
UNIVERSITY OF NORTH TEXAS
HEALTH SCIENCE CENTER AT FORT WORTH
1970

Le, Tuan D., Barriers to Health Care Access among Vietnamese Refugees in Tarrant County, Texas. Master of Public Health (Health Management & Policy), May 2004, 88 pp., 17 tables, 11 illustrations, bibliography, 56 titles.

The refugee community is the most vulnerable community due to existing medical conditions without proper treatment and many barriers in accessing the health care system, including different language, cultural conflict, legal restrictions, and socioeconomic status. The purpose of this study is to determine the nature of these barriers that keep the Vietnamese refugees from accessing the health care system in Tarrant County. The study found that 45.8% have no health insurance, 17.4% received Medicaid, 53.7% have no primary care physician, and 57.14% of Vietnamese elderly refugees, who have been living in the U.S. between seven and ten years, and have lost SSI and Medicaid. These findings are significant at $p < .001$. Vietnamese refugees perceived factors that kept them from accessing the health care system as major barriers, including language (14%), legal issues (17%), misunderstanding of the medical system (15%), lack of insurance (14%), and different culture (11%). These results may assist social service providers, health care providers, and policy activists to enhance their services and advocate for legal issues, in order to remove these barriers and help refugees to access health care better.

BARRIERS TO HEALTH CARE ACCESS AMONG VIETNAMESE REFUGEES

IN TARRANT COUNTY, TEXAS

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BARRIERS TO HEALTH CARE ACCESS AMONG VIETNAMESE REFUGEES IN TARRANT COUNTY, TEXAS

THESIS

Presented to the School of Public Health

University of North Texas
Health Science Center at Fort Worth

in Partial Fulfillment of the Requirements

for the Degree of

Master of Public Health

By

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Fort Worth, Texas

May 2004

ACKNOWLEDGEMENTS

A warm and heartfelt thanks to Fort Worth Catholic Charities Refugee Services, Universal Beauty College, Huong Dao Buddhist Pagoda, and Quang Chieu Meditation Monastery for their help in completing the survey for this study. Especially, thanks to Dr. Chiehwen Ed Hsu, my major professor, for his time, kindness, patience, thoughtfulness and expertise to guide me through this research project. Thanks to Dr. Sue Lurie and Dr. Raghbir Sandhu for agreeing to serve on the committee and for supporting me through the Master of Public Health program. Finally, thanks to my parents, my wife and daughter, and my brothers. Without their support, this master's degree would not have been possible.

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CHAPTER I

INTRODUCTION

Most Vietnamese refugees have had a tragic experience at "reeducation camps" and "new economic zones" with the fear of persecution in Vietnam and have faced brutal conditions at "refugee camps" and on the way to seek freedom. In addition to inappropriate medical treatment for previously existing medical conditions, Vietnamese refugees have faced many barriers to access health care after arriving in the United States. Most of them cannot speak English and do not know where to get a translator, because either a translator is not available at any medical clinic or hospitals where refugees have sought medical care. Furthermore, cultural conflicts, legal issues, and socioeconomic status have affected access to health care among Vietnamese refugees.

According to Office of Refugee Resettlement (ORR) Annual Report to Congress in 2001, the Vietnamese refugees have underutilized Refugee Medical Assistance (RMA) program or Medicaid and other federal benefits. Moreover, the Vietnamese refugees usually seek medical care services when they are sick and have very few scheduled healthy check ups and limited preventive care (McColloster, 2000), even when they have Medicaid or health insurance. Others cannot access health care when they are sick due to the lack of government health insurance, private health insurance, and financial constraints. Some only seek care from self-prescribed traditional medicine/herbal medicine.

Like other refugee communities, the Vietnamese refugee population is relatively small, but their health and illness patterns may have a great effect on the larger population in general when their needs are not met. The epidemiology of refugee illness is extraordinarily complex, since health care may not be the highest priority for newly arrived refugees (Kemp & Rasbridge, 1999), and the delay in seeking health intervention and progression of diseases may add to the complexity of illness. They may have many chronic diseases, affecting both physical and mental conditions, because of the consequences of war and trauma experience, displacement, torture, rape, imprisonment, fear, hunger, and other experiences. After arriving in the United States, refugees may access health care with a maximum of up to eight months under the RMA program. Once they start to work, they are not eligible for RMA, and they cannot afford employer-based health insurance for themselves and their family members due to the high premiums and/or high deductibles.

The Supplemental Security Income (SSI) for elderly refugees and Medicaid has been cut or will be cut if they do not become U.S. citizens after seven years of living in the United States, due to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) or Welfare Reform Act. Therefore, underutilization of health care among Vietnamese refugees may be a major problem affecting not only the Vietnamese family or Vietnamese community but also the entire society in medical expenditure for acute and chronic illnesses, and there is the potential of spreading communicable diseases and reduction in productivity of the labor force.

According to Health Objectives for the Year 2010, the notion of access to health care has long been viewed as "a given" in terms of the basic rights and privileges of Americans (Lincohn-Lancaster County Health Department, 2000). Access to health care in a timely and appropriate manner has significant implications for individuals' immediate and long-term health. Therefore, lack of access to health care services due to language, legal, cultural, and socioeconomic barriers is of great importance to the Vietnamese refugee community. Medical expenditures for refugees becomes a burden not only to their families but also to the society, due to medical care costs of acute, chronic, the potential of spreading communicable diseases, and complicated consequences of inappropriate treatments. Hence, removing the barriers to accessing health care among refugees is an important step not only in the enhancement of refugee health to produce a healthy labor force and healthy community, but also cost-saving in the long run. The purpose of this study is to determine the nature of the barriers that keep the Vietnamese refugees from accessing the health care system. The information gained from this study may assist social service providers, health care providers, and policy activists to enhance their services and advocacy of legal issues, in order to remove these barriers and help refugees to access health care better.

This study used a cross-sectional descriptive survey to collect data among Vietnamese refugees in Tarrant County, Texas at community-based sites between February 12, 2004 and February 29, 2004. The 201 qualified participants were voluntarily participating in the study and choosing either Vietnamese or English version to complete a 25-question survey questionnaire. This study focused on four main

categories, including language barriers, legal barriers, cultural barriers, and socioeconomic barriers, to determine whether they were some of the perceived barriers that Vietnamese refugees have been facing when accessing health care.

CHAPTER II

BACKGROUND AND LITERATURE REVIEW

Background

"A refugee is any one who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that county."

(United Nations, 1951)

Vietnamese refugees are persons who fled their homeland to seek freedom in the United States or other country, shortly after the fall of South Vietnamese Government in April 1975, or after surviving a long time in refugee camps in the surrounding Asian countries, or in the "re-education" camps and/or "new economic zones" in Vietnam. They were political refugees or persons who were forced to leave without any preparation due to their fear of persecution (Do, 2002).

More than 700,000 Vietnamese refugees arrived in the United States in several waves under an oppressive political climate in Vietnam, or under legal issues and agreement between the Government of the United States and the Government of Socialist Republic of Vietnamese in the last three decades. The Office of Refugee Resettlement (ORR) Annual Report to Congress of 2001 and U.S. Department of State Proposed

Refugee Admissions for the fiscal year 2004 of Report to the Congress reported that more than 705,000 Vietnamese refugees arrived in the United States from 1946 to 2004. The new arrivals have included nine persons (1951-1970), 150,266 refugees in the 1970s, 324,453 refugees in the 1980s, 206,857 refugees in the 1990s, and declining to 2,730 in the 2001 and 3,312 in the 2002, as well as an estimated of 3,100 Vietnamese refugees in the 2003 and a proposed 3100 Vietnamese refugees in the 2004 (Table 1 & Figure 1).

