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Identifying the Physical Health Needs of Refugee and Asylum-Seeking Clients at the Center for Victims of Torture in Atlanta, GA: A Special Studies Project

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2018

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An abstract of
A thesis submitted to the Faculty of the
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Abstract

Identifying the Physical Health Needs of Refugee and Asylum-Seeking Clients at the Center for Victims of Torture in Atlanta, GA: A Special Studies Project

By Kayla M. Johnson

Introduction: This special studies project is an expansion of a Rapid Community Health Assessment (RCHA) that was conducted for the Center for Victims of Torture (CVT) in Atlanta. CVT Georgia serves clients who are either refugees or asylum seekers who have experienced torture. The Center for Victims of Torture (CVT) provides rehabilitation care to address the mental and emotional sequalae of the traumatic experienced by survivors of torture. Many survivors of torture experience physical sequalae as well however the unmet physical needs of CVT clients is unknown. The objective of this study was to identify the physical health needs of clients, as well as barriers and facilitators to accessing care.

Methods: This study employed a mixed methods survey to explore clients' physical health needs. The survey tool was designed using a community-engaged research (CEnR) approach in order to meet the needs outlined by the partner organization. Descriptive statistics were used to analyze quantitative survey results and qualitative analysis was used to analyze qualitative results.

Results: Survey results were obtained from 12 CVT clients. Demographics of the respondents included a total of seven asylum seekers and five refugees, 11 countries represented among the respondents, and seven of the 12 respondents required interpretation. All clients reported challenges with accessing healthcare for their physical needs as well as barriers to obtaining, managing and understanding health insurance. The majority of respondents evaluated their physical health as either average health (5/12) or very poor health (4/12). Chronic pain and chronic headaches were the most identified chronic health issue among respondents.

Conclusion: In order to improve unmet physical health needs, CVT should consider: 1) Conducting regular assessments of physical health needs of clients as well as long-term follow ups for identified chronic health problems, 2) Advocating for funding to provide financial assistance to clients for services and prescription medication, 3) Referring or providing in house social work/case management services that can assist clients with obtaining health insurance when appropriate.

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Chapter 1: Introduction

Introduction and rationale

This special studies project is an expansion of a Rapid Community Health Assessment (RCHA) that was conducted for the Center for Victims of Torture (CVT) in Atlanta by a team of Master of Public Health students from the Rollins School of Public Health at Emory University during the Fall of 2020. The RCHA team included the author of this study project, Ms. Kayla Johnson. The assessment was focused on CVT's asylum seeking clients and findings suggested this group of the client population did not have appropriate access to physical health services, especially for chronic pain conditions. The RCHA documented many barriers to accessing care for the asylum-seeking population, mainly cost of care and being unsure of where to receive care. The RCHA also documented that many clients connected their physical health issues to their past trauma.

CVT is an international non-profit organization that was founded in 1985 as the International Clinic of St. Paul Ramsey Medical Center, in Minnesota. Since its founding, it has expanded globally to serve countries in Africa and the Middle East. In 2016, CVT expanded to Atlanta, Georgia to serve and assist refugees and asylum seekers in their process of resettlement. CVT Georgia currently serves approximately 30 to 50 clients who are either refugees or asylum seekers who have experienced torture. The CVT in Georgia provides rehabilitation care that incorporates psychotherapy to address the mental and emotional sequalae of the traumatic experiences that their clients have been through. CVT also provides its clients with the assistance of a case manager to help them gain access to necessary services meant to aid in the improvement of their mental and physical health, as well as in the process of resettlement. While

CVT Georgia works to provide comprehensive mental health services to their clients, they do not currently have services that address their physical health needs.

Although not often clear to the general public, refugees and asylum seekers are defined by immigration laws in the U.S. as two distinct types of immigrant statuses. Both types are characterized by seeking refuge and escaping persecution, or fear of persecution, in their home countries. However, refugees are granted legal status prior to arrival whereas asylum seekers arrive with varying levels of temporary status and must apply for asylum upon entry into the U.S. The differentiation in the immigration status of these two groups has important consequences related to access to healthcare and other social services.

Many refugees and asylum seekers are often survivors of torture, adding another layer of complexity to their healthcare needs (Quiroga & Jaranson, 2005). Thus, it is important to understand the intricate processes refugees and asylum seekers experience prior to arrival to the U.S., upon entry, and after arrival, and how these processes impact their physical, mental, and emotional health.

This project produced a list of programmatic recommendations for CVT Georgia to aid in the development and improvement of the services they offer related to their clients' physical health needs. This was done through the refinement and administration of a previously created survey tool used to identify of the unique physical healthcare needs that CVT's population has.

Problem statement

Many refugees and asylum seekers in the United States face personal and systematic barriers to accessing healthcare services. Governmental policies restricting health insurance coverage for those without legal status result in challenges to accessing and receiving healthcare.

As a consequence, many survivors of torture living in the U.S. have unmet mental and physical healthcare needs (Utržan & Northwood, 2017) .

While CVT Atlanta provides mental health services, they do not currently provide physical health services to their clients. Given the significant systemic barriers for refugees and asylum seekers to obtaining appropriate healthcare, many clients at CVT have ongoing and unmet physical health needs that can negatively impact their mental health, highlighting the importance of addressing both physical and mental health needs. Without understanding underlying physical health needs, CVT is unable to help their clients achieve a higher quality of life. It is hoped that the information gathered from this special studies project would help not only CVT but other organizations that serve refugees and asylum seekers who are victims of torture to develop comprehensive health programing, obtain new sources of funding, and address all health needs of their clients.

Purpose statement

CVT Georgia supports their clients by providing mental health and rehabilitation services for the trauma they have endured. The purpose of this research project was to collect primary data to aid CVT in program development. Primary data collected was analyzed to identify physical health needs, as well as barriers and facilitators to accessing healthcare and to develop recommendations for the organization on how they can address the physical health needs of their clients programmatically through healing, training, and advocacy.

Study Goal and Objectives

Goal: To develop a list of programmatic recommendations that aim to address the physical healthcare needs of refugee and asylum-seeking clients through healing, training, and advocacy

Objective 1: Further develop and administer a culturally appropriate, mixed methods survey informed by the literature and a previous RCHA to gather primary data on the physical health needs of refugee and asylum-seeking clients.

Objective 2: Identify common physical healthcare needs of refugees and asylum seekers as well as unique physical healthcare needs of victims of torture.

Significance statement

This research will contribute to the body of literature on refugee and asylee health in the U.S.. It will also contribute to the growing body of literature about victims of torture and their needs as an under-resourced, but growing, population. Additionally, the programmatic recommendations provided could help CVT to better address the full spectrum of needs identified by their clients. Information collected through this project could also be used by CVT and similar organizations to support advocacy efforts on behalf of the refugee and asylum-seeking populations. More specifically, it is hoped that results from this special study project will aid CVT Atlanta in applying for funding to expand the services they provide. Finally, the recommendations have the potential to be used by CVT locations outside of the Atlanta area.

Chapter 2: Background and Literature Review

Overview of Refugee and Asylum Seeking Populations in the United States

Every year, thousands of refugees and asylum seekers enter the U.S. to seek refuge, escaping persecution, or fear of persecution, in their home countries. Many individuals who flee have faced unimaginable challenges that result in unmet physical and psychological needs. However, access to healthcare services in the U.S. can be limited depending on their location of resettlement, leaving many with undiagnosed and untreated health problems. The process of resettlement for both refugees and asylum seekers can be long and arduous with many individuals residing in unstable locations while in transition, with ongoing and new challenges upon entry into the U.S. (American Immigration Council, 2020b).

The U.S. operates one of the world's largest refugee resettlement programs, resettling more refugees than any other country (United Nations High Commissioner for Refugees, n.d.). Since the Refugee Act of 1980, the U.S. has resettled over 3.1 million refugees (U.S. Department of State, n.d.). The annual number of refugees resettled reached a maximum in 1990 at 122,066. Numbers peaked again in 2016 at 84,988 under the Obama administration. Over the last four years, the number of refugees resettled has drastically decreased; however, the estimate for future years will likely reach pre-2016 numbers. The state of Georgia has welcomed refugees for many years, having one of the highest resettlement rates in the U.S. in 2019 (Baugh, 2020).

Definitions and Distinction of Terms and Processes in the United States

While many people may use the terms refugee, asylum seeker, and asylee interchangeably, they are not. Understanding these distinctions will better illustrate the challenges individuals face during the different pathways to citizenship.

Refugees

The U.S. government is legally obligated to provide protection for those who qualify as refugees, as this group is defined and protected in international and U.S. law (American Immigration Council, 2020a; U.S. Citizenship and Immigration Services, 2015). The legal definition for 'refugee' that is recognized by the U.S. is described in section 101(a)(42) of the Immigration Nationality Act (INA) which defines a refugee as:

> *"someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion." (American Immigration Council, 2020a)*

Refugee status is a form of protection granted to individuals who meet the above definition (U.S. Citizenship and Immigration Services, 2015). Individuals applying for refugee status can only seek a referral for refugee status outside of the U.S. (U.S. Citizenship and Immigration Services, 2015). Refugees are identified by the U.S. government in partnership with United Nations High Commissioner of Refugees (UNHCR) while they are living abroad in camps, settlements, or cities (Harris, 2016). A refugee is someone who is not firmly resettled in another country and would otherwise be admissible to enter the US (U.S. Citizenship and Immigration Services, 2015). Those applying for refugee status must demonstrate that they have been persecuted or fear serious harm due to race, religion, or other reasons (U.S. Citizenship and Immigration Services, 2020b). In 2016 the Department of State reported that the process for refugees to be admitted to U.S. can take up to 18 –24 months (American Immigration Council, 2020b).

