University of Nebraska Medical Center
BREAKTHROUGHS FOR LIFE.

Refugee Health Needs Assessment in Omaha, Nebraska

Prepared by:

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Table of Contents

Executive Summary 1

Introduction 3

Background 4

Data and Methods 6

Ethical Considerations 6

Analysis and Results 7

Discussions 21

Limitations and Strength 23

Recommendations 23

Conclusions 24

References 25

Executive Summary

The refugee population in Nebraska has been growing rapidly. Since 2000, over 6,000 refugees have resettled in Nebraska, pointing to the importance of addressing the health needs of refugees as they strive to adapt to a new health care system and receiving communities. The purpose of this assessment was to understand the health care needs, preferences, and barriers faced by refugees in Omaha, Nebraska.

To meet the goals of this study, we conducted a survey of refugees living in Omaha from late 2015 to early 2016. We attended refugee-related events, worked with refugee leaders, and community partners to administer the survey. With the help of interpreters, we interviewed 291 refugees in their preferred languages.

HIGHLIGHTS OF FINDINGS

- Nearly 70% of the refugees in the sample were from Burma, 62.5% were female, and the average age was 36.2 years. More than 50% of the refugees had an annual income of $10,000 or less. About 47% were unemployed.
- Over one-third (35.4%) of the refugees reported no health insurance coverage.
- Approximately one out of four refugees delayed seeing a health care provider because of cost during the past 12 months before the survey, and one out of seven postponed buying medication because of cost during the same period.
- The most self-reported medical conditions were hypertension (13%), allergies (8%), obesity or overweight (7.7%), high cholesterol (6.2%), and diabetes (5.6%).
- Out of the 291 refugees in the sample, 107 (36.8%) reported that they had never gone to a health care facility in the U.S. The top reasons included 1) they didn't believe their health issues were severe (42.1%); 2) they had language difficulties (35.5%); 3) they did not have health insurance (35.2%); and 4) they were not able to afford health care cost (29%).
- Respondents reported interest in community health education and services such as flu shots, physical activities, health fairs, healthy eating, women's health, diabetes education, and mental health.
- Ability to speak English was an important priority for refugees. Over 90% of refugees in the survey reported interest in programs that can help improve their English speaking skills.

RECOMMENDATIONS

Based on the findings from this study, we recommend that health care providers, refugee resettlement agencies, policy makers, refugee communities, and other stakeholder organizations work together to:

1. Increase availability and time-flexibility of English language classes, and raise awareness about these classes among refugees.
2. Work closely with employers in Omaha to provide job training and employment opportunities for local refugee population.
3. Provide information and resources for health insurance coverage purchase and enrollment among refugees.
4. Promote health literacy and patient navigation among refugees through trained community health workers recruited from the refugee community.
5. Mobilize the needed resources and partnerships to provide the health services refugees reported they were most interested in such as the provision of flu shots, exercise facilities, health fairs, healthy eating education, and women's health services.
6. Equip health care providers with the language support they need when serving refugees with no or limited English proficiency.

Introduction

The refugee population in Omaha, Nebraska has increased substantially over the past decade, bringing global health matters to our backyard. 764 refugees arrived in Nebraska in 2012, and this number increased to 1,200 in 2015 (Office of Refugee Resettlement, 2015).

Refugees resettling to Nebraska might have different needs, barriers, and preferences in access to health services compared to native Nebraskan residents. Capturing those differences is crucial for addressing unmet medical needs among the refugees. For this purpose, the Center for Reducing Health Disparities at the College of Public Health of University of Nebraska Medical Center conducted a health needs assessment of refugees in Omaha, Nebraska from late 2015 to early 2016 to assess their perceived needs, barriers, and preferences regarding health care access and utilization. We expect that findings from this study will help guide community health services and health promotion efforts, improve communication between refugees and health care providers and advocate for more support and investment committed to addressing health disparities among refugees.

Different refugee populations have been coming to Omaha for decades. However, challenges still exist to reduce health disparities among refugees. For example, in the 2015 Community Health Needs Assessment conducted in the Omaha metropolitan area, one physician reported unique barriers in health care access for refugees:

> *"There is a large refugee population in Omaha. There are huge issues with lack of appropriate translation/interpretation services, alternative clinic hours, and poor clinician/staff training to work with refugees."*

A local social service provider further testified about cultural barriers in Omaha when serving certain racial and ethnic minority populations, listing issues like lack of cultural competency, public transportation, health literacy, and ability to navigate the health system for racial and ethnic minority patients. Distrust of healthcare institutions was also listed as an issue (Professional Research Consultants, 2015). These problems could hamper access to health services for refugees and compromise the quality of the health services they receive.

Background

After living in difficult situations such as malnutrition, unsanitary housing, and insecurity in refugee camps, as well as the complicated process of relocation to the United States, many refugees experienced struggles and traumas with immediate and long-term health consequences. Newly arrived refugees have only 90 days with the resettlement agency to receive initial assistances such as housing, employment, and cultural orientation. Most refugees have a financial debt the moment they arrive to the U.S. because they have to pay their travel expenses within five years of their arrival (U.S. Department of State, 2017).

According to the Office of Refugee Resettlement (2015), the reported newly arrived refugee population was 764 in Nebraska in 2012. This number increased to 997 in 2013, 1,076 in 2014, and 1,200 in 2015. At the same time, Nebraska also received secondary refugee immigrants who initially resettled in other states and then moved to Nebraska. The increase in the refugee population portends the growing importance of understanding their unmet needs and unique barriers in health services before these disparities can be addressed.

Refugees who have settled in Nebraska originate from different areas of the world. From 2012 to 2015, the top countries of origins were Bhutan, Burma, Iraq, Somalia, Republic of South Sudan, Sudan, and Iran (Office of Refugee Resettlement, 2015). Refugees from different countries might have different health needs due to differences in living conditions, burden of diseases, and the reasons that have compelled refugees to leave their native countries.

Singer and Wilson (2006) observed that basic needs, such as health care access, housing, and schooling consume a significant role in refugees' transition to the U.S.. Some other problems include lack of familiar and affordable foods, access to junk food, and sedentary lifestyles. In addition, refugees felt a need for assistance in learning English, transportation, job skills, and financial planning (Refugee Health Technical Assistance Center, n.d.). According to findings from a study conducted in California (Brouwer, 2007), the top five health access barriers among refugees were language, logistical barriers and transportation, lack of health insurance, cultural differences, and limited knowledge of the U.S. healthcare system. These barriers are interrelated, and together they pose a serious challenge to health care access for the refugee population. Participants in the study also provided recommendations for improvements in health care services, which focused on health education and health promotion activities. Many refugees felt that improvements in educational programs would lead to an increase in health awareness, which would improve the long-term health of refugees (Brouwer, 2007).

The acculturation process usually changes eating and exercise habits of refugees after they come to the U.S. (Franzen & Smith, 2009). An assessment of Nuer and Dinka refugees resettled in Omaha revealed that refugees tend to adopt prevailing diet from host community and gradually gravitate towards convenience store foods because of unfamiliarity with local fresh foods (Willis & Buck, 2007).