In the first wave, about 135,000 Vietnamese fled to America between 1975 and 1977. Most of them were upper middle-class urbanites with high professional occupations, higher education, ex-military, and government officials and their families, and some had worked for the United States during the war (Do, 2002; SEARAC, 2001). Those predominantly consisted of well-educated, English speaking Vietnamese, with some Roman Catholics, and they were familiar with Western culture (McColloster, 2000; Gold, 1992). This group rapidly adapted to American culture and had a high income. Almost all of them may be U.S. citizens now, and are not the primary focus of this study.

The second wave popularized in the press as the "boat people," fled out of the country from 1978 to late 1980s (Gold, 1992). There were two main groups in this worst wave of emigration. From 1978 to 1979, most were ethnic Chinese or Sino-Vietnamese who were merchant class and middle-upper class, and had become the targets of the new communist government. Another group who were Vietnamese were predominantly rural farmers and fishermen and their families, who had no knowledge of Western culture. Vietnamese and Sino-Vietnamese sought to escape the country in small fishing boats. No one knows exactly how many thousands of Vietnamese took to boats to seek freedom

perished at sea, were buried in jungles, or faced other brutal conditions, such as murdering or raping by Thai pirates, getting lost, being starved to death. Some estimates are that half of them luckily reached refugee camps in Hong Kong, Indonesia, Malaysia, Philippines, and Thailand (Do, 2002; SEARAC, 2001). Almost all of them were poor and uneducated, as well as experiencing long term stays in refugee camps apart from their families, so they were less likely to adapt to American culture easily and are often dependent on federal benefits because of low income (McColloster, 2000; Gold, 1992).

The third wave was created under the Orderly Departure Program (ODP) in 1979, as the result of an agreement between the Socialist Republic of Vietnam, and 26 participating countries called "the third countries", including the United States. The refugees who have come to the United States under the Humanitarian Operation (HO) Program were typically based on their status as political prisoners, commonly referred to as "H.O.s", or under the Amerasian Homecoming Act, children of Vietnamese women and American servicemen, referred to as "Amerasians." This was the major wave of Vietnamese refugees who faced serious discrimination in Vietnam (Kemp, & Rasbridge, 1999). In the last two decades of operation, the ODP has allowed over 500,000 refugees to come to the United States.

Approximately 100,000 Amerasians, called "mixed blood," and almost illiterate, were regarded as "bui doi," or "the dust of life" by the Vietnamese government and had very miserable lives. Even when America accepted them as refugees, the government still refused to allow their departure because of allayed discrimination (SEARAC, 2001). They arrived in their "fathers' land", but they have "isolated from American life and the

Vietnamese community by the chasm of illiteracy, language barriers, distrust and discrimination," and "most have had great difficulty in adapting to American society" (Vaughn, 2003).

In "H.O.'s" group, the males, mainly well educated, especially the ex-political detainees, were forced to "reeducation camps", where most were starved and forced to work long hours clearing and working fields for many years, under harsh conditions. Most of the women had minimal education and were rice farmers (Hinton et al., 2001). Like political detainees, the wives and the children were frequently sent to "new economic zones" and they often endured starvation and overwork (Hinton et al., 2001; SEARAC, 2001). Finally, in 1988, the U.S. Department of State reached an agreement with the Vietnamese Government to allow about 100,000 former political prisoners to resettle in the United States.

Currently, the processing of residual ODP, after April 1, 1995, the McCain Amendment under H.R. 1840 is to extend eligibility for refugee status to the unmarried sons and daughters of certain "H.O" survivors that has allowed them to join with parent(s) in the United States. These children had been without their fathers throughout the time their fathers were in "reeducation camps" at least three years, and in some cases for 10 to 15 years in order to be eligible for "H.O's" Program. Another approximately 21,000 individuals of Vietnam who had been repatriated from Asian refugee camps to resettle in America if they are qualified for refugee status under the Resettlement Opportunities for Vietnamese Returnees (ROVR) program (SEARAC, 2001; H.R. Report 107-254, 2001; U.S. Department of States, 2003). The resumption of processing of the

U11 caseloads for former U.S. government employees, has allowed those Vietnamese who were direct-hire employees of the U.S. government for a minimum of five years before 1975 to resettle in the U.S. That was suspended in 1996 and was authorized in 1999. In 2000, officers of the Department of State reviewed the files of all 2,282 applicants in this caseload, and 946 applicants were determined eligible for refugee interviews (U.S. Department of State, 2003) to resettle in the U.S.

Vietnamese refugees have combined with the family reunification program and American-born Vietnamese to create a fast growing ethnic population in the United States. In the Vietnamese Studies Internet Resources Center in 2003 (as reported in U.S. Census 2000), there are 1,122,258 Vietnamese living in the United States. The largest number of Vietnamese refugees have settled in Los Angeles, Orange County, and San Diego, California; Houston and Dallas/Fort Worth area, Texas; suburbs of Washington, DC; Seattle, Tacoma, and Bremerton, Washington; Boston, Worcester, and Lawrence, Massachusetts; Philadelphia, Wilmington, and Atlantic, Pennsylvania; and Atlanta, Georgia (Figure 2).

The Vietnamese Studies Internet Resource Center (2003) reported that there were 47,090 Vietnamese living in Dallas-Fort Worth area (as reported in U.S. Census, 2000), including 3074 Vietnamese refugees who arrived in Tarrant County from July 1993 to June 2003 (TDH, 2003) (Figure 3). Almost all of them were poor and uneducated, as well as existing medical conditions without treatment properly. Furthermore, they have faced may barriers, such as lack of language, cultural conflict, restriction of legal issues, and low socioeconomic status when accessing health care system.

Health status

Based on the ORR Annual Report to Congress in 2001, the comparison of surveys from 1997 to 2001 between Vietnamese refugees and other refugee communities revealed that Vietnamese refugees had underutilization of public benefits, including Medicaid/RMA or cash assistance programs. For example, in 2001, only 13.7 % of the Vietnamese refugees received Medicaid/RMA and 12.7% were not covered by Medicaid/RMA, whereas 62.3% former Soviet Union refugees received Medicaid/RMA and only 5% were not covered by Medicaid/RCA in the past 12 months after arriving (Figure 4 & Appendix A).

The Vietnamese refugees have had a serious experience in dealing with medical conditions in the war, in the "refugee camps," in the "reeducation camps," and in the "new economic zones," as well as in the United States. The Vietnamese refugees have faced many barriers to access health care. Barriers were defined as primarily internal, subjective beliefs and perception of the "costs" of health behaviors that were not necessarily evident from ether the consumer's sociocultural characteristics or the structure of the health care system (Melnyk, 1988). Other external barriers also keep them from utilizing health care, such as the lack of English language ability, cultural conflict, legal issues, and lower socioeconomic status.

Like other refugee communities, Vietnamese refugees are at high risk because of existing chronic diseases, transmitted diseases, and underutilization of health care services. These barriers may affect not only the Vietnamese refugee community or other refugee communities, but also our entire society. Therefore, these barriers should be

removed in order to improve refugee health and contribute better health to the entire society.