Asylum seekers & Asylees

Asylum is "*protection granted to foreign nationals who are already in the U.S. or arriving at the border or port of entry*" and meet the international definition of refugee recognized by the U.S. (American Immigration Council, 2020a). In summary, an asylum seeker is someone who meets the same definition of a refugee, has fled their country of origin, and is already present in the U.S. when applying for asylum status (Baugh, 2020). Regardless of whether they have counsel to represent them during the process, those applying for asylum must show that they meet the earlier quoted definition of a refugee (American Immigration Council, 2020a). Individuals seeking asylum must apply within 1 year of their arrival to the U.S. or establish an exception (Baugh, 2020).

There are generally two ways an individual can apply for and be granted asylum -- through affirmative asylum or defensive asylum (American Immigration Council, 2020a). Affirmative asylum is for those who have arrived in the U.S. on a legal permit, such as a visa, and are not in removal proceedings. They would submit an application for asylum through U.S. Citizenship and Immigration Services (USCIS), a division of the Department of Homeland Security (DHS) (Baugh, 2020). There were 96,952 affirmative asylum filings with USCIS in 2019 (Baugh, 2020). Asylum seekers may arrive on different visa statuses such as tourist, student, or other visas. However, in trying to acquire a visa, expressing fear of return to their country would suggest "immigrant intent", making them ineligible for most visas to the U.S., thus potentially prolonging the process of reaching their destination, and possibly requiring them to reach their destination in less safe ways (Harris, 2016).

Those who arrive through a port of entry without inspection generally must apply for defensive asylum (American Immigration Council, 2020a). Defensive asylum is for those in

removal proceedings and is done through the Executive Office for Immigration Review (EOIR) in the Department of Justice by an immigration judge. This type of asylum procedure also applies to individuals whose asylum applications have been denied and now must renew their application defensively to remain in the U.S. (American Immigration Council, 2020a). Asylum seekers face forcible deportation if their case is denied by the U.S. Government (Utržan & Northwood, 2017) and tragically for many, especially victims of torture, a forced return to their home country can be life threatening and even considered a death sentence (Utržan & Northwood, 2017).

As previously mentioned, asylum seekers must apply for asylum within one year of their arrival to the U.S. (Baugh, 2020). There can be systematic barriers to meeting the deadline to apply for asylum, jeopardizing their ability to remain in the US (American Immigration Council, 2020a). Additionally, the asylum process can take years to conclude, delaying important resources and benefits for this group (American Immigration Council, 2020a). Once an asylum seeker arrives in the U.S. and applies for asylum, they must wait for their application to be processed for legal proceedings, which includes a hearing that can take years to schedule and conclude (Utržan & Northwood, 2017). The U.S. government does not provide an estimated timeline for legal proceedings, but historically the asylum process can take up to four years (American Immigration Council, 2020a). In 2015, only 30% of asylum-seeking applicants received an interview; 53% had wait times for processing applications of one to two years or more (Utržan & Northwood, 2017).

The term asylum seeker should not be confused or interchanged with the term asylee. An asylee is someone who has officially been granted asylum and is protected from being returned to their home country (Harris, 2016). While asylum seekers have severely limited protections

during the asylum-seeking process, asylees have similar protections as refugees (American Immigration Council, 2020a), (Harris, 2016). One year after being granted asylee status, asylees can apply for permanent residence and subsequently for U.S. citizenship, after four years of having a permanent resident status (American Immigration Council, 2020a).

United States Work and Health Insurance Policies for Refugees and Asylum Seekers

Newly admitted refugees gain access to important services through the Refugee Admissions Program (RAP) including six to eight months of refugee Medicaid, limited financial assistance, and short-term housing and employment assistance (American Immigration Council, 2020b). These benefits are vital in supporting refugees during the resettlement process. Those who are granted refugee status can work immediately upon arrival to the U.S. and are eligible for medical and cash assistance upon arrival as well (U.S. Citizenship and Immigration Services, 2015). Refugees receive initial resettlement assistance, work authorization, as well as legal assistance to help them reunify family (Utržan & Northwood, 2017).

Asylum seekers, however, are not eligible for resettlement assistance or benefits (Utržan & Northwood, 2017). Unlike refugees who receive travel loans to come to the US, asylum seekers flee to the US at their own expense, financially and otherwise (Harris, 2016). Adding to the financial stress, asylum seekers are not permitted to apply for work authorization at the same time they apply for asylum (U.S. Citizenship and Immigration Services, 2020a). Policy in previous years stated that asylum seekers could apply for work authorization after their case has been pending for 150 days or longer (American Immigration Council, 2020a). However, recent changes under the Trump Administration have extended the period before an individual can

apply for work authorization to 365 days (Immigrant Law Center of Minnesota, 2020; U.S. Citizenship and Immigration Services, 2020a).

Because of these policies, asylum seekers face limited access to public services including food, housing, employment, transportation and healthcare (Utržan & Northwood, 2017). However, if granted asylum by the US government, asylees may then apply for a social security card, request permission to travel overseas, petition to have their family brought over, and be eligible for government programs like Medicaid or Medicare (American Immigration Council, 2020a).

Health Insurance

The Office of Refugee Resettlement (ORR) is responsible for funding and administering programs to aid in the process of resettlement for refugees and asylees (Office of Refugee Resettlement, 2019). In terms of health insurance, refugees receive short-term health insurance called refugee medical assistance (RMA) which is available to them for up to 8 months (ORR, 2019). While many other immigrant groups have to wait over five years before they are eligible for benefits like Medicaid, refugees who are admitted to the US meet the immigration status eligibility requirement for immediate access to Medicaid, Children's Health Insurance Program (CHIP), and marketplace insurance under the Affordable Care Act (ACA) (Office of Refugee Resettlement, 2013). However, acquiring health insurance after RMA expires can be challenging due certain barriers refugees may experience when adapting to a new country such as a lack of knowledge or understanding of a new and complex healthcare system.

A 2016 study found that 40% of refugees resettled in states that did not expand Medicaid, creating unanticipated gaps in access to affordable insurance for refugee populations (Agrawal & Venkatesh, 2016). Another study found that refugees who have been in the U.S. for 3 –5 years

were less likely to have insurance than those who had been in the U.S. for 3 years or less (Su et al., 2019). Su et al. concluded that this is most likely due to refugees lacking assistance in obtaining alternative and affordable forms of health insurance after RMA runs out. Research has continuously shown that the health needs of this population go beyond the eight month period of coverage that RMA provides. Based on findings among other immigrant groups, access to healthcare tends to resemble that of native-born U.S. citizens over time; however, this was not the case for refugees. Health literacy, language barriers, and limited knowledge of the U.S. healthcare system were all identified as barriers to enrollment in insurance plans (Su et al., 2019).

While asylum seekers are not immediately eligible to receive services through ORR or other government programs like Medicaid or marketplace insurance, they may be eligible if they are granted asylum (Administration for Children and Families, 2012; Office of Refugee Resettlement, 2013). Individuals can receive limited cash and medical assistance for up to 8 months from the date they are granted asylum (Administration for Children and Families, 2012).

Trauma and Torture Survivors

Amnesty International has defined torture as "*when a person or group of people in an official capacity inflicts severe mental or physical pain or suffering on someone else for a specific purpose*" (Amnesty International, n.d.). Torture can be inflicted by governments, community groups, political groups, and religious groups and used to extract information from individuals or to spread fear in a community to generate oppression and compliance (Amnesty International, n.d.). Torture methods can vary from physical to psychological to sexual, all leaving the victim with lasting scars mentally, emotionally, and physically (Amnesty

International, n.d.). CVT has found that the most common forms of torture reported by clients are beatings and psychological torture (Center for Victims of Torture, n.d.). Torture can occur anywhere and despite laws protecting people from such heinous acts, at least 141 countries from every part of the world have reported acts of torture (Amnesty International, n.d.).

Many individuals who flee to the U.S. have experienced torture or other "displacement related trauma" (Utržan & Northwood, 2017). It's hard to determine the exact number of torture survivors currently living in the U.S. that entered through the refugee resettlement process or are seeking asylum. Measuring the prevalence of and knowing the exact number is challenging given the complexity of the population and the sensitivity of their past experiences (Higson-Smith, 2015). In 2015, CVT performed a systematic review to update the prevalence of torture victims in the U.S., estimating that there may be as many as 1.3 million torture surviving refugees in the US; a number more than three times higher than the previously reported (Higson-Smith, 2015).

A cross-sectional epidemiological study conducted in Minnesota explored the prevalence of torture among Somali and Ethiopian resettled refugees (Jaranson et al., 2004). The study surveyed a sample of 1134 participants to assess torture techniques, traumatic events, social, physical, and psychological issues, including symptoms of posttraumatic stress disorder (PTSD). The survey was administered by staff with experience in healthcare or interviewing and backgrounds in relevant or related fields. Researchers identified that all but six participants reported having traumatic experiences, with a prevalence of torture as high as 69% among Oromo (Ethiopian) men and 47% among Somali women, with torture survivors having more health issues like PTSD and related symptoms such as depression and anxiety (Jaranson et al., 2004).

Healthcare Needs of Torture Survivors

Torture has been shown to be a strong predictor of a wide range of long lasting and encumbering physical and mental health issues (Quiroga & Jaranson, 2005). CVT reports symptoms of torture can include chronic pain in muscles and joints, headaches, sleep disorders, stomach pain, severe depression and anxiety, PTSD and thoughts of suicide (Center for Victims of Torture, n.d.). Many resettled victims require significant and specialized healthcare services to appropriately address the residual effects of these traumatic experiences (Higson-Smith, 2015). Refugees who report experiences of torture are four times more likely to suffer from PTSD and 2.5 times more likely to suffer from depression (Steel et al., 2009).