Refugees are more likely to report chronic health problems than other immigrants. Prevalence of overweight, obesity, and hypertension is high among refugees (Dookeran, Battaglia, Cochran, & Geltman, 2010). Refugees commonly seek medical attention for musculoskeletal pain, which can originate from jobs that involve physical labor or difficult living conditions, such as sleeping on couches or floors. Often, refugees are employed in low paying jobs that may not provide health insurance benefits or refugees don't know how to access health insurance. In addition, low paying jobs tend to have strict attendance policies, making health care access difficult when missing hours or days from work are limited (Eckstein, 2011).

A New York study (Shibusawa & Mui, 2010) investigated health service utilization among Asian immigrant elders and found that limited English proficiency was a major barrier to health care utilization, and resulted in limited medical knowledge and access to health services. Asian American immigrant elders were less likely than native elders to have health insurance and less likely to use health care services. The unpredictability in health care costs and lack of transportation prevented many Asian American immigrant elders from seeking medical treatment. Overwhelmingly, 80% of women and 84% of men in the study reported that they delayed seeing a health care provider due to cost during the 12 months before the study. It was also found that Medicare and Medicaid enrollment was the most important predictor of health care utilization; however, Medicare and Medicaid enrollment rates were much lower in Asian American immigrant elders compared to Caucasian elders, even though 84% of the Asian American sample were eligible.

The "Health and Related Factors for Sudanese Refugees in Nebraska" study (Willis & Nkwocha, 2006) observed that 40% of Sudanese refugees had no dental or health insurance, 20% have never visited a dental or eye care professional, and 11% have never visited a doctor. It was reported that Sudanese refugees were under-insured compared to Nebraska residents and that one-third of the Sudanese refugees felt racism as a barrier to receiving health care. It was also observed that Sudanese refugees want to become educated about the U.S. health care system to be able to engage in it better. However, they feel they lack the resources and knowledge to do so.

Current assistances to refugees are focused on the period immediately following arrival in the U.S., and funding for longer-term health care services is limited, making it challening for refugees with chronic health conditions (Yun, Fuentes-Afflick, & Desai, 2012). While refugee resettlement agencies located in Omaha are well known and respected in the community, scarcity of resources only allows them to provide refugees with limited services and information related to health and cultural orientation. Additionally, refugees could easily lose their health insurance and other services after eight months of short-term insurance from the Refugee Medical Assistance in the United States, which exposes them to the consequences of poverty.

The purpose of this report is to assess refugees' perceived needs, barriers, and preferences regarding health care access and utilization based on first-hand survey data collected from refugees living in Omaha, Nebraska.

Data and Methods

We conducted a refugee health needs assessment survey among adult (19 years of age and older), self-identified refugees in Omaha, Nebraska. The assessment instrument was developed by the Center for Reducing Health Disparities (CRHD) at the College of Public Health, University of Nebraska Medical Center and the data were collected from late 2015 to early 2016. The survey was distributed at events involving refugees, as well as different community settings where refugees gather (i.e. English Learning classes, places of worship, college campuses, etc.). Refugee leaders also assisted with distributing surveys to their community members. A total of 291 paper surveys were completed. IBM SPSS Statistics 23 was used to analyze the data.

Ethical Considerations

The survey included a cover letter explaining the purpose of the study and informing potential participants that their participation in this study was confidential and entirely voluntary. Participants were free to choose not to participate, not to respond to individual questions, and to stop the interview at anytime. The cover letter also stated that by completing the survey, participants were consenting to take part in the study, indicating that they understand the study purpose, risk, and benefits of the research. Interpreters were present to assist refugees to translate the cover letter of consent.

This study was approved by the Institutional Review Board of the University of Nebraska Medical Center on October 29, 2015 (IRB# 757-15-EX).

Analysis and Results

SAMPLE DEMOGRAPHICS AND SOCIOECONOMIC STATUS

The majority of this sample was female (62.5%). Over 41% were between 19 and 29 years old, with a mean age of 36.2 years. A total of 70% of the refugees were from Burma/Myanmar. In terms of religious background, the majority of this sample self-reported as Protestants or Catholics, followed by Muslim and Buddhist. About 45% of the sample had 6 or more members in their households (Table 1).

Table 1. Participant Demographics

VARIABLES	FREQUENCY (N)	PERCENT (%)
Sex		
Male	107	37.5
Female	178	62.5
Age		
19-29	113	41.7
30-39	61	22.7
40-49	48	17.7
50-59	29	10.7
60-69	14	5.2
70-79	5	1.9
80+	1	0.4
Country of Origin		
Burma/Myanmar	193	69.8
Viet Nam	19	6.9
Somalia	18	6.5
Other Countries	49	17.7
Religion		
Protestant	145	52.3
Catholic	59	21.3
Muslim	31	11.2
Buddhist	29	10.5
Hindu	8	2.9
Other	5	1.8
Household Size		
1	1	0.4
2	16	5.6
3	34	11.9
4	50	17.5
5	56	19.6
6 or more	128	44.9

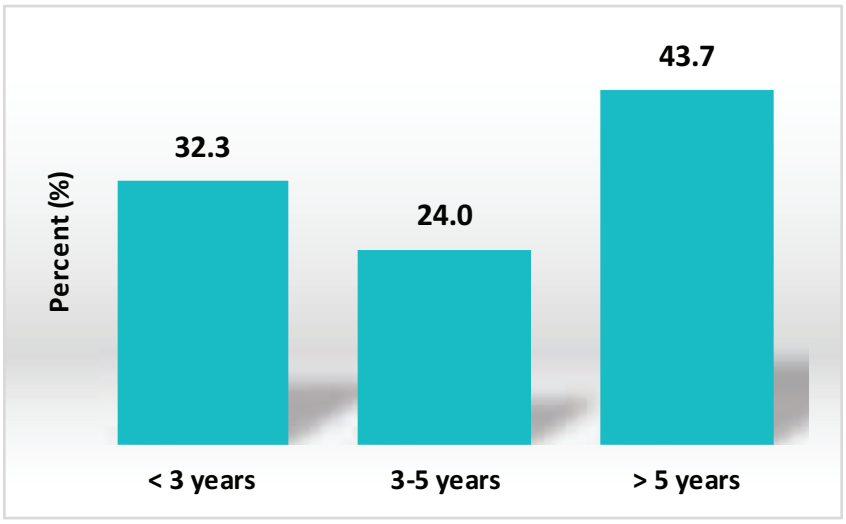
Table 2 displays the socioeconomic status of the participants. More than half (54%) of the sample reported an annual income of $10,000 or less. Over a quarter of the sample (26.7%) reported no schooling and the majority had an education of high school or below. 47.2% of the participants were unemployed and another 14.4% were employed part-time. About 84% of the sample reported having a cell phone and more than half (56%) owned a car. Close to 7% of the sample skipped meals due to cost during the past month.