Literature Review

Generally, health care may not be the highest priority to newly arriving refugees (Kemp & Rasbridge, 1999). The Vietnamese refugees always obtain health care services on an episodic basis with few scheduled visits and limited preventive care, and consequently, they do not comply with preventive therapy, appointment scheduling, and long-term treatment (McColloster, 2000). That may be a result of numerous obstacles to effective health care utilization, including language barriers, cultural barriers, such as competing health beliefs and practices, and socioeconomic barriers, such as lack of health insurance or financial resources to pay for services, may exist for this community (Lin et al., 1979; Tripp-Reimer & Thieman, 1981; Kemp & Rasbridge, 1999). Furthermore, refugee health status is very complex and wide-ranging because they have diverse backgrounds, pre- existing medical conditions, and the lack of knowledge to access government or charity health care assistance programs (Kemp, & Rasbridge, 1999). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Act) has kept elderly and disabled refugees from receiving SSI and Medicaid once they do not become U.S. citizens after seven years of living in the United States (Sheridan, 2003; Mautino, 2000). The Refugee Medical Assistance Program only covers adult refugees for basic medical needs, with three medications per month, except dental and eye care, just within the first eight months only if their income does not exceed the income limitation.

Many refugees arrived in the United States with health problems suffering from long-standing illnesses (ORR, 2001) because of uncured disease or inappropriate treatment when they were in "reeducation camps" and "new economic zones" in Vietnam, or in "refugee camps" in Asian countries. In the United States, numerous barriers of lack of language ability, cultural conflicts, restriction of legal issues, low socioeconomic status have kept Vietnamese refugees away from accessing timely health care. Compared to native-born Americans, refugees are more likely to have a variety of health problems (Sonis et al., 1999). Kemp & Rasbridge (1999) reported that Vietnamese refugees are at high risk for many communicable diseases like tuberculosis, hepatitis B, and parasitism when they first arrived in the acute phase of adjustment. For example, in the period of 1986-1994, the percentage of Vietnamese TB cases under age 35 was 44% and overall Vietnamese refugee population was 52% as compared to Sun-Saharan African was 67-80% and to former Soviet Union was 19-51% (ORR, 2001). They are at high risk for more chronic diseases like hypertension, heart disease, cancer, and diabetes, as well as mental health problems like post-traumatic stress disorder (PTSD) and depression. Within two months of arriving in the United States, appropriately 6% of Vietnamese refugees met the criterion for a probable case of depression, because of cultural shock shortly after arrival (Buchwald et al., 1995). Buchwald et al (1995) also stressed that being divorced, separated, or widowed and poorly educated were strongly associated with depression.

Health Objectives for the U.S. for the Year 2010 includes the notion of health care access that has long been viewed as "a given" in terms of the basic rights and privileges

of Americans. Access to health care in a timely and appropriate manner has significant implications for the individuals' immediate and long-term health. A more complicated and costly resolution is the result of delaying treatment for an acute condition, affecting significantly individual long-term health and vitality. Barriers to care were defined as primarily internal, subjective beliefs and perception of the "costs" of health behaviors that were not necessarily evident from ether the consumer's sociocultural characteristics or the structure of the health care system (Melnyk, 1988). These barriers are also what the Vietnamese refugees have faced when accessing the health care system.

The United States is a multicultural and multilingual society; however, the health care system here is largely geared toward serving English-speakers (Chang & Forties, 1998). The study of Lincoln-Lancaster County Health Department in 2000 (as cited in the Minority Health Survey in Lincoln, Nebraska in 1994) found up to 23% of population surveyed reported that they could not receive health care services because of their lack of English skills. The ability to speak English is one of the most important factors influencing the economic self-sufficiency of refugees (ORR, 2001) and access to public benefits, especially health care (Ackerman, 1997; Chignoli, 2002). Language and cultural barriers make it imperative for the physician to know which medical problems are common and what laboratory tests should be considered when caring for the refugees (Ackerman, 1997). D'Avanzo (1992) in determining the dynamics of why Vietnamese refugees may not optimally use existing health services in the United States, found that the majority (99%) said that they went for health care only when ill, because of the lack of a translator. Recently, they have become more confident in accessing health care,

because they can see the Vietnamese speaking physicians, but they may not feel comfortable speaking English because of limited English language skills. Therefore, they have significant needs for health care (Stand et al., 1983). Previously, Hoang & Erickson (1985) reported that refugees have probably underutilized the health care system due to cultural barriers between patients and health care providers (Allotey, 1988; Harris et al., 2001).

Jenny (1989) suggested that cultural patterns and health care resources heavily influence health protection and health restoration. In 1992, Geissler stated that differences in language refer to the language barrier alone, but differences in culture have a much broader etiology, involving different values, beliefs, customs, and nonverbal mannerisms between health care providers and patients (refugees). In addition to culturally competent health care, Gervais (1996) emphasized that societal changes affect health care practices, and an intercultural health care ethic will elaborate the conditions essential to cultural respect, conditions that enable ethnically informed decision-making.

A typical Vietnamese family is comprised of structure based on patriarchal authority and respect from Confucian ideology, so the father or oldest family member always makes all the important decisions, even health care decisions (Do, 2002). Specific cultural beliefs and practices that influence health and health care are very diverse (Ahmed & Lemku, 2000). For example, Vietnamese refugees practice traditional folk healing techniques that may affect access to health care (Ackerman, 1997) because they delay seeking health care, and the health care providers lack cultural

sensitivity. This may waste millions of dollars annually for inappropriate tests and misdiagnoses (Andrew, 1992). Those traditional folk treatments are influenced by Chinese traditional concepts of Yin and Yang. For example, diarrhea contributes to a "cold" stomach or pimples, or pustules, which are attributable to an excess of the "hot" element (Nguyen, 1985). Some Vietnamese refugees frequently use folk treatment concurrently or before seeking Western medical care (Rocereto, 1981). Furthermore, mistrust of health care providers and misunderstanding of the health care system restricts timely and effectively access to health care.

Refugees have faced the constraint of legal issues in accessing health care and other federal benefits. Refugees are eligible for state health care upon arrival under the Medicaid program or Refugee Medical Assistance Program (RMA) for the first eight months after arriving if they are eligible. Yet, they may not receive health care if they do not receive a Medicaid card because of system lags and lack of documentation or the income limitation.

Under the Personal Responsibility and Work Opportunity Reconciliation of 1996 (Welfare Reform) signed by President Clinton on August 22, 1996, thousands of qualified individuals, mainly those admitted as refugees under section 207 of the INA, lost their benefits unless they are naturalized, became U.S. citizens within seven years of arrival, or accrued 40 qualifying quarters for the purpose of social security. To become a U.S. citizen within seven years, they must pass a civic test, and be able to speak, read, write, and understand the English language (Mautino, 2000; Loue, 2000). Sheridan (2003) said that many elderly and disabled refugees receiving the SSI as their sole

income, Medicaid, and other public benefits have faced cancellation unless they become a U.S. citizen. However, many elderly refugees spent a long time in "reeducation camps," "refugee camps," or in "new economic zones", thus making them too ill or traumatized to learn English. Moreover, they may have little schooling, especially female refugees in Vietnam due to war. Therefore, they are hardly able to pass the citizenship test in English to become U.S. citizens. Nationwide about 4,300 people lost their federal benefits in 2003, and about 7,800 more people will lose their benefits every year thereafter. Many of them are at risk of becoming homeless and encountering many health problems because of losing SSI and Medicaid (McGann, 2003).