Many asylum seekers, especially torture victims, have not received any healthcare or social services for extended periods of time, both before and after arriving in the U.S., due to various barriers (Utržan & Northwood, 2017). According to Utržan and Northwood, research has found a strong correlation between having legal authorization to remain in the U.S. and an improvement in mental health issues (2017). As asylum seekers have limited access to mental health services during the asylum-seeking process, their psychological needs may go unaddressed, and may potentially be exacerbated by the stress of their immigration status.

A review of the literature done in 2005 by Quiroga and Jaranson highlighted a number of considerations specific to healthcare needs of torture survivors, including a high prevalence of chronic pain that is underdiagnosed and undertreated and understanding whether chronic pain begins before or after experiences of trauma or torture. Relatedly, this review found that the long term psychological sequalae of torture may be more persistent than the physical sequalae (Quiroga & Jaranson, 2005). While it is imperative that survivors of torture receive tailored and

comprehensive mental health services, it is equally important that they receive quality medical care for physical sequalae of trauma and or torture.

Barriers to Healthcare for Refugees and Asylum Seekers

Common barriers to accessing healthcare services among refugees and asylum seekers include language, transportation, lack of insurance, cultural differences, and knowledge of the U.S. healthcare system (Su et al., 2019). A study using Community Based Participatory Research (CBPR) methods explored barriers to accessing healthcare impacting refugees with chronic health problems (Mirza et al., 2014). The barriers identified in this study were lack of health insurance or inadequate coverage, language and communication, and complexity of service systems. It has also been found that being able to access healthcare is important for this population, as refugees and asylum seekers, especially torture victims, are more likely to immigrate with pre-existing conditions and health problems due to the circumstances of their migration (Mirza et al., 2014).

Mental health, stigma, and immigration status are also among other important barriers to healthcare. A 2011 study identifying barriers among asylum seekers found mental illness to be an obstacle to obtaining healthcare (Asgary & Segar, 2011). Stigma of sharing experiences of abuse and torture, mistrust of medical providers, fear of deportation, detention, or loss of legal status also act as barriers to accessing care (Asgary & Segar, 2011). Other barriers identified in this study included navigating a new health system, lack of community support, affordability, cultural and linguistic differences, prioritization of needs, and resettlement stressors (Asgary & Segar, 2011).

Addressing Health Needs of Victims of Torture

In order to best address the complex health needs of refugees and asylum seekers who have experienced torture, barriers to care must be addressed at multiple levels – system, provider, and individual (Asgary & Segar, 2011). Effective practices show that human rights clinics could work to educate providers on the special needs of populations (training providers to screen for history of abuse and torture), while advocacy organizations can work closely with populations to build a sense community and connect them to resources (Asgary & Segar, 2011). A study done in 2010 sought to identify best programmatic practices for mental health interventions among refugee populations and found that targeting culturally similar client samples to be the most effective, demonstrating positive outcomes on traumatic stress and anxiety reduction (Murray, Davidson, & Schweitzer, 2010). Community-based interventions that facilitate growth and change, both personal and at the community level, were also identified as promising practices (Murray et al., 2010). Additionally, training staff to have a comprehensive understanding of the diverse cultures the organization serves as well as implementing long-term interventions that work in partnership with refugee and asylum seeking clients through the stages of resettlement, are also encouraged (Murray et al., 2010).

Chapter 3: Methodology

The purpose of this special studies project was to collect data from the clients at CVT in Atlanta about their healthcare needs, access to healthcare, and barriers to care. The data collected was used to develop a list of programmatic recommendations for CVT to utilize in order to develop three main aspects of their organization and the services they provide – healing, advocacy, and training. Using a community-engaged research (CEnR) approach in order to meet the needs outlined by the partner organization, this project employed a mix of qualitative and quantitative methods for data collection and analysis.

Population and Sample

The study population consisted of the CVT Atlanta client base, who are asylum-seeking individuals and refugees. A total of 12 mixed methods surveys were able to be completed with CVT clients. Survey participants consisted of even numbers of men and women, seven asylum seekers, five refugees, and English speakers and non-English speakers. Participants were recruited based on their availability and attendance at scheduled CVT therapy sessions, and the matching availability of the researcher.

Procedures

The researcher collaborated with CVT staff to outline the goal, objectives, and aims for the project. Based on the specified goal and objectives, the researcher refined an existing survey tool to collect the requested data about clients' physical health. The final research tool was reviewed and approved by CVT staff before data collection began.

The researcher was not permitted to interface with clients outside of survey administration. The researcher partnered with CVT's client services coordinator to schedule a time and day for survey administration based on regularly scheduled therapy appointments of the clients. Because many clients at CVT have weekly therapy sessions, if they could not make the scheduled appointment for survey administration it would be rescheduled for the next week. Given the transient nature of the clients, some appointments were not able to be rescheduled within the data collection period.

Due to COVID-19 safety standards, the surveys were administered through a virtual, video interview format via Zoom video chat platform. Once the appointment had been scheduled and confirmed with the researcher, CVT's client services coordinator would share the Zoom login information with the researcher via email. Survey Zoom sessions were conducted immediately after CVT therapy appointments finished, at which point the researcher would log into the video call and the CVT therapist would exit the session and allow for the survey to be conducted by the researcher. If a CVT language interpreter was required, they would be present for the survey. Survey data was collected over five weeks during the months of February to March 2021.

A data-use agreement was developed prior to data collection and signed by the researcher, establishing that all data collected belongs to CVT. The survey responses were recorded on an electronic copy of the survey. All survey data was kept by the researcher in a secure folder via Microsoft OneDrive. All files required a password and could only be accessed by the researcher. Once the research project concluded, the researcher transferred the collected survey data to CVT partners to no longer be used by the researcher. All data was permanently erased from the researcher's online files once the project concluded.

Data Collection Instrument

The data collection instrument for this research project was a mixed methods survey, incorporating quantitative and qualitative questions. The instrument used was the second iteration of the original survey instrument that was created for a RCHA done in the Fall of 2020 and was updated for the purpose of this project, based on what was found in the RCHA as well as CVT's priorities. This project sought to improve the original survey instrument.

The survey tool consisted of 20 questions and was designed to be administered in 30 minutes or less, including language interpretation. The survey was split into five sections based on specific topic areas: Section A: Introductory questions, Section B: Physical healthcare needs, Section C: Health seeking behaviors, Section D: Barriers and enablers, and Section E: Open-ended questions. Introductory questions asked about demographics, moving into more area specific questions related to physical health needs as the survey continued (see Appendix A). The number of open-ended, qualitative questions was be kept to a minimum at the request of the organization.

Data Entry & Analysis

During survey administration, data was collected on an electronic copy of the survey. For privacy and sensitivity reasons, the conversations with the research participants were not recorded. The researcher took detailed notes of responses given by the participants for each interview using the notes section of the survey guide. Each research participant was assigned a respondent ID number based on the day and time of the interview.

Once data collection was completed, survey data was be entered into an Excel spreadsheet. The researcher used Microsoft Excel to analysis survey qualitative and quantitative

results. The survey data was triangulated with findings from published academic literature, as well as with data owned by CVT.

Ethical Considerations

This special studies project was determined to be exempt from review by the Emory University Institutional Review Board (IRB). Verbal consent was obtained from each participant at the beginning of the survey. All participants were read a statement of purpose for the project and survey procedures. All participants were made aware of their right to refuse to answer any questions or stop the survey at any time without reason. To discourage response bias, participants were informed that their responses would not impact the services they receive from CVT. Research participants were not asked any identifiable information during the survey.

Limitations

The research project did encounter some limitations. Based on discussions with CVT staff, the organization served about 31 clients as of February 2021. Given the total number of served clients, this project intended to collect 20 – 25 surveys to ensure a representative sample of the population. However, due to unforeseen logistical difficulties in recruiting participants, the intended number was not met. Additionally, because the responses of participants could not be tape-recorded, there may have been information missed by the researcher while taking notes during survey administration. Lastly, the information from this project may not be generalizable to the greater asylum seeking, refugee, or torture victim community given the small sample size as well as the specific location of the project. The responses gathered from participants were

limited to those living in the Atlanta area. The convenience sample decreases the generalizability of the findings.

Programmatic Recommendations

The study was designed to identify, develop, and deliver a list of programmatic recommendations to CVT based on the survey data and addressing their three main organizational components – advocacy, healing, and training. The recommendations were rooted in evidence-based approaches and identified promising practices.

Chapter 4: Mixed Methods Survey Results

Demographics

Of the 12 respondents surveyed, seven were refugees and five were asylum seekers. There were five different languages spoken among the respondents – Arabic, English, Portuguese, Spanish, and Tigrinya. Several respondents who spoke English also spoke another language but chose to respond to the survey in English without the use of an interpreter. There were 11 countries represented among the respondents – Brazil, Cameroon, Equatorial Guinea, Eritrea, Guatemala, Honduras, Iraq, Jamaica, Mexico, Sudan, and Syria. Participants identified four counties of residence based on survey responses – Cobb, Dekalb, Fayette, and Houston. The number of years respondents have lived in the U.S. ranged from six months to 23 years. There were six participants that identified as female and six that identified as male. A total of seven asylum seekers and five refugees were surveyed.