Table 2. Participants' Socioeconomic Status

VARIABLES	FREQUENCY	PERCENT
Individual Annual Income		
<$10,000	145	53.7
$10,000-$24,999	74	27.4
$25,000-$49,999	37	13.7
$50,000-$74,999	5	1.9
$75,000-$100,000	4	1.5
>$10,000	5	1.9
Educational Attainment		
No Schooling	75	26.7
Grades 1-8	66	23.3
Grades 9-12	37	13.2
High School Graduate	61	21.6
College or more	44	15.7
Ownership of Personal Belongings		
Cell-Phone	236	84.3
Car	156	55.7
Computer	113	40.4
Land-Line Phone	42	15.0
Radio	35	12.5
Employment Status		
Unemployed	134	47.2
Part-Time	41	14.4
Full-Time	103	36.3
Skipped Meals Due to Cost during the Past Month before the Survey		
Yes	20	6.9
No	268	93.1

We found a mixture of length of time residing in Nebraska, with 43.7% of the refugees living in Nebraska for over five years, followed by 32.5% for less than three years (Figure 1).

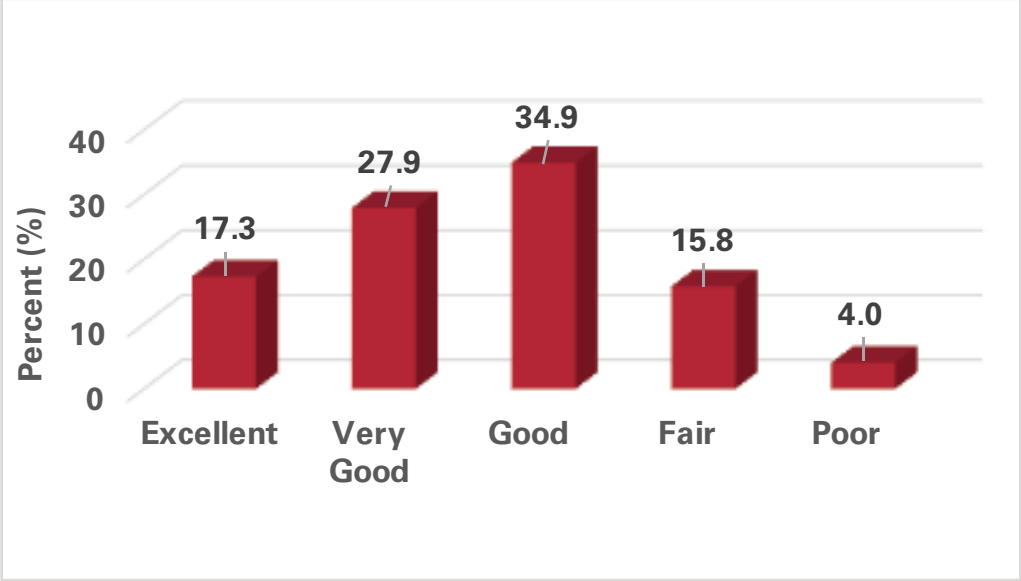
Figure 1. Amount of Time Resided in Nebraska (n=279)



HEALTH STATUS OF REFUGEES IN THE SAMPLE

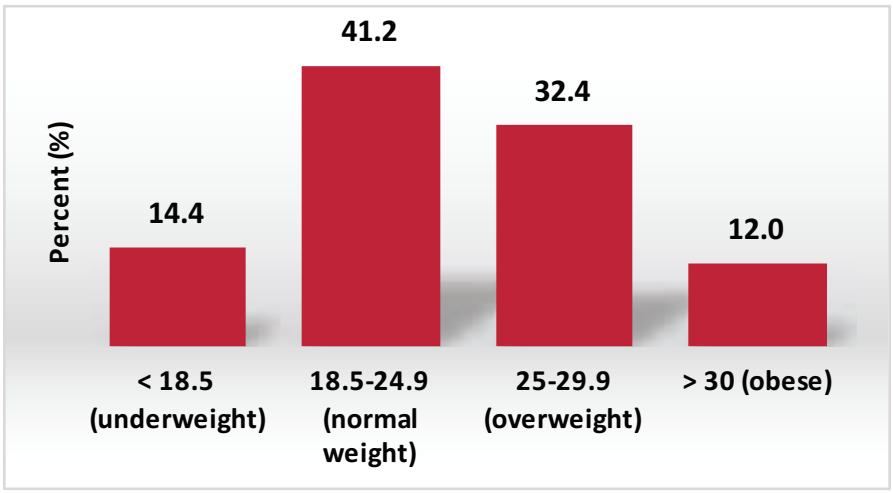
In terms of the overall health status of refugees in the sample, 34.9% rated their health as 'Good', followed by 'Very Good' (27.9%), 'Excellent' (17.3), 'Fair' (15.8%), and 'Poor' (4.0%). Almost 20% of the sample rated their health 'Fair' or 'Poor' (Figure 2).

Figure 2. Self-Rated Health (n=272)



Approximately 32% of the participants were overweight, and 12% were obese, for a total of 44% with overweight or obese BMIs. 41% reported normal BMI and 14.4% were underweight (Figure 3). It should be noted that the proportion of overweight or obese BMIs would be substantially larger if we use the weight classification standards for Asian adults who have an average BMI much lower than the average BMI of adult Americans.

Figure 3. Self-Reported BMI (n=284)



Refugees in the survey were asked if they had problems with any part of their mouth (e.g. a toothache, bleeding gums, abscessed or broken tooth) during the 12 months before to the survey. 26% reported that they had mouth problems (Figure 4).

Figure 4. Mouth Problems in the Past 12 months of the Survey (n=288)

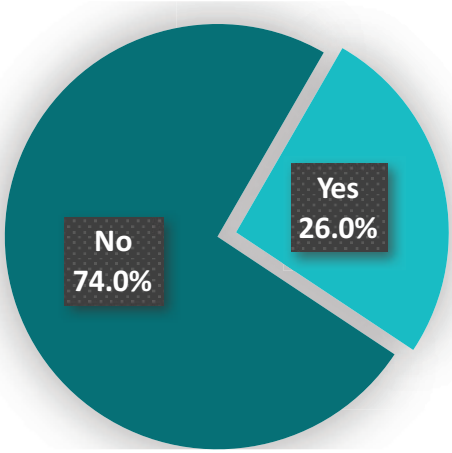
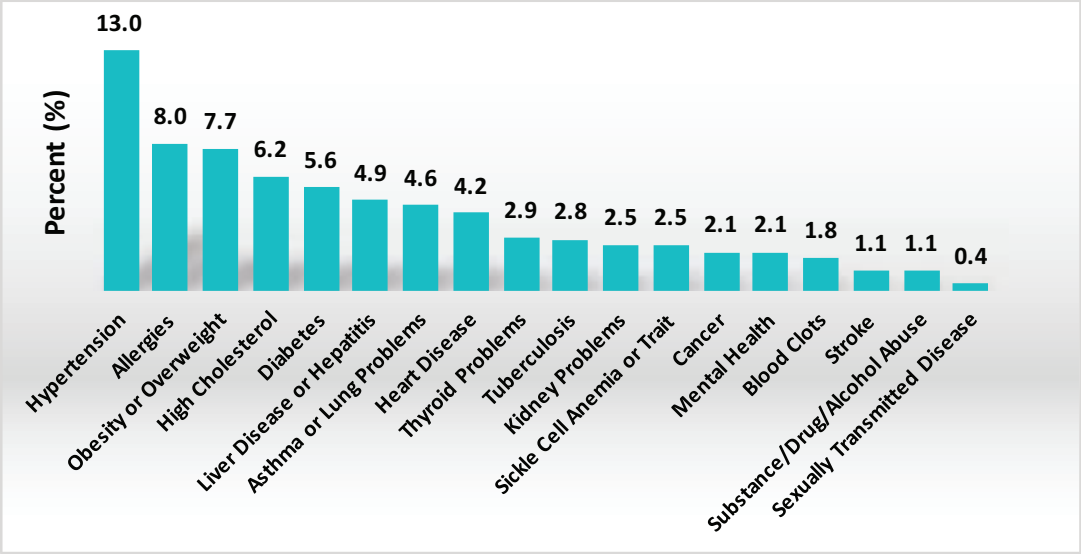


Figure 5 displays commonly diagnosed diseases in the sample. The highest reported medical condition was hypertension (13%), followed by allergies (8%), obesity or overweight BMI (7.7%), high cholesterol (6.2%) and diabetes (5.6%). All other conditions had less than 5% prevalence.