Because of being traumatized and exhausted from the war, tortured in imprisonment, fear of unfavorable fate on the way to flee out of Vietnam, Vietnamese refugees have had a great number of health needs as a result of poor access to appropriate health care. The poverty and social deprivation experience in their new country have exacerbated their health concerns (Hargreaves et al., 2002). Most of the insured refugees have low-income jobs and work for companies that do not offer health insurance (Chignoli, 2002). Financial constraints, the cost of transportation, the costs of health care services not covered by Medicaid, such as dental care or eye care, can influence refugees' decisions in accessing health care, so dental and oral health are a real problem (Lamb et al., 2002).

In regard to lack of health insurance, difficulty in obtaining health care and lack of regular resources for care affect refugee health (Mey et al., 2002). Limited trust of health care providers can keep some refugees from accessing health care (Moreno et al.,

2001). Elderly refugees have the lowest levels of economic, status, health, and functional capacities (Binstock & Jean-Baptiste, 1999). Lack of information about charity health care and other available services in the community and financial constraints are also real barriers that prevent refugees from accessing preventive care and appropriate health care services. In addition, educational level seems to positively affect use of health services (Pender & Pender, 1980).

Study objectives

Previous studies in the literature-reviewed show that Vietnamese refugees have accessed health care services to a lesser degree than their Caucasian or English speaking counterparts, even other refugee communities. These findings have demonstrated that Vietnamese refugees probably do not utilize the health care system usefully because of different language, cultural conflicts between patients and providers, legal issues, and financial constraints. Therefore, the objectives of this study were to determine:

1. Whether lack of English is a barrier to accessing health care among Vietnamese refugees.
2. Whether lack of legal knowledge and legal issues are barriers to accessing health care among Vietnamese refugees.
3. Whether cultural factors are barriers to accessing health care among Vietnamese Refugees.
4. Whether socioeconomic status is also a barrier accessing health care among Vietnamese refugees.

These objectives were accomplished through either face-to-face or self-reported survey administration and data analysis, as described in the next chapter.

CHAPTER III

STUDY DESIGN AND METHODOLOGY

The cross-sectional descriptive survey has used to collect data and analyze the barriers of health care access among Vietnamese refugees in Tarrant County, Texas. This study focused on four main categories: (1) language barriers; (2) legal barriers; (3) cultural barriers; and (4) socioeconomic barriers.

Subjects and Sample

The sample included 201 Vietnamese refugees living in Tarrant County who are 18 years old or older, with whom the author met at the office of Refugee Services or satellite ESL classes of Catholic Charities, Huong Dao Pagoda or Quang Chieu Meditation Monastery, or Universal Beauty College between February 12, 2004 and February 29, 2004. Participants were recruited with the convenience sampling method.

Survey Instrument

The 25-question survey was designed to investigate a broad range of issues, including socioeconomic status (e.g., gender, age, marital status, income, educational level, and occupation), lack of language and legal literacy, and cultural status. Many of these variables were used in either descriptive or analytic presentation of the data. Data was collected either by a face-to-face interview or by a self-reported response to the survey questionnaire, with or without the investigators' assistance. Qualified subjects

were given a survey and asked to complete a survey questionnaire either in an English or Vietnamese version. In this survey questionnaire, the Flesh-Kincaid Grade Level score was 4.4, which means that an individual with a fifth grade education could understand the survey questions. The Flesh Reading Ease score was 79.1, which means that the survey questionnaire was easy to understand.

Data collection procedure and analysis

All participants were recruited from Refugee Service office and ESL classes of Fort Worth Catholic Charities, Universal Beauty College, Huong Dao Pagoda, and Quang Chieu Meditation Monastery. Qualified subjects participated in this study voluntarily. Data were collected from a cross-sectional descriptive survey conducted on 201 participants (80.4%) by either face-to-face interview or self-reported response from 250 questionnaires given to Vietnamese refugees. The Likert Scale was used to codify the collected data, then import the data into SPSS Version 12.0, for descriptive and analysis by applying multiple regression analysis and Chi-square to reveal the associations between the dependent variables, such as health insurance rate, last time to visit doctors, etc., and independent variables, such as demographic predictors, socioeconomic status, etc. See Table 17 for a complete description. A particular test is significant when and only when $p <= .05$. The findings were compared with the study of Texas Refugee Study from Texas Office of Immigration and Refugee Affairs conducted in Houston in 1993 (Taylor et al., 1993), the ORR Annual Report to Congress in 2001, and other related studies to identify the barriers.

CHAPTER IV

RESULTS

Demographic characteristics of survey sample

Table 2 illustrates the characteristics of the survey sample. A sample of 201 respondents was drawn from 250 qualified subjects who are Vietnamese refugees living in Tarrant County. The response rate was 80.4%. Of these respondents, 95 were men (47.3%) and 106 were women (52.7%). The age distribution in this study included 29.4% (n= 59) for the age of 18 to 34, 28.9% (n= 58) for the age of 35 to 29, 26.9% (n=54) for the age of 50 to 64, and 14.9% (n=30) for the age of 65 and older. In this sample, most Vietnamese refugees are currently married, 61.2% (n=123). Only a small percentage was in partnership, separated, divorced, and widowed [5.0% (n= 10), 2.5% (n= 5), 4.0% (n= 8), and 6.0% (n= 12) respectively], and 21.4% (n= 43) remained single.

The Vietnamese refugees almost always have strong family ties that may include partial or the entire three generations in the same family at a time, including parents, children, and grandchildren. In this sample, the family size of five and more was 21.4% (n= 43), and the most predominant family sizes were two, three, and four, [19.9% (n= 40), 22.4% (n= 45), and 24.9% (n= 50)] respectively.

The sample contained a broad range of socioeconomic status, including the major occupations of participants had "no skills", 54.2% (n=109). These included mostly general labor jobs, such as assemblers, carpenters, etc., and only 10.4% (n=21) had

"skill" jobs gained from US education. Smaller numbers represent elderly/disabled and students [17.9% (n= 36, and 6.5% (n= 13)] respectively. The unemployed rate was high, 10.9% (n= 22). Employment status comprised 43.8% (n= 88) with only one job, 29.4% (n= 59) with two jobs, 13.9% (n= 28) with three or more jobs, and 12.9% (n= 26) with no job in household. This study found that more than 60% earned between $10,000 and $29,999, including 37.3% (n= 75) of between $10,000 and $19,999, and 24.4% (n= 49) of between $20,000 and $29,999. Only 8.0% (n= 16) had income $40,000 and more. On the other hand, one-sixth of them had income less than $10,000.

Table 3 shows the duration of residence in the U.S. of the subjects and educational background with the ability of using English in everyday and health services. Most Vietnamese refugees have been living in the United States between one and ten years, including 32.3% (n= 65) between 1 and 5 years, 12.4% (n= 25) between 5 and 7 years, and 35.3% (n= 71) between 7 to 10 years. Only 10.4% (n= 21) and 9.5% (n= 19) have lived more than 10 years or less than one year, respectively. The data also show that 43.8% (n= 88) of Vietnamese refugees had a high school diploma and higher degree in Vietnam. After they arrived in the United States, only 12% (n= 24) had a high school diploma and higher degree, and 15.4% (n= 31) attended or are attending vocational training to be technicians, especially beauty technicians such as hairstylists, manicurists, and pedicurists. Up to 71.6% (n= 144) have never attended any school in the U.S., except that some of them attended English as the Second Language (ESL).