Demographic Characteristic	Number of Participants (n)
Gender	
Male	6
Female	6
Immigration Status	
Asylum seeker	7
Refugee	5
Language Spoken	
Arabic	2
English	5
Portuguese	1
Spanish	3
Tigrinya	1
Counties of Residence	
Dekalb	9
Houston	1
Fayette	1
Cobb	1

Table 1: Demographic characteristics of 12 survey participants

Introductory and General Questions

When asked about their current employment status there was an equal distribution of answers among respondents; four respondents worked full time, four worked part time, and four were not currently working. When asked to rate their physical health, the majority of respondents evaluated their physical health as either average health (5/12) or very poor health (4/12). The remaining respondents evaluated their health as good health (2/12) and somewhat poor health (1/12). No one of the respondents selected excellent health.

What is your current work status?	**Count**
(1) Full time	4
(2) Part time	4
(4) I am not currently working	4

Table 2: Employment status of respondents

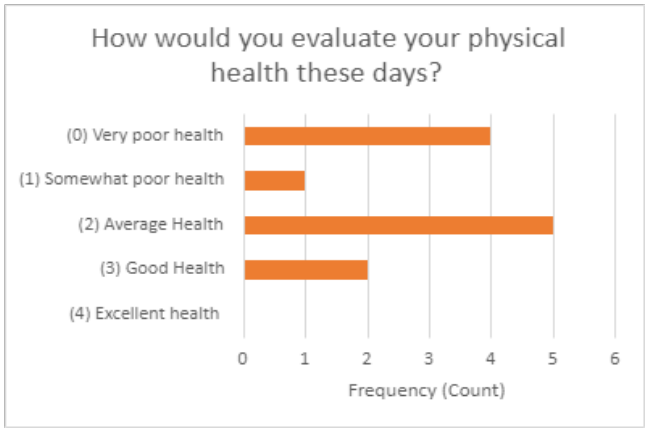

Figure 1: Self-evaluation of physical health

In the first section of the survey, participants were asked a series of open-ended questions about their health. Respondents were asked to describe what health means to them. The themes identified were: positive feelings about their health, the absence of illness, feelings of health

being of high importance, negative feelings towards their health, and mention of mental and emotional health in addition to physical health. When asked what concerns they had about their physical health, themes identified were: specific physical health issues, nutrition, feelings of overall worry about their health, stress, and mental and emotional health. Participants were then asked what makes them happy or hopeful about their health. The themes identified were specific physical activities, feelings of happiness about their health, optimism regarding their current and future health status, and the possibility of better health.

Qualitative Question	Themes Identified	Sample Quotes
What does health mean to you? What do you think of when you hear the word health?	Positive feelings	*I feel everything should be alright*
	Absence of illness	*Being strong and not being sick*
	Feelings of importance towards health	*Health is everything, being healthy is being functional, having a better life, less stress. If you're healthy you can reach anything, is above all.*
	Negative feelings	*It means I have a lot of stuff to do, too much stress, too much bad stuff.*
	Mental and emotional health	*When I'd think of health I think of physical health and also mental health or psychological; I think of my physical person.*
What makes you concerned about your physical health?	Specific physical health issues	*My blood pressure being too high.*
	Nutrition	*What kinds of foods to put in my body.*
	Feelings of worry	*I really don't understand myself; I'm lost and not even understanding what wrong with me.*
	Home-life Stress	*I've been having a hard time. I was working full time, now after COVID I'm a full-time mom and I can't leave for work. I have kids that are doing class online and I have to be home to help my kids.*
	Mental and emotional health	*A lot. I have a lot of concerns; mainly mental and emotional health and my personal health – men's health – and depression.*
What makes you happy or hopeful about your health?	Physical Activities	*I've been working out so that makes me hopeful because I didn't think I was going to like working out.*
	Feelings of Happiness	*Happy when I find the time to put to myself to fix things that make me stressed. I feel happy.*
	Optimism Regarding Health Status	*In general, our diet is 90% healthy so this is that makes me feel good and optimistic about my physical health*
	The Possibility of Better Health	*I'm happy that I don't have worst health conditions like cancer. The hope of getting health back to where it was before*

Table 3: Qualitative themes and responses

Chronic Health Issues

When asked about chronic health problems experienced, all respondents expect for one identified at least one or more chronic health problems. Chronic pain and chronic headaches were each identified by half of the respondents, four respondents identified high blood pressure, four respondents identified trouble walking, three respondents identified heart related problems, five respondents identified other chronic health problems not listed in the survey, and one respondent did not identify any chronic health issues. Locations of chronic pain identified by respondents included knees, face, full body, joints, and waist area. Other chronic issues identified by respondents include stomach aches, high cholesterol, hernia of the stomach, chronic cough due to past COVID-19 diagnosis, diabetes, anemia, vitamin D deficiency, low blood pressure, and improper circulation of blood in the body.

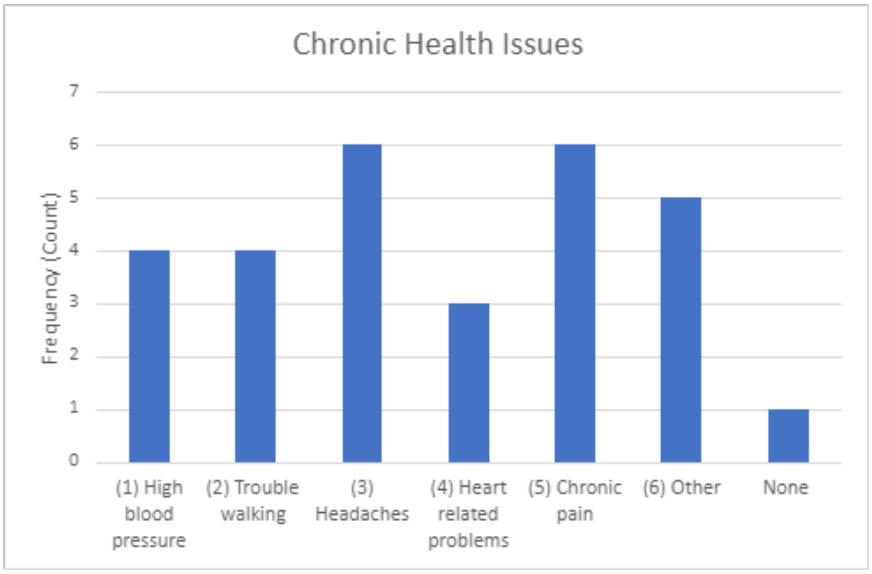

Figure 3: Chronic health issues identified by respondents

Self-Maintenance of Physical Health

Using a multiple-choice option, participants were asked what actions they take to maintain their physical health since living in the U.S. Eight respondents said they take vitamin supplements, eight respondents said they eat healthy, seven respondents said they do physical activity, and three respondents identified other actions they partake in. When survey respondents chose the response option "other actions" they identified the following actions: sitting in the sun, sanitizing everything, taking prescription medications, and going on walks. When asked if they feel the actions they take are effective in treating their health issues, eight respondents said yes, two respondents said no, and two respondents said they were unsure.

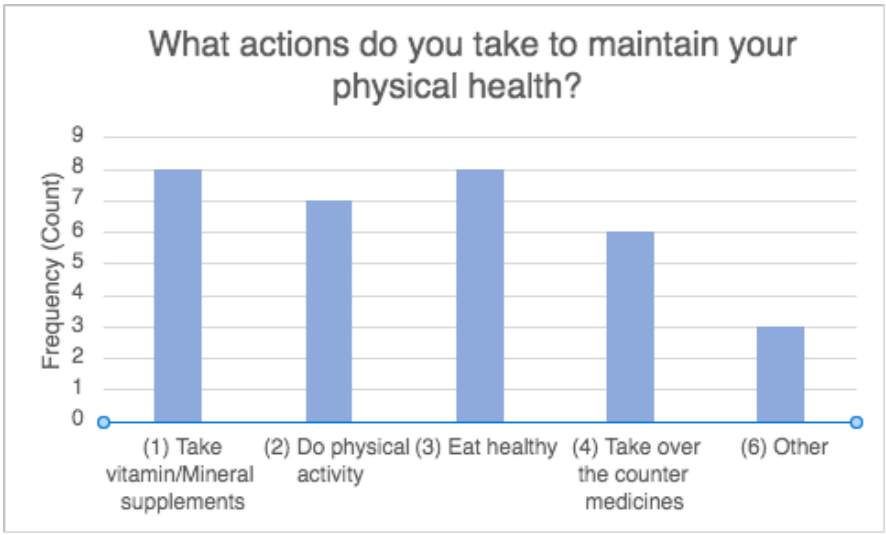

Figure 4: Actions taken to maintain physical health

Do you feel the actions you take are effective in treating your health issues?	Count	Percent
(2) Unsure	2	17%
(1) Yes	8	67%
(0) No	2	17%

Table 2: Perceived effectiveness of self-maintenance actions to treat health issues

Access to Care and Health Seeking Behaviors

When respondents were asked if they ever felt unable to access the care they need in the U.S., seven respondents said yes and five said no. Respondents were also asked a multiple-choice question about where they go when they need medical attention for something that is not an emergency. Six respondents said they would go to a family doctor or primary care physician (PCP), four respondents said they would go to a friend or family member, three respondents said they would go to an organization that serves asylum seekers and refugees, two respondents said they would not seek medical attention, one respondent said they would go to the emergency room, and one respondent selected "other", specifying that they would go to a Hispanic clinic nearby. When respondents were asked where they would go in the event of an emergency, the multiple-choice responses included going to a family member, going to a specific clinic or PCP, calling 911, going to the hospital, or they have never had an emergency. When asked if they have ever felt unable to access care for physical health issues, seven respondents said yes and five said no.