Figure 5. Diagnosed Diseases & Conditions (n=270)



HEALTH BEHAVIOR OF REFUGEES IN THE SAMPLE

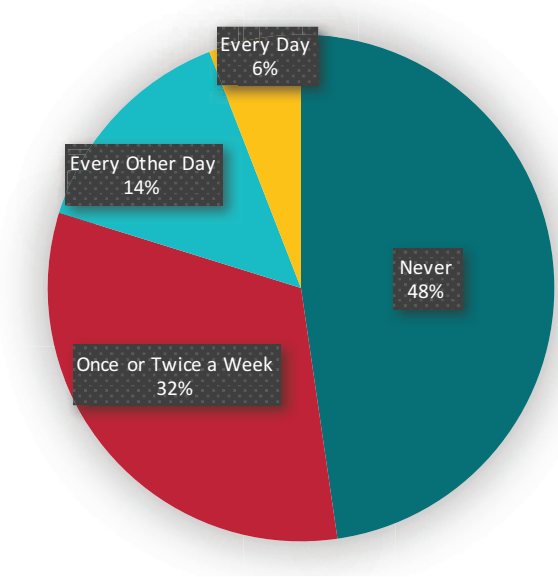
We asked specific questions related to preventative health behaviors as well as risky health behaviors such as betel nut use, smoking, and illicit drug use (Table 3). About 22% of the sample reported that they were dieting to lose weight, and 27.7% reported reading nutrition labels when purchasing food. 6.4% reported smoking one or more cigarette or e-cigarette each week, and 3.1% reported illicit drug use. About one out of every five refugees were chewing betel nuts one or more times each week. 23% of the sample reported alcohol drinking.

Table 3. Health Behavior of Refugees in the Sample

VARIABLES	YES		NO	
	N	%	N	%
Dieting to Lose Weight	62	22.1	217	77.9
Read Nutrition Labels When Purchasing Food	78	27.7	204	72.3
Have Chewed Betel Nuts on Average of one or more times each week	67	23.4	219	76.6
Currently Chew Betel Nuts one or more times each week	59	20.8	225	79.2
Smoke on Average one or more Cigarettes/e-cigarettes each week	18	6.4	259	93.6
Have Used Illicit Drugs (i.e. marijuana, cocaine, heroin)	9	3.1	280	96.9
Current Alcohol Consumption	66	23.1	220	76.9

When asked "How often do you spend doing physical exercises such as walking, running, riding bicycle, basketball, swimming, etc.?" 48% of the sample reported 'never' (Figure 6).

Figure 6: Frequency of Physical Exercises (n=287)



HEALTH CARE UTILIZATION AMONG REFUGEES

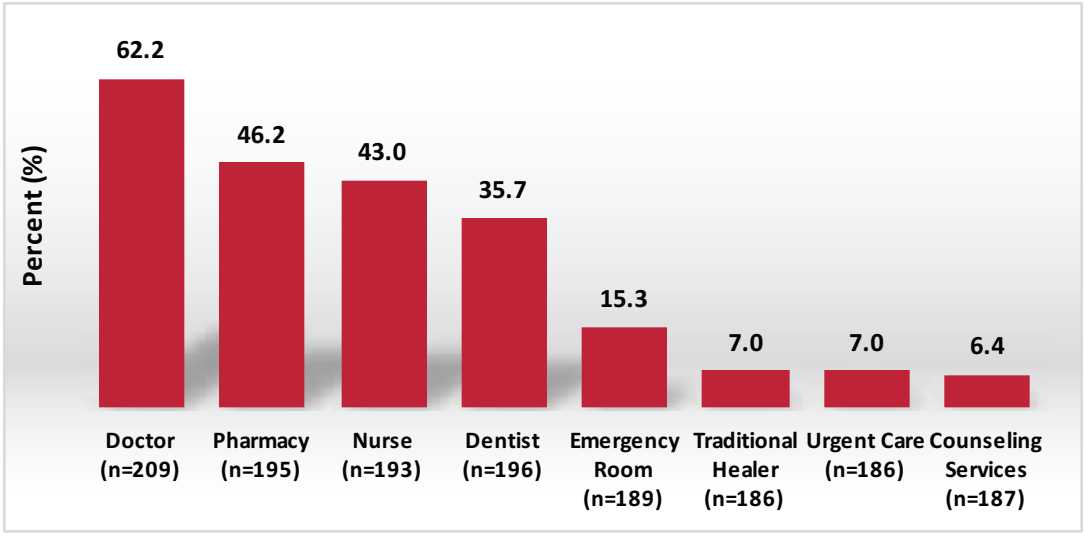
Table 4 displays refugees' health care utilization during the last 12 months before the survey. About 42% of the refugees in the sample had a physical examination. 23.3% delayed seeing a provider because of cost and 15.4% postponed buying medication because of cost.

Table 4. Health Care Utilization among Refugees During Past 12 Months

VARIABLES	FREQUENCY	PERCENT
Had Cholesterol Checked	42	14.9
Had Blood Pressure Checked	126	44.4
Screened for Diabetes	62	22.4
Had a Physical Exam	111	41.9
Delayed Seeing a Provider because of Cost	56	23.3
Postponed Buying Medication because of Cost	37	15.4
Took Multivitamins or Vitamin Supplements	45	15.9

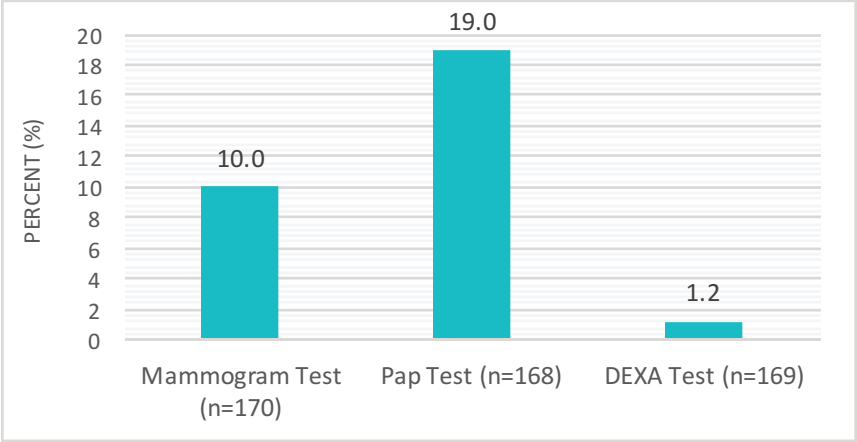
Figure 7 shows visits to health care providers by refugees during the 12 months before to the survey. About 62% of the sample visited a doctor, followed by visits to pharmacies (46.2%), nurses (43%) and dentists (35.7%).