In terms of the ability to use English everyday, approximately 65% of Vietnamese refugees in this sample cannot speak and understand as well as read and write English or

just can use basic words; only 6.0% (n= 12) speak English fluently and 6.5% (n= 13) can write anything. In utilizing health services, only 21.9% (n= 44) can access health services themselves in English, and using friends or relatives as interpreters was the predominant method [60.7% (n= 122)] of accessing and utilizing health care. A very small number of Vietnamese refugees know how to use social workers [9.5% (n= 19)] and interpreters [8.0% (n= 16)] in order to access health care.

Health insurance and access to health care

Tables 4 & 5 show that 45.8% (n = 92) of respondents had no health insurance, 17.4% (n= 35) were Medicaid or Medicaid/Medicare recipients, and 36.8% (n= 74) of them had private health insurance either employer-based insurance with employer payment for part, or whole premiums and medical expenditures, or self-pay. Of these reported, 66.1% (n = 133) have very good or good health status, 20.9% (n = 42) said okay or fair, and up to 12.0% claimed poor or very poor health status. The Chi-Square Test of current health status among those "who have private health insurance", "received Medicaid/Medicare", or "had no any kind of health insurance" was significant, [χ^2 (10, N= 201) = 45.556, $p < .001$], indicating that overall their current health status significantly differs, due to the three kinds of health insurance status.

In addition, Table 4 & 6 show 46.2 % (n= 93) of participants reported that they have family doctors or primary care physicians (PCP) for either seeing him/her routinely when they felt sick 32.3% (n = 65) or accessing general check up 13.9% (n = 28). 53.7%

(n = 108) of them have no PCP. The Chi-Square Test of having a primary care physician and kinds of health insurance was significant, [χ^2 (4, N= 201) = 123.708, $p < .001$], indicating that overall, accessing a family doctor or PCP for health check up or just for medical care when in need are differentiated among the three kinds of health insurance status.

Table 7 illustrates that the Vietnamese refugees visited the doctor lately within six months 43.8% (n = 88), from six months to one year 43.8% (n = 88), from one to two years 9.0% (n = 18), from two to five years 1.0% (n = 2), over five years 1.0% (n = 2), and never 1.5% (n = 3). The Chi-Square Test of frequency of doctor visits (last visit to doctor) and the kinds of health insurance was significant, [χ^2 (10, N = 201) = 82.387, $p < .001$], indicating that last visit to the doctor or PCP for health check up or just for medical care when in need, differentiated significantly among the three kinds of health insurance status.

Table 8 shows that 63.2% (n = 127) of respondents preferred to see doctors at their private clinics, including 93.2% (n = 69) of respondents who had private insurance, and 85.2% (n = 30) of them who received Medicaid/Medicare, and 23.9% (n = 48) accessed medical care at charity clinics in case without health insurance. The Chi-Square Test of place they received medical care or advice and health insurance status indicated that the predictors differentiated significantly among the three kinds of health insurance status, [χ^2 (8, N= 201) = 91.911, $p < .001$].

Table 9 shows that 82.6% of the Vietnamese Refugees have never gone to a wellness center, community care, or Happy Health Care, health fair, for preventive care.

The Chi-Square Test of healthy clinics and health insurance types was not found to be significantly different between the three kinds of health insurance statuses and accessing preventive health care at healthy clinics as showed on Table 7, [χ^2 (8, N= 201) = 11.254, p = 1.88]. This finding may be affected by cultural factors. The Vietnamese refugees usually see doctor when they are sick and are less likely to pay for preventive health care at a wellness center or somewhere else.

The study also focused on dental care. Data shows in Table 10 that only 7.0% (n = 14) saw dentists recently within the last six months, 20.9% (n = 42) saw dentists every six months to one years, 12.4% (n = 25) saw dentist every one to two years, 21.9% (n = 44) saw dentists at least two years ago, and 37.8% (n = 76) have never seen dentists. This finding was significantly different, comparing the frequency of visiting to dentist and health insurance status with Chi-Square Test of last visit to dentist and health insurance status, [χ^2 (10, N= 201) = 82.387, p < .001].

Figure 5 illustrates that most uninsured Vietnamese refugees have accessed medical care at John Peter Smith Health Network (63.0%) considered as a charity clinic, 25% paid cash for care at the doctor's office, and 4% still use traditional/herbal medicine, including coining, cupping, and herbal medication.

The survey also focused on reasons why Vietnamese refugees did not apply for Medicaid or/and CHIPS as illustrated on Figure 6. 143 participants reported the reasons that kept them from obtaining public medical benefits for their children, included not knowing how to apply for Medicaid 20.0% (n = 28) and CHIPS 15.0% (n = 2), 25.0% (n = 35) not knowing whether their children would be eligible for Medicaid or CHIPS, even

16.0% (n = 23) never heard about CHIPS and 11% (n = 16) thought the process was too difficult.

Data gained from the survey summarized on Figure 7 confirmed that Vietnamese refugees conceived factors that kept them from using health care as major barriers, including 24% because of language barriers, 17% because of legal barriers, 15% because of lack of understanding medical system, 14% of because of lack of health insurance, 11% because of different culture, and so on.

Figure 8 shows that 67% Vietnamese refugees perceived their Medicaid/Refugee Medical Assistance Program were or will be cut because of their living in the United States for more than eight months. Eleven percent said that government-aided health insurance was cut because of high incomes, 9% claimed that their Medicaid/Medicare was or will be cut because of not being a US citizen after being in the U.S. more than seven years, and 13% had other reasons.

Another finding obtained from the survey was that 47% and 40.8% of respondents said that they agreed strongly or agreed that using English was a barrier to access health care, whereas only 11.5% agreed some extent or did not agree that English was a barrier to access health care. Hence, 87.5% said that they had problems with spoken English in accessing health care with varying level of a problem, a large problem, and very much a problem, representing 19.4%, 31.8%, and 36.3% respectively (Figure 9 & 10)

Table 11 shows that 12.9% (n = 26) of Vietnamese refugee families have one elderly person in the family, including 84.6% (n = 22) are receiving SSI and Medicaid/Medicare and 15.4% (n = 4) are not receiving SSI and Medicaid/Medicaid,

10.0% (n = 20) Vietnamese refugee families have two or more elderly in the family, including 50% (n = 10) are receiving SSI and Medicaid/Medicare and 10.0% (n = 10) are not receiving SSI and Medicaid/Medicaid, as well as 77.1% (n = 155) of Vietnamese refugees have no elderly in their families. However, 2.6% (n = 4) non-elderly refugees are receiving SSI and Medicaid/Medicare due to disability. In this sample, 30.4 % of Vietnamese elderly refugees are not receiving SSI and Medicaid/Medicare due to either 1) non-US citizen status after seven years, or 2) high income. In addition to losing of SSI and Medicaid/Medicare, 57.14 % of elderly refugees who have been living in the US for seven to 10 years lost their benefits. The distribution of SSI and Medicaid/Medicare by Vietnamese elderly refugees is significant with Chi-Square Test, [χ^2 (4, N= 201) = 207.863, $p < .001$].