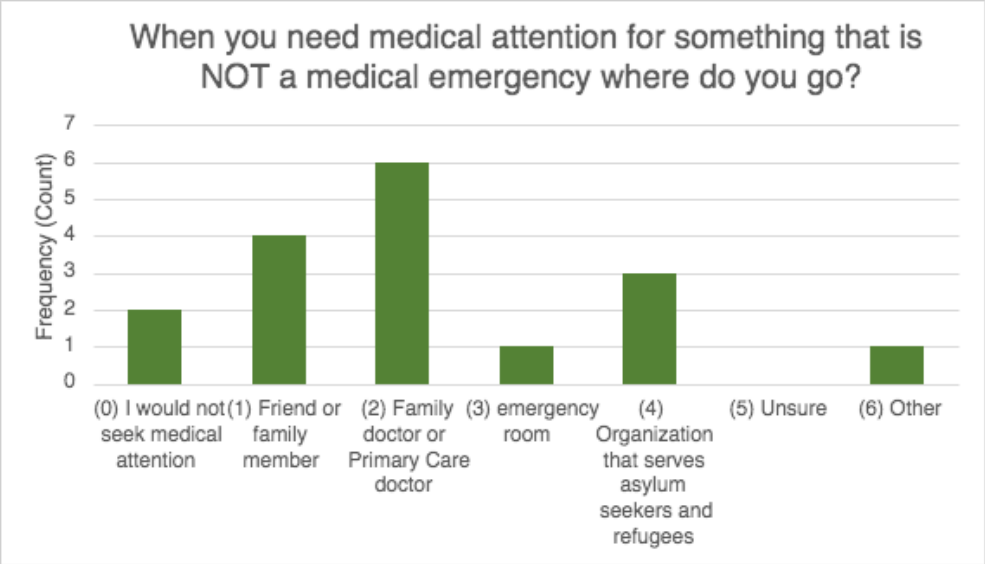

Figure 5: Health seeking behavior for a non-emergency

Have you ever felt unable to access healthcare for physical health issues in the US?	**Count**	**Percent**
(0) No	5	42%
(1) Yes	7	71%

Table 3: Ability to access care needed in the U.S.

Barriers, Enablers, and Medical Advice Adherence

When asked if they felt there are sufficient healthcare services and resources in their area, the majority of respondents reported yes (8/12), two reported no, and the remaining two respondents reported unsure. Participants were asked to evaluate cost and language as personal barriers to accessing healthcare services. When asked how often cost was a problem when wanting to receive physical health services, four respondents said never, three respondents said

rarely, two respondents said from time to time, one respondent said frequently, and two respondents said very frequently. When asked if language is an issue when seeking or receiving physical health services, a majority (8/12) of respondents said never, two respondents said from time to time, one respondent said frequently, and one respondent said very frequently.

Do you feel there are sufficient healthcare services and resources in your area?	**Count**	**Percent**
(0) No	2	17%
(1) Yes	8	67%
(2) Unsure	2	17%

Table 4: Counts and percentages of sufficient resources

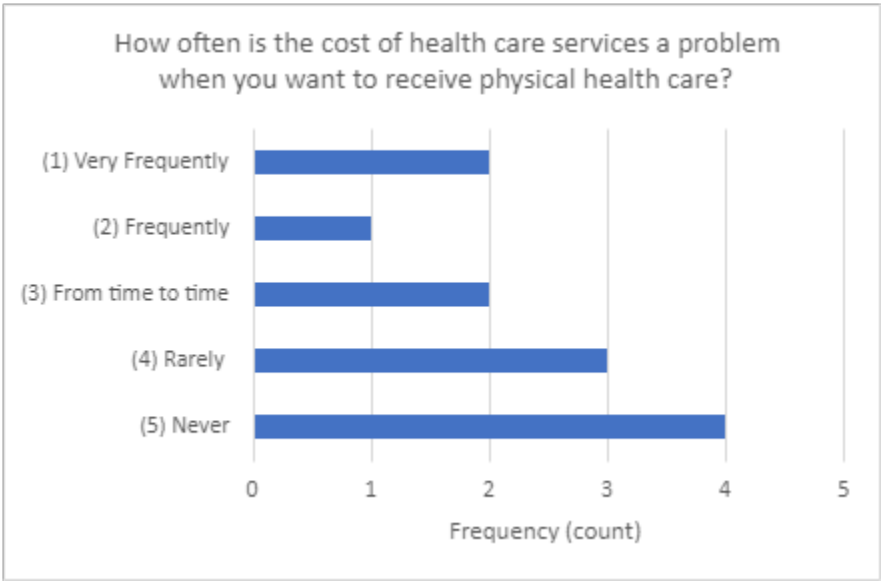

Figure 6: cost as a barrier to care

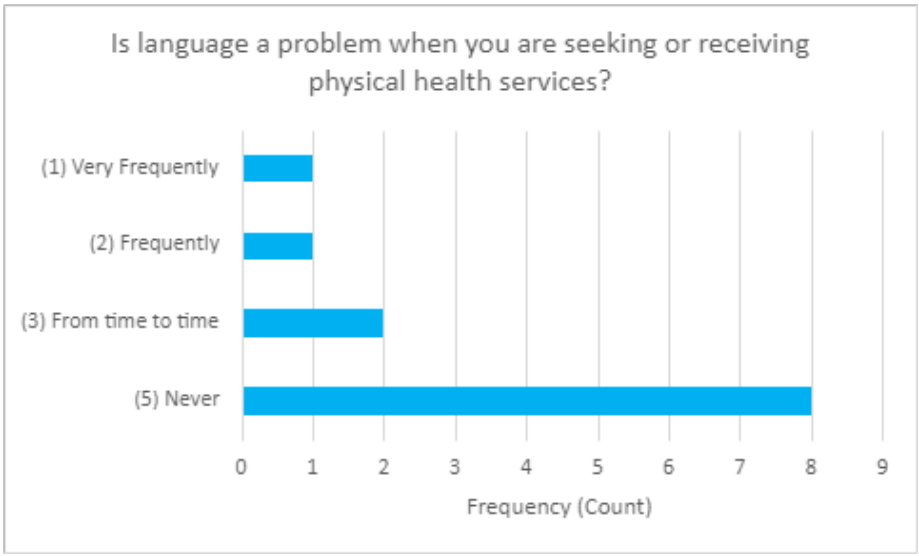

Figure 7: Language as a barrier to care

To help identify enablers to access healthcare, participants were asked who or what helps connect them to services for physical health issues. Six respondents said an organization that serves asylum seekers and refugees, five respondents said a friend or family member, one respondent said a community member or neighbor, one respondent said a religious organization or member, two respondents said there is no one who connects them to healthcare, and one respondent said other identifying their PCP as someone who connects them to care.

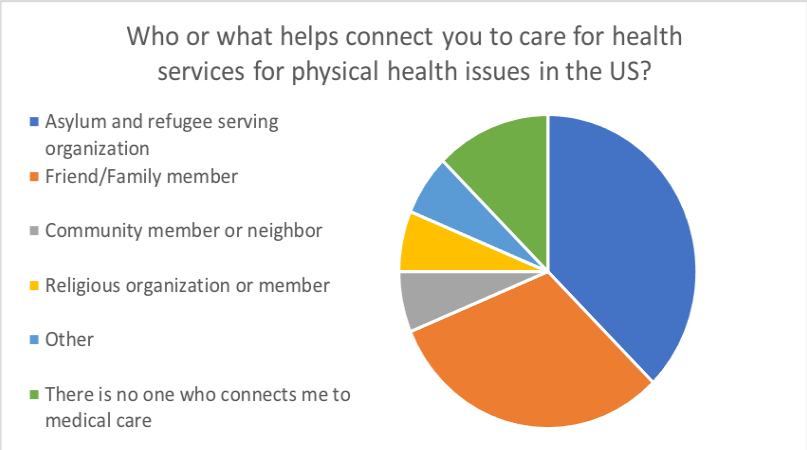

Figure 8: Who helps connect respondents to healthcare

To further identify potential enablers to accessing healthcare, respondents were asked what resources would be beneficial in helping them meet their physical health needs; they were instructed to select all answer options that applied to them. The majority of respondents (7/12) selected help managing or understanding health insurance, six respondents selected help paying for prescriptions and medications, six respondents selected help paying for health services, five respondents selected referrals for places to receive care, two respondents selected "other" and specified assistance paying for oral care specifically, and one respondent did not select any option.

