resettlement arrivals, and in 2019, the North Carolina Triangle area experienced the lowest number of arrivals since the establishment of the Refugee Act in 1980 [9].

The aim of the present study is to gain a more comprehensive understanding of the health care services provided and the barriers faced by refugee children and families that drive health inequities in this population, and to provide recommendations for improving local health care access for refugees in the North Carolina Triangle area.

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.

APPENDIX A. Focus Group Interview Questionnaire

This appendix is available in its entirety in the online edition of the NCMJ.

Organization Surveys

Organizations providing services for refugees were identified using a directory from the North Carolina Department of Health and Human Services. Convenience sampling was employed to garner representation from a broad scope of organizations offering a variety of services for refugees in North Carolina. Some organizations focused on social determinants of health (e.g., health education, social services), while others provided acute or preventive health care. Email invitations were sent to 36 organizations to complete a 24-question Qualtrics online survey instrument; nine responses were received (25%). The survey consisted of multiple-choice questions addressing basic information about the organization (e.g., funding sources, employee composition), services provided (e.g., health screenings, oral interpretation services), and populations served (e.g., countries of origin, languages spoken). Organizations were also asked to respond to four open-ended questions about the specific barriers they face when serving refugees and the ways they have attempted to address them.

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).

Barriers to health care. Participants from all focus groups reported multiple challenges in accessing health care since their arrival to the United States (Table 2). Consistent themes included: difficulties with transportation, access to translators, clinic wait times, and the price of services. French-speaking participants also reported negative experiences at pharmacies, stemming from a lack of understanding of differences between prescriptions and over-the-counter medications. Participants were under the impression that they needed a new prescription for refills or purchasing drugs like Tylenol. Participants reported that newly arrived families typically have limited English proficiency and do not have a car for transportation. As a result, they rely on public transportation but must navigate this system without being able to communicate with bus drivers or other passengers to ask for directions. Van transportation provided by Medicaid was adjudged a helpful service but was often unreliable and could be difficult to access, particularly due to the language barrier in communicating with the operator and the need to schedule transportation well in advance.

With regard to oral interpretation services, participants reported that health clinics varied in their ability to provide interpretation assistance, their willingness to provide that support, and the quality of the services offered. Some participants felt they needed an English speaker to accompany them in order to receive appropriate care for their children. As one participant shared, "It's easy to get a French interpreter, but if you want to speak Sango...usually you have to bring a friend [who can interpret] with you." Participants also reported frequent challenges with telephone translation services, such as impatient translators or variations in dialect that hindered comprehension. One participant described their challenges in this way: "I can tell when something isn't translated well, so if it's not, I can request another translator with a different dialect."

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 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" "They have adapted very well."

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 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.

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%)

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 to 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 4.
Organization Responses to Open-Ended Questions (N = 7)

Domains and Categories	Frequency	Illustrative Quote
Challenges facing refugees in accessing health services		
<i>Transportation</i>	3	"Public transportation in Durham is fairly convenient, but many refugees find it daunting to use when going to new places. Community service providers arrange transportation when possible, but refugees become reliant on it and miss appointments if an issue arises."
<i>Finances</i>	3	"Some patients have difficulty getting off work to tend to costly medical issues."
<i>Language</i>	3	"Interpreters are not reliably available at primary care providers. Communication of diagnosis, treatment, and prognosis is difficult."
<i>Health care literacy</i>	5	"Some need more help to understand medication management."
<i>Cultural differences</i>	1	"Health beliefs and cultural differences play a huge role."
Steps being taken at organization to overcome barriers		
<i>Working with more interpreters</i>	4	"We are working with partnering agencies to train more interpreters."
<i>Fostering community partnerships</i>	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."
<i>Applying for grants</i>	3	"We have applied for pilot funding to assist patients with transportation expenses."
<i>Teaching health care literacy earlier</i>	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."
<i>Dedicated staff for health-related questions and care coordination</i>	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		
<i>Develop partnerships between resettlement agencies and medical providers</i>	7	"Medical providers gain expertise and the continuum of care is strengthened through working together."
<i>Increase funding</i>	2	"More funding is desperately needed."
<i>Lengthen resettlement period</i>	2	"We need comprehensive case management programs dedicated to assisting refugees with acculturation for at least 1-5 years after arrival."
<i>Improve interpretation services</i>	3	"Ensure that interpreters are trained in practice with refugee survivors of war trauma and sexual violence."

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**

Kelly Hunter graduate student, Sanford School of Public Policy and Department of Political Science, Duke University, Durham, North Carolina.

Brandon Knettel, PhD, MA assistant professor, Duke University School of Nursing and Duke Global Health Institute, Duke University, Durham, North Carolina.

Deborah Reisinger, PhD affiliate faculty in the Duke Global Health Institute and associate professor of the practice in romance studies, Duke University, Durham, North Carolina.

Pranav Ganapathy undergraduate student, Trinity College of Arts and Sciences, Duke University, Durham, North Carolina.

Tyler Lian undergraduate student, Trinity College of Arts and Sciences, Duke University, Durham, North Carolina.

Jake Wong undergraduate student, Trinity College of Arts and Sciences, Duke University, Durham, North Carolina.

Danielle Mayorga-Young undergraduate student, Trinity College of Arts and Sciences, Duke University, Durham, North Carolina.

Ailing Zhou undergraduate student, Trinity College of Arts and Sciences, Duke University, Durham, North Carolina.

Maram Elnagheeb undergraduate student, Trinity College of Arts and Sciences, Duke University, Durham, North Carolina.