Figure 7. Visits to Health Care Providers in the Past 12 Months



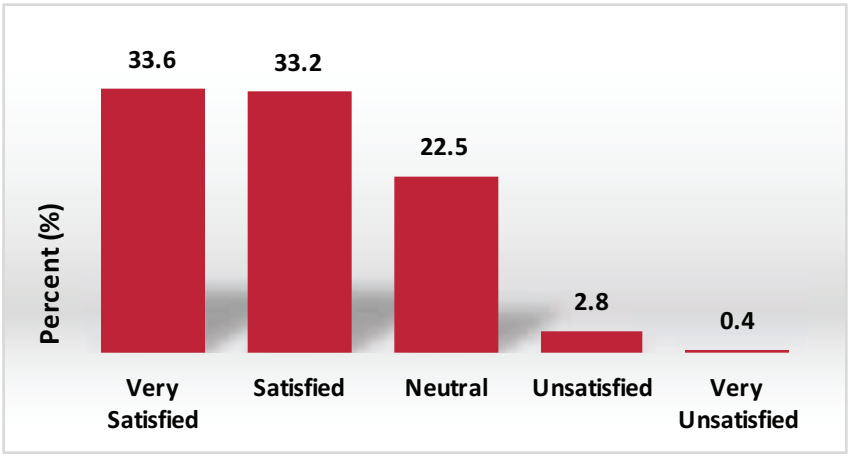
Female participants in the survey were asked questions regarding their utilization of female specific health services such as mammograms, PAP Smears, and DEXA tests during the 12 months before the survey. About 19% of the female respondents reported having Pap Smears, followed by 10% for mammogram, and 1.2% for DEXA exam (Figure 8).

Figure 8. Female Specific Health Services Utilization



Satisfaction with the U.S. healthcare services was also assessed (Figure 9). About one-third of the sample reported that they were very satisfied with the health services they received, with another one-third reporting being satisfied and the rest of the sample reported 'neutral', 'unsatisfied', 'very unsatisfied', or 'not receiving any health care in the U.S. so far' (not shown).

Figure 9. Satisfaction of U.S. Health Care Services (n=234)



BARRIERS TO HEALTH CARE ACCESS

About 37% of the refugees in the sample reported that they had never gone to health care facilities in the U.S. The top reasons for their not using health care services included 1) they don't believe their health issues are severe (42.1%); 2) they had language difficulties (35.5%); 3) they did not have health insurance (35.2%); and 4) they were not able to afford health care (29%). Other reasons included that refugees thought their health issues went away on its own, preferred their traditional medicine, doctors made them uncomfortable, clinic hours weren't flexible, and they didn't know where to go (Figure 10).

Figure 10. Reasons Refugees Don't Go to Health Care Facilities in the U.S. (n=107)

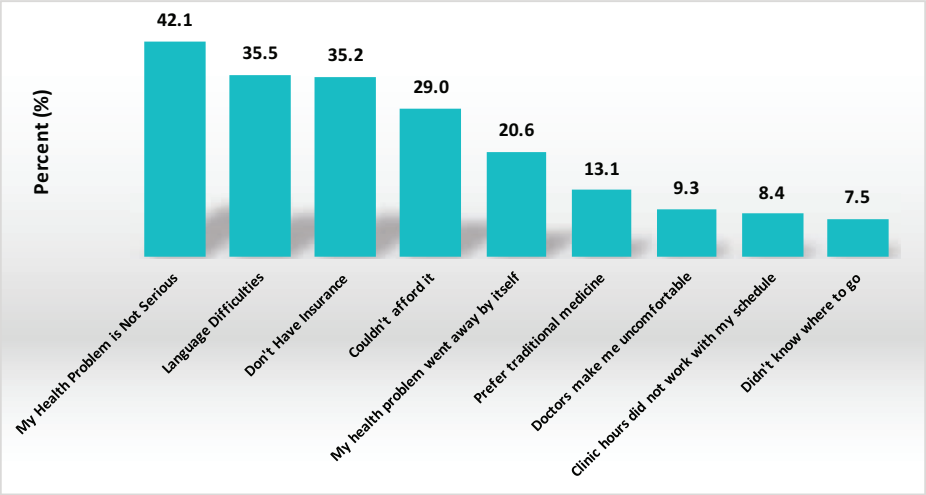
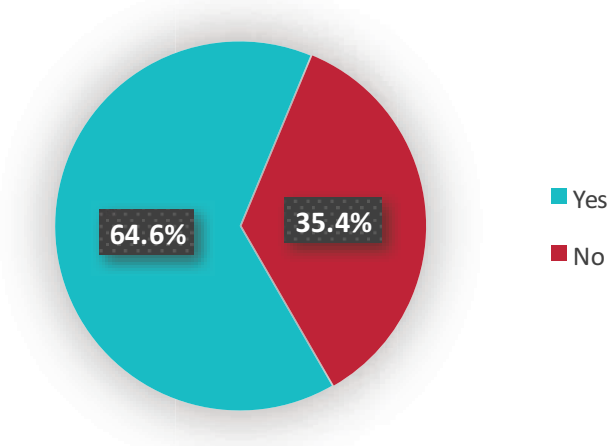


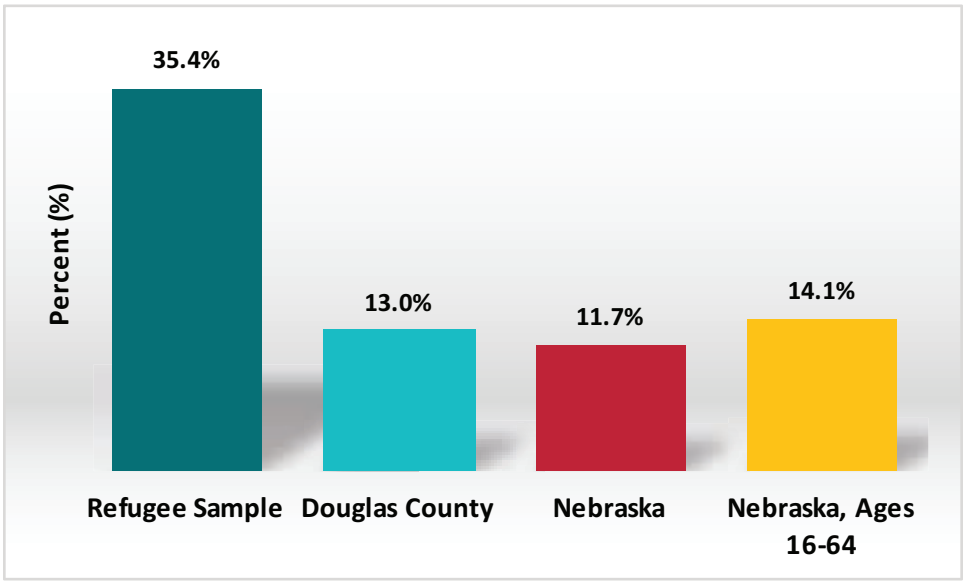
Figure 11 shows participants health insurance status. Over one-third (35%) of the sample did not have health insurance at the time of the survey.