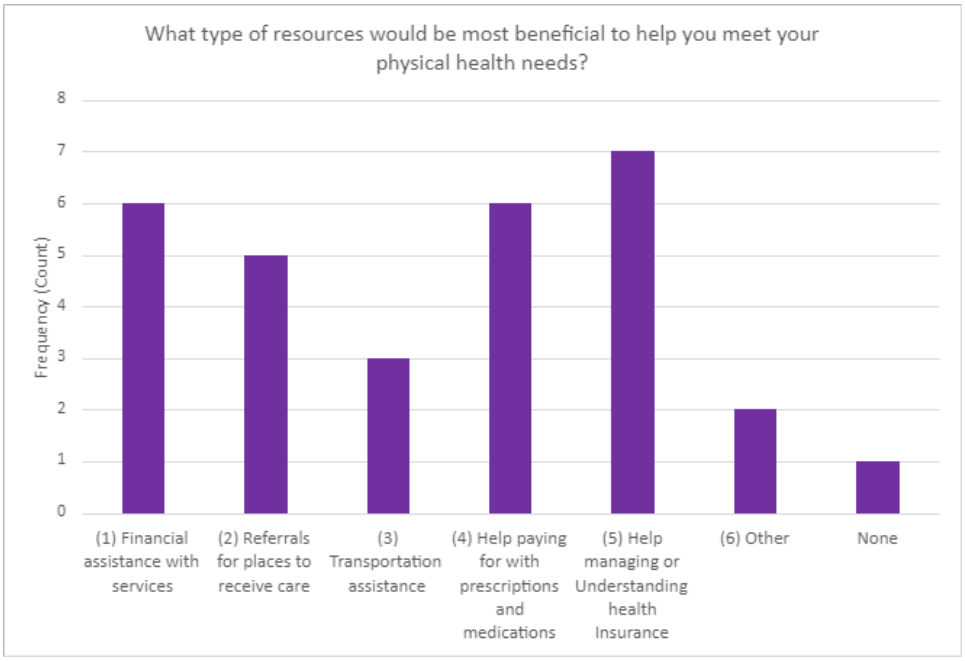

Figure 9: Beneficial resources identified by respondents

To evaluate medical advice adherence, participants were asked how often they follow instructions given to them by medical professionals. The majority of respondents (7/12) said they follow instructions all of the time, two respondents said almost all of the time, and two respondents said sometimes. This question was skipped for one respondent because they had mentioned in the previous question that they had never been to the doctor. For those who said they followed instructions almost all of the time or sometimes, answers as to why included "I don't know", "sometimes I forget to take my medication", and "because I feel better without doing it."

How often do you follow the instructions given to you by medical professionals?	**Count**	**Percent**
(1) All the time	7	58%
(2) Almost all the time	2	17%
(3) Sometimes	2	17%

Table 5: Counts and Percentages for Medical Adherence

Qualitative Responses to Unresolved Health Concerns

The final question of the survey was an open-ended question asking participants what health concerns they have not been able to get help with, if any. While one participant did not identify any health issues, 11 respondents identified at least one health issue and a reason as to why it has gone untreated. Health issues identified included chronic pain, dental, hearing, vision, chest pain, nasal issues, and not receiving an annual checkup. Reasons or explanations for issues going untreated included the doctor's not being able to help with/solve the medical problem; cost; issues with health insurance; language barriers/needing an interpreter; the process of referrals to see a specialist.

Crosstabs Analysis

A crosstabulation analysis was conducted to look at variation in answers among refugee and asylum-seeking respondents, and to see where responses differed based on immigrant status. When asked if they had ever felt unable to access the care they needed, asylum seekers responded yes more than refugees. When asked about their current employment status, those who worked full-time were all asylum seekers, asylum seekers and refugees equally selected part-time, and the majority of those not working were refugees. When looking at ratings of physical health, asylum seekers were more like to select average health (5/7), while refugees were more likely to select very poor health (4/5).

Chapter 5: Discussion and Conclusions

Qualitative Responses to Defining Health

To begin the survey, participants were asked a series of questions meant to contextualize the conversation and orient the respondents to think about how they define health and perceive their own health and wellbeing. This aspect of the survey was designed with the intention to identify potential understandings of health specific to the refugee and asylee population as well as potential cultural differences in the definition of health. When asked "what does health mean to you?", respondents gave a variety of answers and several significant themes were identified from the responses: mental and emotional health, absence of illness, and feelings of health being of the highest importance in a person's life.

Holistic Understanding of Health

The first theme examined was the mention of mental and or emotional health in their responses. The responses that made mention to mental or emotion health also included mention of physical health or the physical body. Mentioning different aspects of health could indicate that survey participants have a holistic understanding of health, understood as both physical and mental wellbeing. Respondents awareness of various aspects of health could suggest the various areas of health as being of value or importance to them, as well as the desire to take care of their physical, mental, and emotional health. Holistic approaches to healthcare that incorporate interdisciplinary teams and partnerships have been widely identified as promising practices in achieving better health outcomes (Murray et al., 2010). Additionally, Bridging Refugee Youth and Children's Services (BRYCS), an organization that aims to strengthen the capacity of

refugee-serving organizations, identified holistic approaches to health and healing as ones that are likely to resonate with many refugee's world views (Bridging Refugee Youth and Children's Services, n.d.)

Health as the Absence of Illness

The second theme examined was the absence of illness. Those who associated health with not being sick connected it to being without physical illness as well as mental illness. While responses where this theme was present used the terms 'sick' or 'sickness', based on literature that identifies the distinction between disease, sickness, and illness, respondents were describing illness. Illness is defined as "an experience of unhealth which is entirely personal, interior to the person of the patient" where sickness is defined as "the external and public mode of unhealth; a social role, a status" (Boyd, 2000).

Feelings of Importance Towards Health

The third theme identified under the provided definitions of health was expressing feelings of health having the highest importance to the individual, or in other words, health as a personal priority. Respondents expressed sentiments such as health being equivalent to "life", being "the most important part of wellbeing", considering health to be "everything", or being "above all else". Further examination into this theme could help to better understand how this population views health and the priority it may take in their lives. While this theme would suggest health as being a priority to respondents, this may not always be reflected in individual health behaviors or actions.

Self-Evaluation of Physical Health

When respondents were asked to evaluate their physical health on a Likert scale from *'very poor health'* to '*excellent health*', the majority (5/12) selected '*average health*'. The scale used is as follows:

Very poor health.....0
Somewhat poor health....1
Average health.....2
Good Health.....3
Excellent Health.....4

Even so, a significant number (4/12) of respondents also said they have '*very poor health'*, and none of the respondents selected '*excellent health'*. There does appear to be some correlation between the number of health issues identified by the individual and their rating of their physical health. The majority of those who selected '*very poor health'* identified more chronic health issues than those who selected '*average'* or '*good health'*. Health ratings were seen to be correlated with the number of chronic health issues identified; a higher number of health issues generally coincided with a lower health rating. However, this was not always the case. In some instances, respondents who selected a higher health rating identified more health issues than respondents who selected a lower health rating. This could potentially be attributed to the individual's perceived severity of their conditions; if the perceived severity of their health issue is low, it may not necessarily lead to a lower health rating.

Self-Perception of Physical Health and Employment Status

When a crosstabs analysis was preformed, it could be seen that an individual's rating of their physical health could have a correlation with their employment status. Those who worked part time or full time were more likely to select *average health* as opposed to the lower ratings. Those who were not currently employed were more like to rate their health as *very poor*. These findings are in line with a previous study done with African refugees in Australia (Wood et al., 2019). Participants in the study felt healthier when they were employed or working and felt unhealthy when unemployed, regardless of any illness being present, in addition to feeling isolated. This study found that paid work and volunteering encouraged a sense of belonging, connectedness, and self-fulfillment as well as saw direct positive benefits on physical and mental health (Wood et al., 2019).

Health Seeking Behaviors

In order to evaluate differences in health seeking behaviors based on the urgency of a health issue, participants were asked where they would seek care for emergency versus non-emergency medical issues. When asked where they would seek care in the event of a medical emergency, responses varied and only four respondents indicated they would go to the hospital or call 911. While several respondents mentioned they have never had an emergency, others said they would call a family member or go to a specific clinic or PCP. Although not specified in the survey responses, reasons for not going to an emergency department in a hospital could include cost or a triggering medical environment (Dawood, 2006). Survivors of torture can find medical settings intimidating if their torture involved medical professionals or similar settings (Dawood, 2006). Additionally, it is not uncommon for hospital visits to come at a high cost and many asylum seekers and refugees do not have insurance that would assist in covering the costs (Moore & Liang, 2020).

Continuity and Trust in Healthcare

When evaluating health seeking behaviors among CVT clients, it can be seen that half of the respondents said they would see a PCP or family doctor when seeking medical attention for a health problem that is not an emergency. This finding indicates that clients have access to a PCP and have a preference to receive care from them. Some respondents who indicated they would go to a PCP also indicated they would go to a friend or family member. Based on survey notes, seeking friends or family as a healthcare resource could indicate a perceived lack of severity of certain medical issues or only being able to access a physician some of the time or not at all.

A study that examined the healthcare experiences of refugees and asylum seekers in the United Kingdom found that continuity of care was shown to be important to participants in terms of medical care as well as interpretation during medical visits (Bhatia and Wallace, 2007). In this same study, refugee and asylum-seeking patients were more interested in utilizing a medical professional who listened to their concerns rather than only prescribed medication. The significance of continuity of care is reiterated in the findings from our study which respondents preferring to receive care from the same PCP or health clinic. This should be considered when thinking about avenues to help connect this population to healthcare. This finding indicates CVT's potential to become a greater resource to this population in terms of providing or connecting them to appropriate medical services.

Barriers and Facilitators

Addressing barriers and understanding facilitators to accessing medical care is a fundamental part of resolving the issue many refugees and asylum seekers face of having physical health problems that go untreated (Asgary & Segar, 2011). It's necessary to identify barriers at different levels such as personal and internal barriers as well as structural and

systematic barriers (Asgary & Segar, 2011). This study focused on structural and systematic barriers; the two barriers that were specifically asked about in the survey were language and cost. These two barriers were selected to be asked about based on a RCHA done in October of 2020. Findings from the RCHA indicated that cost was a significant barrier for CVT clients and language was not. It is important to note that the sample of clients surveyed for the RCHA was comprised of mainly English speakers, thus prompting further prompting further investigation with a larger non-English speaking population.