Table 12 shows that 59.4% (n=63) Vietnamese refugee women and 30.5% (n=29) Vietnamese refugee men do not have any kind of health insurance. The difference of uninsured rate in Vietnamese refugee in this sample by gender is significant with Chi-Square Test [χ^2 (2, N= 201) = 17.107, $p < .001$].

The results of the analysis are shown on Table 13. A multiple regression analysis was conducted to evaluate how well the strength of measures predicted receiving SSI and Medicaid/Medicare affected by other predictors. The first set of predictors, reasons for losing government-aided health insurance was significant, [$R^2 = .258$, F (1, 199) =69.265, $p < .01$]. The second predictors, reasons of losing government-aided health insurance and current health status were significant, [$R^2 = .300$, F (1, 198) =13.827, $p < .01$], and the third set predictors, reasons for losing government-aided health insurance, current health

status, and place of received medical care or advice were also significant, [$R^2 = .324$, $F(1, 197) = 5.054$, $p < .05$].

The results on Table 14 show the first set of predictors, the duration of residence in US and reason of losing government-aided health insurance, was significant, [$R^2 = .063$, $F(1, 199) = 13.431$, $p < .001$]. The second set of predictors, the duration of residence in US and last visit to doctor with reason of losing government-aided health insurance The regression equation with these predictors was significant, [$R^2 = .100$, $F(1, 198) = 8.178$, $p = .005$].

Table 15 shows that the findings gained from a multiple regression analysis between a set of predictors, including gender, education in Vietnam, education in the U.S., occupation, marital status, average annual income, health status, and age group and dependent variable, last visit to doctor is significant, [$R^2 = .114$, $F(8, 192) = 3.099$, $p = .003$]. Table 15 also demonstrated that the socioeconomic predictors, including gender, education level in the U.S. and in Vietnam, age group, occupation, and income level significantly affected health insurance [$R^2 = .203$, $F(7, 193) = 7.012$, $p < .001$].

CHAPTER V

DISCUSSION

Discussion

There are several implications that can be derived from the results of this study. The findings demonstrated that the most common reason for the lack of health care access is the language barrier. Twenty-four percent of respondents confirmed that "lack of language" kept them away from utilizing health care. This is similar to results of the population surveyed (23%). Jenkins et al. (1990) stated that nearly half of persons interviewed reported limited English-language proficiency and stressed that different language was not a barrier to health care access if health care providers were Vietnamese and translators were available widely. In this study, 47% and 40.8% of respondents among Vietnamese refugees in Tarrant County reported that they agreed strongly or agreed that using English was a barrier to accessing health care, whereas only 11.5% agreed to some extent or did not agree that English was a barrier to access health care. Furthermore, 87% of the respondents said that they had problems speaking English in utilizing health care with varying levels from moderate (problem) to severe problems (very much of a problem) (Figure 9 & 10).

The Kaiser Family Foundation on Medicaid and Uninsured (2003) reported that 28.2% of all Vietnamese speakers spoke English "not well" or "not at all". Many researchers stressed that the lack of language ability negatively affects access to the

quality and quantity of health care, and language barriers create significant access issues in communicating with health care providers (Kaiser Family Foundation, 2003).

Both language access responsibility under the Federal Civil Rights Laws of Title VI of the Civil Rights Act of 1964 said, "*No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance*" and the President Clinton issues Executive Order (EO) 13166 entitled "*Improving Access to Services for Persons with Limited English Proficiency*" must provide an interpreter to those in need to access health care services. This study shows that only 8.0% of Vietnamese refugees utilized an interpreter when accessing health care services, and only 9.5% of them know how to access health care services with assistance of social services. Most (60.7%) of them accessed and utilized health care services with either friends or relatives as translators. This finding demonstrated that most Vietnamese refugees do not know about Title VI, which can help them eliminate a language gap to improve the quality and quantity of their health care.

According to the ORR-Annual Report to Congress in 2001, 56.7% Vietnamese refugees cannot speak English at all, 39.1% can speak English at some level, and only 3.5% speak English well. In this study, approximately 65% of Vietnamese refugees in this sample cannot speak or understand, as well as read and write in English or just basic words, and about 30.0% can write, read, speak, and understand at some levels. Only 6.0% speak English fluently and 6.5% can write anything. The findings from this study are similar to ORR Annual Report to Congress in 2001. Compared to the Texas refugee

study among Vietnamese Refugees in Texas conducted in Houston in 1993, the percentage of ability using English in this study and ORR Annual Report was higher in "no English" level (56.7% and 65% respectively), than 12% of ability to speak and understand English and 15% of ability to read and write in English in study in Houston in 1993 (Taylor et al., 1993). The difference may be a result of different backgrounds of the selected sample. The sample recruited in Houston in 1993 had an educational background before and after arrival in the U.S., including 67% having at least a high school degree, 41% with some college, and 22% with a college degree. In this study, 44.8% of respondents have at least high school diploma in Vietnamese and 71% of them have no education in the U.S. Furthermore, compared to the study in Houston in 1993 that contained 39% female and 61% male, in this sample, female refugees (52.7%) are more predominant than male refugees (47.3%). As we know, Vietnamese women had less education than men did in Vietnam. In this study, 60% Vietnamese men had at least a high school diploma, and only 30% of Vietnamese women had at least high school diploma. There are some statistical differences in several previous studies related to the level of using English in accessing health care. However, there are similar findings that English is a significant barrier to accessing health care among Vietnamese refugees, especially in Tarrant County, Texas.

Other findings from the study demonstrated that the cultural difference is a significant barrier affecting health care access among Vietnamese refugees. Eleven percent respondents reported that cultural difference and 15% respondents said that the lack of understanding of the medical system are barriers (Figure 7). These factors are

barriers that keep them from using existing health care services effectively. As Geissler (1992) stressed, cultural differences are a much broader etiology than language involving different values, beliefs, customs, and nonverbal mannerisms between health care providers and patients, especially in culturally competent health care. Societal changes affect health care access by the patients and intercultural health care between health care providers and the patients. Several cultural factors may affect access health care, such as culture shock, beliefs, and traditional medical folk practice.

Since refugees left behind family, friends, homes, possessions, and livelihood and have been cut off from their culture and thrown into a completely new and different environment, they may feel culture shock. They may then adapt to the new environment gradually through cultural adjustment, from being fascinated and thrilled by the new things they see and tend to only see the similarities with their own country (Touristic Stage), then beginning to feel uncomfortable with differences between this culture and their own and very critical of the new culture (Aggressive Stage), to recovering slowly by being interested and sensitive to the new culture and people around (Accepting Stage), finally adjusting to the new culture almost completely by truly understanding and experiencing the new environment in a meaningful way (Adjusted Stage) (Bridge Refugee and Sponsorship Services, 1982).

In this study, 63% of all respondents and 93.2% of those who have private health insurance reported that they preferred to see the doctor at their private office. Most go to see the doctor when they are sick, and up to 82.6% respondents reported that they have never gone to any kind of preventive or healthy clinics in the last two years. This finding

was not significantly different between health insurance status and focusing on preventive health care at any kind of health clinics. There is no difference among those who have private health insurance, those who receive Medicaid, and those who are uninsured in this study. This is similar to Kemp & Rasbridge's findings (1999) that health care may not be the highest priority to newly arriving refugees. This may be affected by cultural factors that the Vietnamese refugees usually see doctor when they are sick and are less likely to pay for preventive health care at a wellness center or somewhere else.