Figure 11. Current Health Insurance Status (n=277)



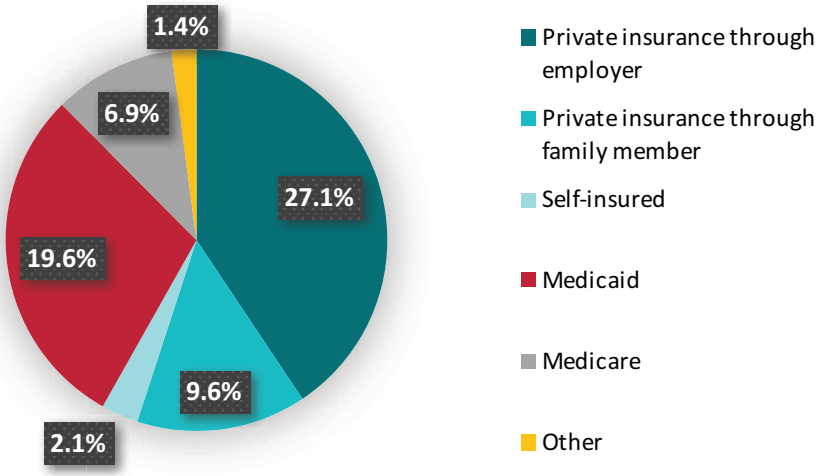
When compared to the overall adult population of Nebraska, and the overall population of Douglas County, the refugee sample had a much higher rate of uninsurance (Figure 12).

Figure 12. Uninsurance Rate Comparison



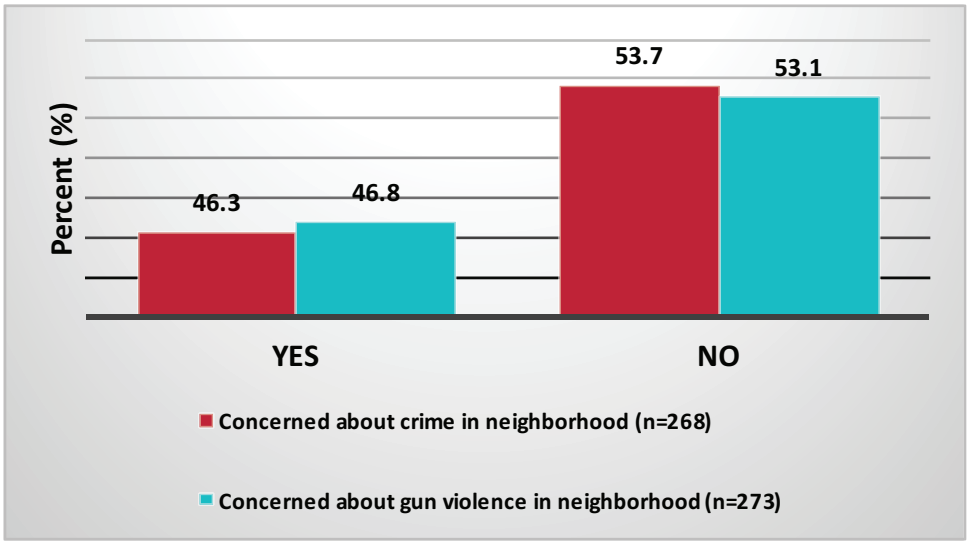
Among refugees with health insurance coverage, the largest health insurance type was private insurance through an employer, which consists of over one quarter of the sample (Figure 13). The next most major breakdown was Medicaid with 19.6% of the sample.

Figure 13. Insurance Type (n=194)



We also asked about violence as a potential barrier for refugees seeking health care. Over 46% of refugees were concerned about crime or gun violence in their neighborhoods (Figure 14).

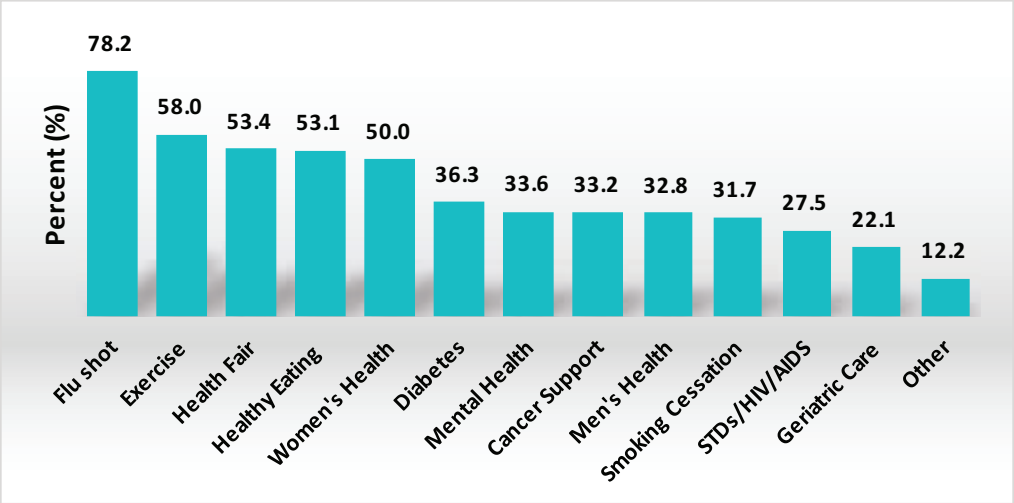
Figure 14. Community Violence Concerns



PREFERENCES FOR HEALTH SERVICES AMONG REFUGEES

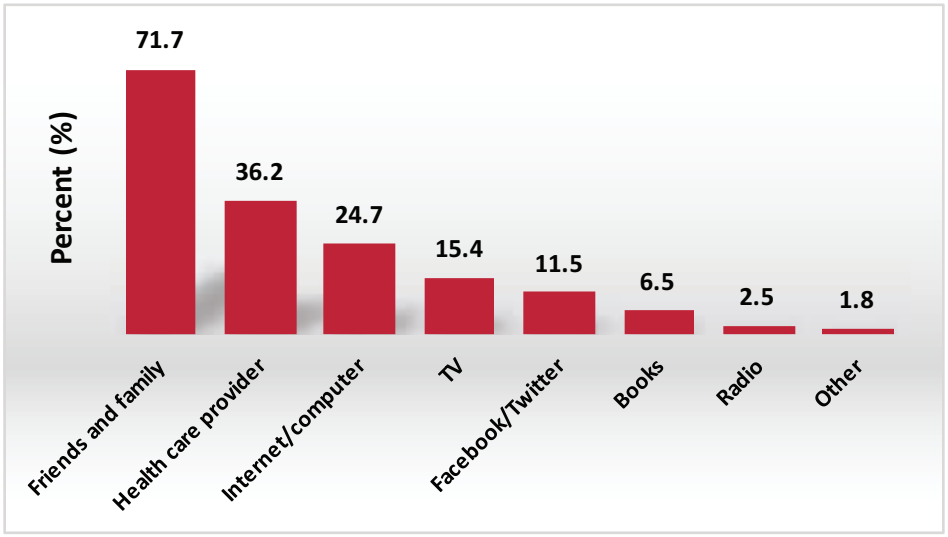
Refugees answered diversely on health education programs they would be interested in if offered in their community. The top five interested services include receiving flu shots, exercise programs, health fairs, healthy eating education, and women's health services, all of which were recommended by at least half of the sample. Overwhelmingly, the sample wanted to receive flu shots (78.2%). Service programs on diabetes, mental health, cancer support, men's health, smoking cessation, STIs/HIV, and geriatric care also received considerable recommendations from the refugees (Figure 15).