Melissa McGovern research coordinator and administrative assistant to the director, Center for Health Policy and Inequalities Research, Duke University, Durham, North Carolina.

Nathan Thielman, MD, MPH professor of medicine and global health, Duke Global Health Institute, Duke University School of Medicine, and Duke Hubert-Yeargan Center for Global Health, Duke University, Durham, North Carolina.

Kathryn Whetten, PhD, MPH professor, Sanford School of Public Policy and Duke Global Health Institute; Director of Center for Health Policy and Inequalities Research, Duke University, Durham, North Carolina.

Emily Esmaili, DO, MA adjunct assistant professor of global health, Center for Health Policy and Inequalities Research, Hubert-Yeargan Center for Global Health, Duke University; and pediatrician at Lincoln Community Health Center, Durham, North Carolina.

Acknowledgments

This research was funded by Bass Connections, a Duke University initiative dedicated to inquiry across the disciplines. This study was approved by the Duke University IRB and conducted in accordance with its requirements and regulations. Our thanks go out to Carolina Outreach, North Carolina Refugee Health, Church World Service, Lincoln Community Health Center, and the Center for Child and Family Health. This study would also not have been possible without the generous input of participating refugee families.

Potential conflicts of interest. The authors have no conflicts of interest to declare in relation to this research.

References

1. Su D, Wang H, Michaud T, Toure D, Do K, Tak HJ. Acculturation and unmet health needs among refugees in Omaha, Nebraska. *J Immigr Minor Health*. 2018;1-7. doi: 10.1007/s10903-018-0723-8
2. Viruell-Fuentes EA. Beyond acculturation: Immigration, discrimination, and health research among Mexicans in the United States. *Soc Sci Med*. 2007;65(7):1524-1535. doi: 10.1016/j.socscimed.2007.05.010
3. Lincoln AK, Lazarevic V, White MT, Ellis BH. The impact of acculturation style and acculturative hassles on the mental health of Somali adolescent refugees. *J Immigr Minor Health*. 2016;18(4):771-778. doi: 10.1007/s10903-015-0232-y
4. Gookin D, Kawasaki M, Mason I, et al. Assessing Barriers to Health Care Access for New Americans. Public Health Projects, 2008-present. The University of Vermont website. https://scholarworks.uvm.edu/comph_gallery/255. Published 2018. Accessed September 2020.
5. Woodland L, Burgner D, Paxton G, Zwi K. Health service delivery for newly arrived refugee children: A framework for good practice. *J Paediatr Child Health*. 2010;46:560-567. doi: 10.1111/j.1440-1754.2010.01796.x
6. Fazel M. Psychological and psychosocial interventions for refugee children resettled in high-income countries. *Epidemiol Psychiatr Sci*. 2018;27(2):117-123. doi: 10.1017/S2045796017000695
7. Gadeberg AK, Montgomery E, Frederiksen HW, Norredam M. Assessing trauma and mental health in refugee children and youth: a systematic review of validated screening and measurement tools. *Eur J Public Health*. 2017;27(3):439-446. doi: 10.1093/eurpub/ckx034
8. World Relief Durham. 2016 WRD Statistics: A Glimpse into Refugee Resettlement in Durham. World Relief Durham website. <https://worldreliefdurham.org/refugeesunday>. Accessed September 2020.
9. Walden J, Sienkiewicz H. Immigrant and refugee health in North Carolina. *N C Med J*. 2019;80(2):84-88. doi: 10.18043/ncm.80.2.84
10. Birks M, Chapman Y, Francis K. Memoing in qualitative research: Probing data and processes. *J Res Nurs*. 2008;13(1):68-75. doi: 10.1177/1744987107081254
11. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Qual Quant*. 2002;26(4):391-409.
12. Morris MD, et al. Healthcare barriers of refugees post-resettlement. *J Community Health*. 2009;34:529. doi: 10.1007/s10900-009-9175-3
13. Walden J, Valdman O, Mishori R, Carlough M. Building capacity to care for refugees. *Fam Pract Manag*. 2017;24(4):21-27.
14. Chaves N, Paxton G, Biggs B, et al. Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds. *Med J Aust*. 2017;206(7):310-315. doi: 10.5694/mja16.00826
15. Center of Excellence for Integrated Health Solutions website. <https://www.integration.samhsa.gov/clinical-practice/trauma-informed>. Accessed January 2, 2020.
16. Mejia C. The echo in the room: Barriers to health care for immigrants and refugees in North Carolina and interpreter solutions. *N C Med J*. 2019;80(2):104-106. doi: 10.18043/ncm.80.2.104
17. Walker P, Barnett E, eds. *Immigrant Medicine*. 1st ed. Philadelphia, PA: Saunders; 2007.
18. Lyda-McDonald B. Partnering to improve health: Developing accountable care communities in North Carolina. *N C Med J*. 2019;80(2):124-127. doi: 10.18043/ncm.80.2.124
19. McNeely CA, Morland L. The health of the newest Americans: How US public health systems can support Syrian refugees. *Am J Public Health*. 2016;106(1):13-15. doi: 10.2105/AJPH.2015.302975
20. Plumb E, Knettel B, Fogg M, Owens E, Walinsky S, Plumb J. Envisioning Home: The Philadelphia Refugee Mental Health Photovoice Project as a Story of Effective Relationship Building. In: *Creating Social Change Through Creativity: Anti-Oppressive Arts-Based Research Methodologies*. 2018:331-352. doi: 10.1007/978-3-319-52129-9_18