Only 4% reported that they still use traditional/herbal medicine, including coining, cupping, or pitching. Yet, the Vietnamese refugees frequently use folk treatment either concurrently or before seeking a Western medical care provider (Nguyen, 1985). Vietnamese traditional health beliefs in practicing traditional folk may delay health care access and lead to inappropriate diagnoses and unnecessary expensive workups for unusual illnesses (Ackerman, 1997).

Legal issues are also real barriers affecting significantly refugees in the United States. In this survey, 17% of respondents reported that legal issues are barriers to accessing health care. Under the Refugee Act of 1980, Public Law 96-212, the Office of Refugee Resettlement (ORR) established and authorized cash and refugee medical assistance (RMA) up to 36 months after arrival (Office of Inspector General, 1992). The eligible time for Refugee Cash Assistance (RCA) and RMA reduced to eight months currently to those who are eligible within the prescribed time frame and income. Medicaid covers basic medical needs without dental care and eye care and three medications per month for adults. Physicians are not interested in becoming Medicaid

providers because of low reimbursements for services. Chignoli (2002) reported that 20% of physicians do not participate as Medicaid providers. Two- thirds of physicians accept Medicaid and see less than 50 Medicaid patients per year, and Medicaid recipients need an average of 3-4 months to see a specialist from community center's referral.

According to ORR Annual Report to Congress in 2001, 12.7% of Vietnamese refugees have no Medicaid/RMA coverage in the past 12 months and 13.7% of them were covered by Medicaid or RMA. Adult refugees may not be eligible for RMA or Medicaid once the spouse is working and applying for Medicaid or RMA. Elderly and disabled refugees have faced the impact of PRWORA enacted on August 22, 1996. Thousands of elderly and disabled refugees lost their sole income from SSI and medical care from Medicaid/Medicare because they cannot become a U.S. citizen after seven years of living in the U.S. In this study, 30.4% of elderly Vietnamese refugees are not receiving SSI and Medicaid/Medicare currently due to either non-U.S. citizen after having lived in the U.S. for more than seven years or spouse or household's income. 57.14% of elderly Vietnamese refugees who have been living in the U.S. between seven to ten years lost their benefits. This distribution of losing federal benefits (SSI and Medicaid/Medicare) by Vietnamese elderly refugees is significant (Table 11). Table 13 also demonstrated that the reasons of losing government-aided health insurance for refugees, especially elderly and disabled, are significant. A multiple regression analysis shows that reasons of losing government-aided health insurance affected significantly to current health status, and places received medical care or advice, and the duration of

residence in U.S. and reasons of losing government-aided health insurance was significant because of legal barriers.

Socioeconomic status is also a significant barrier in accessing health care among refugees. The findings gained from multiple regression analysis among a set of predictors, including gender, education in Vietnam, education in the U.S., occupation, marital status, average annual income, health status, age group and dependent variable, last visit to doctor are significant. This study also demonstrated that the socioeconomic predictors, including gender, education level in the U.S. and in Vietnam, age group, occupation, and income level significantly affects health insurance. These results show a significant difference in accessing health care among the racial/ethic minority population. The study by Lincoln-Lancaster County Health Department in 2000 reported that ethnic minority community is 3.5 times more likely not to be covered by any kind of health plan (29%) than the white population (8.5%). Disparities in health care affect most young adults and women and low-income families. The findings in this study also show that socioeconomic status affect health care access significantly. Sixty-eight percent of Vietnamese refugee women have no health insurance, and 31.5% of Vietnamese refugee men have no health insurance. Similarly, in other studies, Vietnamese refugee women always have more difficulty accessing and utilizing health care services because they are less educated than men and have more "menial" jobs than men; these jobs do not usually offer health insurance for their employees and are often laid-off, making employment unstable. Particularly, the age group of between 18 and 25 is highest group without health insurance that was reported by several previous studies (California Healthcare

Foundation, 2003; Employee Benefit Research Institute, 1998; CDC, 1998). In this study shows the age group of between 18 and 34 and between 35 and 49 were highest uninsured rate, 35.1% and 32.6% respectively.

The findings revealed that only 27.9% visited the dentist within one year, 21.9% visited the dentist for the last time, more than two years ago, and 37.8% have never visited a dentist. Medicaid does not cover either dental care or eye care, so Vietnamese refugees are less likely to have access to dental or eye care. The Texas Refugee Study reported that approximately 29% Vietnamese refugees have not visited a dentist in the past five years (Taylor et al., 1993). Compared to the survey conducted in 1993 in Houston with this study, Figure 11 shows that Vietnamese refugees in this sample are less likely to have access to dental care than the Vietnamese refugees that participated in the survey conducted in 1993.

Educational level and occupation also significantly affect utilization of the health care system. This study shows 45% of Vietnamese refugees who have "no skill" job are uninsured, whereas 33.3% of those who have "skill" job are uninsured (unshown in Table). Educational levels gained in Vietnam or in the U.S. are also significantly influent to their cognition and utilization of health care. Furthermore, socioeconomic barriers such as lack of health insurance or financial resources to pay for services may exist for this community (Lin et al., 1979; Tripp-Reimer & Thieman, 1981).

This study shows that 45.8% of Vietnamese refugees are uninsured because of either low-income or restriction of legal issues to be eligibility for Medicaid and underutilization of existing health care system because of other mentioned barriers. The

finding shows currently 58.14% of Vietnamese elderly refugees who are the most vulnerable lost their SSI and Medicaid. This rate has increased gradually because the they are less likely to pass the citizenship test to become U.S. citizen due to their ages are advantaged and their memories have impaired since they were tortured and uncured medical conditions in "reeducation camps" to learn U.S. history and government as well as English language. This rate, in the fact, may be higher than the finding because some of elderly Vietnamese refugees returned to Vietnam due to losing their sole financial resource from SSI allowance and Medicaid. Related to this tragic experience which Vietnamese refugees, especially elderly and disabled persons have faced when accessing the health care system, the most important external barriers are lack of English language and legal issues, particularly the Welfare Reform Act of 1996 have negatively affected access to quantity and quality of health care. Therefore, the federal and state policies should address linguistic access in order to bridge the gap of health care disparities. The Office of Refugee Resettlement, Voluntary agencies (Volags), Department of Health and Human Services (DHHS) Office of Minority Health should focus on educating refugees about their right under Title VI and public health care resource, as well as orienting health care and social service providers about cross-cultural issues and Title VI in order to improving access to health care. Many elderly refugees havelost public benefits because of the Welfare Reform Act of 1996 that has affected seriously elderly and disabled refugees. Even President Clinton when signing this act stated that it went too far and he would work with Congress to restore benefits to the most needy individuals (Mautino, 2000). Based on President Clinton's thought and finding from this study and

others, refugee policy activists, ORR, Volags, DHHS Office of Minority Health should advocate legal decision makers to restore public benefits, especially Medicaid and SSI to elderly refugees, in order to help them survive in the last period of their lives.

Limitations

There are several limitations with regard to this survey. Firstly, the sample is based on convenience rather than random sampling, and has a small number of participants and respondents, who are Vietnamese refugee service clients. Therefore, accuracy level may be affected when data is subjected to weight, and the participants are neither representative of the Vietnamese refugee community nor the entire refugee community, either in Tarrant County or in the United States. The sample size was small, so sampling error may occur. Secondly, another limitation in the interpretation of the data is the inability to explore all data collected to give a detailed view about other difficult factors in health care, except for the four mentioned barriers that have also affected Vietnamese refugees in accessing and utilizing health care services. Thirdly, this survey emphasized the interpretation of the collected data to determine whether these barriers are significant to health care access among the participant's community, but did not focus on a solution to remove barriers and close a gap of disparities of health care.