Figure 15. Topics of Interest in Community Health Programs (n=262)



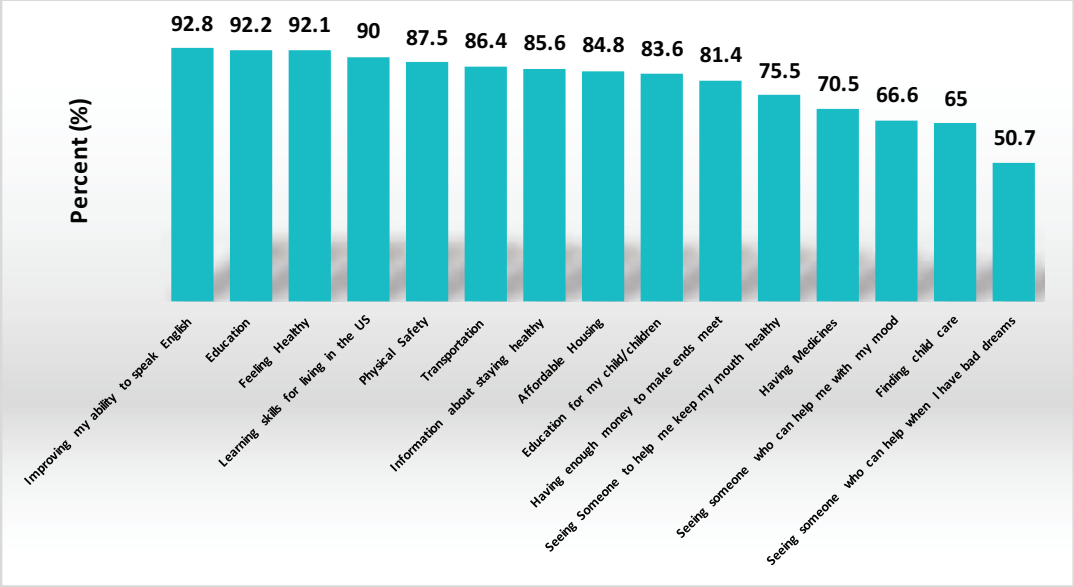
Another finding of interest is how refugees were receiving health information. Figure 16 shows that the majority of the sample reported that they received health information from friends and family (71.7%), followed by from health care provider (36.2%), and the internet/computer (24.7%).

Figure 16. Source of Health Information (n=279)



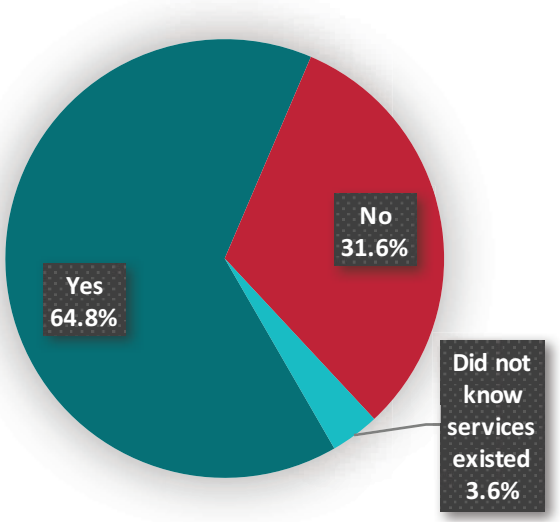
We also assessed the importance of various issues affecting refugees' daily life based on their perception. Improving their English speaking skills was perceived to be important for most refugees, followed closely by education and feeling healthy (Figure 17).

Figure 17. Self-Reported Importance of Various Issues (n=273)



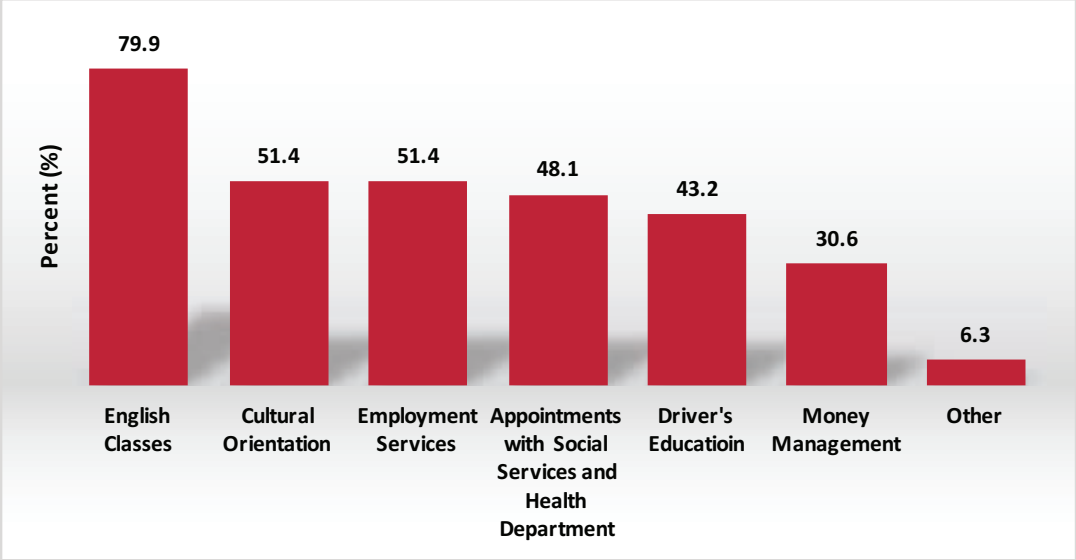
Almost one-third of refugees (31.6%) reported that they had not received any community services (Figure 18).

Figure 18. Reception of Community Services (n=275)



When services were received, English classes were the most frequent community service. About 80% of the subsample reported participation in English classes, followed by cultural orientation services (51.4%), employment services (51.4%) and so forth (Figure 19).

Figure 19. Specific Community Services Received (n=184)



Discussion

Among all health disparity populations in the U.S., refugees are uniquely vulnerable partly because they were forced to leave their native countries, which usually did not allow them to be prepared for transitioning to the U.S. The exceedingly high rates of unemployment and poverty among refugees, as reflected by this report, are indicative of economic hardships many refugees and their families are struggling with. Over half of the refugees in our sample (53.7%) make less than $10,000 per year, which will make it rather difficult, if not impossible, for them to pay for out-of-pocket costs of health care. Furthermore, 47% of the refugees were not employed, pointing to the importance of addressing social determinants and upstream factors (e.g. lack of education, job training, employment opportunities) that have contributed to the unmet needs in health care among refugees.