For this project, it was hypothesized that findings may differ from the RCHA if more non-English speaking clients were surveyed when looking at language as a barrier. However, survey responses for this study indicated that language was not widely identified as a barrier among this population even with seven out of the 12 respondents being non-English speakers. While language can often be a major barrier to accessing care for refugees and asylum seekers, this is not always the case. This could be attributed to the fact that it is in civil rights law for limited English proficient (LEP) patients to have a legal right to language interpretation services, thus lessening the language barrier that can be experienced (Chen et al., 2007). Non-English speakers surveyed mentioned having language interpretation for medical services be provided to them by a friend or family member or set up by an external organization. While language may not be a barrier to receiving care in this study, it can still be a barrier in acculturation and understanding of the U.S. healthcare system.

To the surprise of both the researcher and CVT partners, cost was not identified as a major barrier in the data from the survey sample. While not widely identified as a barrier by respondents, it is acknowledged that there may have been a few issues contributing to this result. One could be desirability bias; respondents may have felt uncomfortable or embarrassed

indicating they experience issues paying for healthcare. Another issue could be misunderstanding of the question; respondents may have interpreted the question as an inability to pay versus assessing the personal burden of cost. Additionally, responses could be skewed if this group of participants does not attempt to access healthcare very often.

Enablers to Accessing Care

To identify enablers to CVT clients meeting their physical health needs, participants were asked what resources would be most beneficial to help them do this. All but one respondent selected at least one option from the following list provided in the survey:

1. *Help paying for health services (**Ranked #2**)*
2. *Referrals for places to receive care*
3. *Transportation assistance*
4. *Help paying for prescriptions and medications (**Ranked #3**)*
5. *Help managing, understanding, or obtaining health insurance (**Ranked #1**)*
6. *Other*

The list was developed in partnership with CVT staff based on barriers and enablers identified from the previous RCHA. Respondents were instructed to select all options that apply. *Help managing, understanding, or obtaining health insurance* was the most selected option, with *help paying for health services* and *help paying for prescriptions and medications* being the next most selected options. This set of results would be the most instrumental in the development of recommendations and assisting clients in accessing care in order to address their physical health issues. Additionally, it shows the need for greater assistance to receiving care for physical health issues. The majority of participants had felt unable to access the care they needed at some point while living in the U.S, with most of them being asylum seekers, showing that access to care to be something this population struggles with, and in line with other studies.

Comprehensive Health Insurance

A common need identified among both groups of participants was the need for comprehensive health insurance. Both refugee and asylum-seeking clients mentioned insurance as a barrier to physical healthcare and being unable to access the care they needed because of a lack of insurance. Throughout the data collection process, several participants stated during survey interviews that they do not have health insurance or that they have problems with their health insurance. These findings are consistent with data showing low rates of insurance coverage for refugees and asylum seekers living in the U.S. Research shows that refugees are actually less likely to have insurance the longer they have been living in the U.S. (Su et al., 2019). These findings reinforce the need for insurance coverage that extends beyond the 8-month period of coverage that RMA provides as well as comprehensive education and support on obtaining insurance after RMA expires (Su et al., 2019).

Refugee and Asylee Support Agencies as Facilitators to Healthcare

Three survey participants stated they would seek healthcare for a non-emergency from an organization that serves asylum seekers and refugees; of those, one refugee respondent mentioned the International Rescue Committee (IRC) specifically. Many refugees who resettle in Atlanta are assigned to IRC and receive different services and assistance from the organization that can aid in addressing physical health issues such as transportation support, professional language interpretation, and assistance scheduling medical appointments (International Rescue Committee, 2021).Additionally, when participants were asked who helps connect them to care, half of the respondents said an organization that serves asylum seekers and refugees. One respondent specifically identified CVT and another identified IRC. These findings from this

section align with other research findings that indicate refugees and asylum seekers said that a support agency was one of their main sources of connection to PCPs and other medical care (Bhatia & Wallace, 2007). This should be considered when thinking about avenues to help connect this population to healthcare.

Chronic Health Issues & Unresolved Health Issues

One of the objectives of the project was to identify physical health issues of CVT clients, both chronic and acute. Collectively, respondents reported a total of 16 chronic health issues, the most common being chronic pain and chronic headaches. Quiroga and Jaranson noted that a significant physical sequela in victims of torture involves pain that is usually characterized by being long-lasting, in multiple sites, and chronic (2005). Locations of pain identified by respondents included joints, knees, waist, face, and all-over the body. However, because of the sensitive nature of the topic area, the researcher was not at liberty to ask participants if the health issues they identified were related to their past trauma. Chronic pain was generally treated with over-the-counter medications such as Tylenol and Ibuprofen, and several respondents indicated that their pain restricts their ability to perform certain activities, like exercising. These findings are consistent with those of other studies showing victims of torture commonly experience chronic headaches and pain related to their torture (Carinci et al., 2010). A previous study found that physical health issues were two times more likely to be present with asylum seekers who had experienced torture compared to those who had not (Masmas et al., 2008).

Specialty Healthcare Gap

To conclude the survey, respondents were asked if they had any health concerns that they have not been able to get help with. The responses to this question were categorized into two area: health issues identified and reasons for going unresolved. The health issues that were identified as being unresolved were centered around specialty care like dental, vision, hearing, radiology or chronic pain concerns, and surgery. This would indicate a need for assistance in receiving specialty care specifically. In terms of why their health problems have gone unresolved, study participants expressed it being due to cost and lack of insurance as well as issues with the referral process or physicians not being able to adequately address the health issue. For instance, some respondents indicated that the care they received by their physician did help to address or improve their health issue.

Holistic Healthcare for Survivors of Torture

Research shows that addressing physical health issues of survivors of torture is best done through programs that combine treatment that targets physical, mental, and emotional health by incorporating psychologists as well as physicians in active treatment and educational roles (Carinci et al., 2010). It's important that healthcare professionals who specialize in chronic pain understand the impact torture has on an individual psychologically and physically given that one in nine foreign-born patients reported having a history of torture (Carinci et al., 2010). Confusion as to why an individual is still experiencing pain years after torture can contribute to poor chronic pain management. Being that certain types of torture are correlated with certain injuries, interacting with specialists and physicians who have an understanding of that can aid in the long-term evaluation of those injuries (Carinci et al., 2010).

Limitations

There were a number of limitations encountered during the data collection process. First, only 12 surveys were able to be conducted due to time constraints on data collection as well as cancellations by the participants. A larger sample size could have captured more perspectives and led to more insightful interpretation of data. However, given that CVT had about 20 active clients at the time of the project, 12 respondents could have offered sufficient data saturation for the purpose of this study. Second, given that the surveys were conducted over video calls instead of in-person, technical difficulties were occasionally experienced, resulting in incomplete thoughts of phrases from the respondents. Third, language interpreters were used for non-English speaking clients; there were a total of five different interpreters utilized throughout the data collection process. It is possible that some data was lost during interpretation. Fourth, because the survey did not specifically aim to explore if health issues are related to past trauma, it was not possible to report if specific health issues identified were unique to victims of torture.

Lastly, the data collected cannot be generalized to the greater population of asylum seekers and refugees or victims of torture outside of the Atlanta area. These results can only be representative of CVT clients living in Atlanta, and cannot be generalized to refugees and asylum seekers who are not receiving services at CVT. It could be anticipated that those actively seeking mental health services are more likely to be aware of their physical ailments and needs. Additionally, given that it was not possible to explore and evaluate physical health in relation to experienced trauma, it is unclear how trauma impacts the health of participants and their physical health needs; if an individual outside of this study has experienced more severe trauma, they may have more physical health needs than described by this study.

Conclusion

According to staff at CVT, a major challenge faced by the organization is identifying routine health services that can be accessed by CVT clients. Based on the survey data, refugee and asylum-seeking clients alike face issues of access to physical healthcare, and both groups could benefit from additional support, financially and otherwise. The most beneficial form of support, as identified by study participants, would be assistance with medical insurance, whether it be obtaining, managing, or understanding insurance. It's important to consider that respondents ratings of their physical health did not always coincide with the health issues they were experiencing. While a higher number of health issues generally coincided with a lower health rating, in some instances, respondents who selected a higher health rating identified more health issues than respondents who selected a lower health rating. Additionally, those who were employed either full time or part-time selected higher ratings of their own physical health compared to those who were not employed. Findings suggest that continuity of care is of value to CVT clients when receiving health services, being that the majority indicated they would seek care from a PCP or revisit the same clinic for both emergency and non-emergency care.

Recommendations to CVT consist of ways they can begin to address the needs and problems identified. This includes recommendations on continued data collection and evaluation of clients' physical health needs (continue to refine and utilize the survey instrument to collect up to date data), identified areas to advocate for funding and policy change, and identified opportunities to partner with community organizations to create a network for clients. The recommendations are categorized based on priorities specified by the organization.

Chapter 6: Programmatic Recommendations

Organizational Priorities

Throughout the duration of the project, CVT partners identified several priorities for the organization and the recommendations that resulted from the survey data. Overall, the organization was interested taking on a more holistic health focused approach to assist their clients. First, with changes in organizational structure, CVT is considering restructuring aspects of the program while still providing quality care to their clients. Second, the organization expressed interest in recommendations for physical healing as well as ways to advocate for awareness and resources. Third, CVT suggested recommendations on how the organization can increase access to appropriate resources for clients.

Recommendations by Area

The following recommendations are aimed at improving elements of CVT's operational structure as well as suggestions on how the organization can help address the physical health needs of their clients. The following recommendations are based on survey findings as well as recommendations and effective practices from literature.

CVT Program Areas	Recommendations
Addressing Medical Needs (Healing)	- Conduct regular assessment of physical health needs of clients - Provide primary preventative care to clients for physical health issues by hiring an on-site PCP/Family doctor - Partner with clinics who specialize in serving immigrant populations and in populations with chronic pain - Conduct long-term follow ups for identified chronic health problems - Referrals for specialty care (chiropractic, dental, vision, etc.)