The survey data used in this report have revealed substantial unmet needs in health care access and utilization among refugees in Omaha, Nebraska. Over 35% of refugees in the sample did not have any health insurance coverage, as compared to the average uninsurance rate of 13% in Douglas County. Approximately one out of every four refugees delayed seeing a health care provider because of cost during the 12 months prior to the survey, and one out of every seven postponed buying medication because of cost during the same period. Not only are refugees delaying seeking medical help, but they are also not receiving adequate preventive care. Approximately 13% of refugees in the sample reported being diagnosed with hypertension, but only 44.4% of refugees had their blood pressure checked in the last 12 months. Similarly, 5.6% of this sample were diagnosed with diabetes, but only 22.4 % were screened for diabetes. About 26% of refugees reported mouth problems, but only 35.7% of them visited a dentist during the 12 months before the survey, whereas the corresponding rate among adult Omaha residents was 70% (Professional Research Consultants, 2015). These findings suggest that it is very likely that chronic conditions such as diabetes, hypertension, and oral diseases among refugees could be under-diagnosed and underreported given the low screening rates.

Besides economic hardships and lack of health insurance coverage, most refugees also need to overcome the language barrier before they can efficiently navigate and engage with the U.S. health care system. This is especially the case for refugees in Omaha, Nebraska where most of the refugees are from countries with native languages distinctive from English. One of the top reasons that many refugees in Omaha were underutilizing health services, as reported by this study, was the language issue. Providing appropriate interpretation services might be difficult for some health care facilities, especially small care providers since they might not be adequately equipped for serving non-English speaking refugees. This will make it difficult for refugee patients with no or limited English proficiency to understand their diagnosis and treatment plans. Furthermore, the relatively low education of many refugees (half the refugees in our sample had either no schooling or an education of 8th grade or less) could also hamper their understanding of medical information and effective communication with their care providers, which might compromise patient compliance including attending necessary follow-up appointments.

Refugees in our sample expressed an interest in receiving certain preventative health services such as flu shots, physical exercise, healthy eating, health fairs,

and women's health. Of these services, promotion of physical activity could be of particular significance based on findings from our survey. According to the prevailing classification standards for body weight in the U.S., 44.4% of refugees who participated in the study were overweight or obese, and this proportion would be even bigger if we use more conservative classification standard for Asians (over 75% of refugees in our sample were from Southeast Asia). Despite the high prevalence of obese and overweight BMIs, 47.1% of refugees in the sample reported that they never participated in physical exercises. Future research is needed to understand why this has been the case, whether it be lack of interest in physical exercises, lack of access to exercise facilities, concerns over neighborhood safety, and so forth.

When asked about the sources of health information they received, refugees overwhelmingly reported that they received their health information from family and friends (72%), followed by from a health care provider (36%). Future effort in health education and patient navigation in the refugee communities can consider adopting a family-based approach to encourage small circle learning. Health care providers can also play a unique role of in health literacy promotion for refugees; however, some health care providers may need to be trained or to have the interpretation services available when they serve refugee patients with no or limited English proficiency.

The Office of Refugee Resettlement reports that during the first eight months of their arrival, refugees usually receive short-term health insurance called Refugee Medical Assistance (RMA). Some refugees may be eligible for Medicaid or the Children's Health Insurance Program (CHIP). After the first eight months since their arrival to the U.S., refugees are eligible to apply for health insurance through the free market (Office of Refugee Resettlement, 2015). However, relative to the native population, refugees are more likely to be excluded from health care expansion programs and reforms because of language barriers, even though they would benefit from new policies and programs (Yun et al., 2012).

In Nebraska, current services available to refugees include Supplemental Nutrition Assistance Program, (SNAP: which provides eligible refugees to buy food based on monthly income), Financial Assistance Program (ADC: Aid to Dependent Children), Refugee Health Screenings, Medicaid eligibility assistance, employment assistance, and English language training. These services are primarily provided through resettlement agencies, such as Catholic Social Services, Lutheran Refugee Services, and Refugee Empowerment Center (Nebraska Department of Health & Human Services, 2015). Even with the existing services, there are substantial gaps between existing service capacity and the growing medical need of the refugee populations in Omaha. Besides, current services focus more on the short-term need of refugees, especially during their first year after arrival to the U.S., without systematic effort in addressing the long-term economic, medical, social, cultural, and other needs of refugee families. Addressing the tremendous unmet needs in health care access and utilization, as reflected by this report, calls for concerted, sustainable effort and long-term strategies from all stakeholders to mobilize the resources and partnerships needed to take care of one of the most vulnerable health disparity populations in Omaha.

Limitations and Strengths

Several limitations of the study are noteworthy. First, our use of a convenience sample, rather than a random, population based sample of refugees calls for caution when generalizing findings from this report to the whole refugee population in Omaha. Second, information on health status, health behavior, and health care utilization in this study was based on the recall of respondents. Underreporting or other recall biases might impact the accuracy of the data. Future study can add to our study by assessing refugee health and health care utilization through the use of medical records and evaluate the robustness of our findings. Finally, the modest sample size (n=291) of the survey has made it difficult for us to conduct subgroup comparisons within the refugee population and examine health disparities within the refugee population. This is also why we did not conduct in-depth multivariate analysis to identify specific predictors of health disparities, health care access barriers, and health care utilization in the sample.

Despite these limitations, this report represents a rare effort in conducting a systematic health needs assessment among the growing refugee population in Omaha, Nebraska. The questions included in the survey were designed based on consultation with refugee partners and a review of the literature on refugee health in Nebraska and the U.S. We also recruited interpreters from the refugee community to conduct on-site translations when needed, which helps improve the accuracy, validity, and reliability of the collected data. Moreover, the support from refugee community leaders has made it possible for us to reach out to different refugee populations in Omaha for participation in the survey within a short period.

Recommendations

Based on the findings from this study, we recommend that health care providers, refugee resettlement agencies, policy makers, refugee communities, and other stakeholder organizations work together to:

1. Increase availability and time-flexibility of English language classes, and raise awareness about these classes among refugees.
2. Work closely with employers in Omaha to provide job trainings and employment opportunities for local refugee population.
3. Provide information and resources for health insurance coverage purchase and enrollment among refugees.
4. Promote health literacy and patient navigation among refugees through trained community health workers recruited from the refugee community.
5. Mobilize the needed resources and partnerships to provide the health services refugees reported they were most interested in such as the provision of flu shots, exercise facilities, health fairs, healthy eating education, and women's health services.
6. Equip health care providers with the language support they need when serving refugees with no or limited English proficiency.

Conclusions

The recent increase in the refugee population in Nebraska portends the growing importance of understanding their unmet needs and unique barriers in health services before these disparities can be addressed. Based on analysis of survey data recently collected from 291 refugees living in Omaha, Nebraska, major reported barriers and unmet needs in health care access and utilization included language barriers, lack of health insurance coverage, underutilization of preventive health services, and delayed reception of medical services due to cost. Underlying these barriers and unmet needs are the exceedingly high rates of poverty and unemployment among refugees and a health care system that has been inadequately prepared to serve the refugee population, especially those with no or limited English proficiency. Addressing these tremendous unmet needs calls for concerted, sustainable effort and long-term strategies from all stakeholders to mobilize the resources and partnerships needed to take care of one of the most vulnerable health disparity populations in Omaha, Nebraska.

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