Advocacy	- Advocate for funding to provide financial assistance to clients for services and prescription medication - Advocate for increased research about health needs of the refugee/asylee population in Atlanta on a large scale - Advocate for comprehensive insurance policies for refugees, extending past 8 months - Advocate for more interpretation staff that can assist asylum seeking clients - Advocating for refugee and asylee assistance agencies to be funded as health promoters/navigators/liaisons - Advocate for hiring staff with a variety of language abilities that can assist asylum seeking clients
Operational Structure	- Incorporate surveying clients on physical health needs as a part of the program's intake process - Utilization of in-person focus groups to better understand physical needs as a population - Providing clients with resources that can aid in the process of obtaining health insurance - Referring or providing in-house social work/case management services that can assist clients with obtaining health insurance when appropriate - Providing employment resources or workshops with potential employers to CVT clients - Providing services or resources to clients for understanding US healthcare system and how to navigate - Providing U.S. cultural immersion classes for clients and cultural awareness and sensitivity trainings for staff
Community Partnership (Training)	- Partnering with local organizations to offer training for medical professionals to better understand context from which clients are coming - Connecting with and educating potential employers of this population on the contexts and strengths of refugees and asylum seekers

Medical needs recommendations are centered around ways CVT can begin to address the physical health issues faced by their clients on a long-term basis. These recommendations are based on survey findings that indicated clients access the care they need through a PCP or asylum-seeking organization. It would be important that CVT has staff that is knowledgeable in

evaluating physical health problems among this population and can provide focused expertise. CVT could consider acquiring funding to employ community health workers who can be consulted by clients and provide referrals for places where clients can receive healthcare.

Advocacy recommendations are centered around funding opportunities CVT can explore that would increase the services provided as well as increase community and public health awareness of the needs of this population on a national and local level. Advocacy recommendation also include policy areas where CVT can advocate for this population at the local, state, and federal level.

Community partnership recommendations are centered around building the capacity of individuals in the community who work closely with survivors of torture and the refugee and asylum-seeking population at large. With the survey results showing a possible correlation between employment status and physical health rating, it could be beneficial for the organization to connect with potential employers who can provide job opportunities for CVT clients. Increased community partnership will create a network of resources for CVT and its clients can continue to refer to in the future.

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APPENDIX A: Mixed Methods Survey Tool

Assessment and Comparison of Physical Health Needs Among Asylum-seeking and Refugee Clients at Center for Victims of Torture in Georgia

Kayla Johnson

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INTRODUCTION FOR INTERVIEWER (READ TO RESPONDENT):

Good afternoon. Thank you for being here today. My name is Kayla and I am a public health student from Emory University. I am working with CVT to learn more about the physical health needs of their clients.

To help us do this, we would like to talk with you and ask you some questions for about 30 minutes.

I will take some notes during our conversation so that I do not miss anything you say. If you notice me looking down, this is why. I will share the information from this conversation with CVT, so that they can understand better the physical health needs of their clients.

- *There are no right or wrong answers to any of these questions; we are interested in learning about your experience.*
- *You should know that your data will be kept confidential outside of CVT.*
- *Nothing you say here will have any impact on the services you receive from CVT.*
- *You are also free to refuse to answer any of the questions.*
- *You can stop the interview at any time without having to provide a reason.*

Verbal Consent

Would you like to participate in this interview?

[Mark the corresponding box for all clients asked to participate]

- ☐ ***No**, I do not want to participate in this interview.*
- ☐ ***Yes**, I do want to participate in this interview, and I consent to the use of information from this conversation as explained by the interviewer (above)*

INSTRUCTIONS FOR INTERVIEWER:

1. Record respondent ID on each page at the top of page
2. Read introduction to participant, and allow for interpretation
3. Fill out start and end times
4. Read each interviewer prompt to respondent, allow for translation by interpreter, and give time for participant to respond
5. Read all questions and response options as written. Stop after each sentence and wait for the interpreter to interpret the statements.
6. Read definitions when provided. Stop after each sentence and wait for the interpreter.
7. Circle the number that applies in the response section

8. Be sure that the participants understand each question and the answer options before moving on to the next question. If necessary, read aloud: *select one, select all that apply, fill in response, etc.* Allow for interpreter to interpret if necessary.
9. For open ended questions, record response as detailed as possible.
10. Be sure to specify "other" if selected
    a. Write EXACT response in space provided

DATE: ___ /___ / ____

START TIME: ____ : ____ AM/PM

END TIME: ____ : ____ AM/PM

Respondent ID: _____

Interviewer: _____

Interpreter: _____

Section A: Introductory Questions			
Interviewer: "In this section I will ask you some general questions about yourself."			
QUESTION		RESPONSE	INTERVIEWER NOTES
1	For how long have you been living in the United States? *Fill in numerical value and circle "month(s)" or "year(s)".*	__ __ month(s) / year(s)	
2	What county do you live in? (*Record response)*		
3	What is your current employment situation? *(Select one)* *"Work status means whether or not you are currently employed and how often you work."*	I work every day about 30-40hrs/week (Full time)….....1 I work most days about 30hrs/week or less (Part Time)….....2 I work on a day-to-day basis as work is available.....3 I am not currently working.....4 Unsure.....5 Other _____..6	
4	What does health mean to you? What do you think of when you hear the word health? *(fill in response)* *"Health being what your body feels from head to toe. These feelings can be pain, illnesses*		

	and sickness or positive or negative feelings related to your body. Health related activities or rituals, etc."		
4a	How would you describe your physical health these days? *(Select one)*	Very poor health….....0 Somewhat poor health….1 Average health….....2 Good Health….....3 Excellent Health….....4	
5	What makes you concerned about your physical health? *(write response in as much detail as possible)*		
6	What makes you happy or hopeful about your health? *(write response in as much detail as possible)*		
Section B: Physical Healthcare Needs			
Interviewer: "Thank you for your responses so far. Now I'd like to ask you some questions about your physical health and healthcare needs."			
7	Do you experience any of the following chronic health problems? *(Select all that apply)* *"Chronic pain means pain in the same place most of the time or all the time and that does not get better permanently."*	High blood pressure.....1 Trouble walking.....2 Headaches ….....3 Heart related problems.....4 Chronic pain.....5 Asthma / trouble breathing...7 Other _____ 6	
8	Since you have been living in the US, do you do any of the following things to maintain your physical health? *(Select all that apply)* *"Eating healthy means consuming any food that you believe is good for your health."*	Take vitamin/Mineral supplements.....1 Do physical activity.....2 Eat healthy.....3 Take over the counter medicines (If yes, which?).....4 Other _____ 6	
9	Do you feel the things you do to have better health are helping with your health issues? *(Select one)*	Yes……..1 Unsure....2 No.....0	

Section C: Health Seeking Behaviors			
Interviewer: "We are now midway through the questions; I want to thank you for your responses so far. Now I'd like to ask you some questions about how you seek health care."			
10	When you need medical attention for something that is NOT a medical emergency (such as a strong pain in your knees, strong headaches, constant pain in your stomach, etc.) where do you go? (*Select all that apply)* *"Organization that serves asylum seeker being a place like CVT."*	Friend or family member.....1 Family doctor or Primary Care doctor.....2 Emergency room.....3 Organization that serves asylum seekers and refugees……..4 Unsure.....5 I would not seek medical attention.....0 Other_____…...6	
10a	When you need medical attention for something that is an emergency (heart attack, serious or unexpected injury, etc.), where do you go? *(write response in as much detail as possible)*		
11	Have you ever felt unable to access health care for physical health issues (which don't include mental health) in the US? *(Select one)*	Yes....1 Unsure...2 No.....0	
Section D: Barriers and Enablers			
Interviewer: "Now I'd like to ask you some questions about barriers to healthcare."			
12	Who or what helps connect you to care for health services for physical health issues in the US? (*Select all that apply)*	Asylum and refugee serving organization.....1 Friend/Family member....2 Community member or neighbor.....3 Religious organization or member.....4 None of these.....5 There is no one who connects me to medical care.....0 Other_____6	

13	Do you feel there are sufficient health care services and resources in your area? *(Select one)*	Yes....1 Unsure...2 No.....0	
14	How often is the cost of health care services a problem when you want to receive physical health care? *(Select one)*	Never.....5 Rarely ….....4 From time to time.....3 Frequently.....2 Very Frequently.....1	
15	Is language a problem when you are seeking or receiving physical health services? *(Select one)*	Never.....5 Rarely ….....4 From time to time.....3 Frequently.....2 Very Frequently.....1	
16	What type of resources would be most beneficial to help you meet your physical health needs? (*Select all that apply)*	Help paying for health services.....1 Referrals for places to receive care.....2 Transportation assistance …..3 Help paying for prescriptions and medications.....4 Help managing or understanding health Insurance.....5 Other _____….....6	
17	How often do you follow the instructions given to you by medical professionals? *(Select one)*	All the time.....1→ E1 Almost all the time.....2 Sometimes.....3 Rarely.....4 Never.....5	
18	If you do not fully follow medical instructions, why is this? *(Summarize response as detailed as possible)* *"Could you explain that a litle more for me?"*		

Section E: Open Ended Questions			
Interviewer: "Your answers have been very helpful, thank you! I have one last question!			
19	What medical or health concerns have you not been able to get help with, if any? *Do you have any comments you would like to make, or questions related to our conversation today?*		

Thank you again for your time and for your help with this project!