CHAPTER VI

CONCLUSION

The results of this show clearly that Vietnamese refugees in Tarrant County have faced significant barriers of language, culture, legal issues, and socioeconomic status when accessing health care services. In addition to the barriers, previous medical condition, traditional medical folk practice, and mistrust of physicians due to misunderstanding the medical system, the Vietnamese refugees have more difficulty accessing and utilizing health care services in a timely and effective manner.

The PROWRA and other legal issues have obviously affected Vietnamese refugees, especially these elderly and disabled refugees in accessing health care and utilizing public benefits, such as SSI or others.

Barriers to health care for Vietnamese refugees have been known for many years since the date they came to and have lived in the U.S. These include both internal barriers, such as health beliefs, medical traditional medical folk practice, and external barriers, such as language, cultural, legal issues, and socioeconomic status. Refugees have significant health problems, are in need of treatment and underutilize the health care system to access health care properly, due to cultural and language barriers between the patients and health care providers (Hoang, & Erickson, 1985). Moreover, lack of health insurance is still high among Vietnamese refugees and the cost of treatment is

also a barrier to access health care treatment, especially specific medical care, oral care, and dental care which are not covered by Medicaid or regular health insurance.

Undoubtedly, language and cultural barriers create difficulty for the subjects to access health care, especially when non-English speaking patients do not know their rights to have an interpreter under Title VI or Executive Order 13166. Due to the lack of language ability, Vietnamese refugees do not have quality health care. In addition, due to Vietnamese culture conflicts with American norms and behaviors, Vietnamese refugees have a difficult time adapting to the new culture, in order to have better health care. Some of them still use traditional medical folk practice and traditional beliefs. This may delay timely access to health care. This study reported that 4.0% have practiced traditional folk medicine, such as coining, cupping, or pitching. Farsano et al (1986) reported that they found root medicines in 7% of Vietnamese families and tiger balm in 54% Vietnamese households.

The results of this study and many other studies about the barriers to accessing health care among refugees, especially Vietnamese refugees and utilization and access of the health care system may help refugees improve their quality of health care by knowing how to use Title VI in order to close a gap of communication. Catholic Charities of Fort Worth gave a laminated Title VI card in English and refugee's language in order to educate Title VI to the clients and health care providers and improve quality of services (Smith, 2003).

The findings show clearly that how well the strengths of measure predicted receiving SSI and Medicaid/Medicare affected current health status and place of

receiving medical care, or advice among elderly and disabled Vietnamese refugees. Therefore, removing these barriers to accessing health care among refugees is significant not only in the enhancement of refugee health to produce a healthy labor force and healthy community by preventing the potential for communicable disease transmission, but also for cost-savings in the long-run. This study shows that Vietnamese refugees did not emphasize health prevention, so health promotion and education should be applied in the Vietnamese refugee community. Moreover, the findings from this study may assist social service providers, health care providers, and policy activists in enhancing their services and advocacy of resolving legal issues in order to remove these barriers. This would help not only Vietnamese refugees but also the entire refugee community to have a better quality of health care in the United States, in order to reduce health disparities and increase health of the society.

TABLES & FIGURES

Table 1

Vietnamese Refugees Arriving in the United States, Fiscal Year 1946-2004

Year intervals	Number of arrivals
FY 1946-50	0
FY 1951-60	2
FY 1961-70	7
FY 1971-80	150266
FY 1981-90	324453
FY 1991-00	206857
FY 2001	10351
FY 2002	6926
FY 2003	3100
FY 2004	3100

Table 2

Vietnamese Refugee Demographic Characteristics in this Sample

		N	Marginal Percentage
Gender	Male	95	47.3%
	Female	106	52.7%
Age group	18-34	59	29.4%
	35-49	58	28.9%
	50-64	54	26.9%
	65 and older	30	14.9%
Marital status	Married	123	61.2%
	Single	43	21.4%
	In Partnership	10	5.0%
	Separated	5	2.5%
	Divorced	8	4.0%
	Widowed	12	6.0%
Occupation	With Skill	21	10.4%
	No SKill	109	54.2%
	Elderly/Disabled	36	17.9%
	Student	13	6.5%
	Unemployed	22	10.9%
Average annual income	Less than $5,000	9	4.5%
	$5,000 to $9,999	27	13.4%
	$10,000 to $19,999	75	37.3%
	$20,000 to $29,999	49	24.4%
	$30,000 to $39,999	25	12.4%
	$40,000 and more	16	8.0%
Number people in family	One	23	11.4%
	Two	40	19.9%
	Three	45	22.4%
	Four	50	24.9%
	Five	25	12.4%
	Six and more	13	6.5%
	7	3	1.5%
	8	1	.5%
	9	1	.5%
Number people have job in family	None	26	12.9%
	One	88	43.8%
	Two	59	29.4%
	Three	24	11.9%
	Four	2	1.0%
	Five	2	1.0%
Valid		201	100.0%
Missing		0	
Total		201	
Subpopulation		157(a)	

a The dependent variable has only one value observed in 138 (87.9%) subpopulations.

Table 3

Duration of Residence in U.S and Educational Background with Ability of Using English in Health Care Services

		N	Marginal Percentage
Living time in US	Less than 1 year	19	9.5%
	1 to 5 years	65	32.3%
	5 to 7 years	25	12.4%
	7 to 10 years	71	35.3%
	More than 10 years	21	10.4%
Education in Vietnam	Under 8 grade	64	31.8%
	9 to 11 grade	49	24.4%
	High school diploma	67	33.3%
	Some college	6	3.0%
	College degree and higher	15	7.5%
Education in US	Under high school	2	1.0%
	High school diploma	2	1.0%
	Some college	14	7.0%
	College degree	3	1.5%
	Vocational training program	31	15.4%
	Graduate school	5	2.5%
	None	144	71.6%
Ability Speak & Understand English	No English	56	27.9%
	Basic words	72	35.8%
	Short conversation	36	17.9%
	5-10 minute conversation	25	12.4%
	Speak fluently	12	6.0%
Ability Read & Write English	None	64	31.8%
	Basic words	68	33.8%
	Simple phrases	32	15.9%
	Notes and letters	24	11.9%
	Anything	13	6.5%
Ability use English in Health Service	Self	44	21.9%
	Friend or relative	122	60.7%
	Social worker	19	9.5%
	Interpreter	16	8.0%
Valid		201	100.0%
Missing		0	
Total		201	
Subpopulation		83(a)	

a The dependent variable has only one value observed in 60 (72.3%) subpopulations.

Table 4

Health Insurance Status and Access to Health Care

		N	Marginal Percentage
Health Insurance	Private	74	36.8%
	Medicaid/Medicare	35	17.4%
	None	92	45.8%
Current Health Status	Very good	31	15.4%
	Good	102	50.7%
	Okay	42	20.9%
	Poor	23	11.4%
	Very poor	1	.5%
	Do not know	2	1.0%
Last visit to doctor	Less than 6 months	88	43.8%
	6 months to 01 year	88	43.8%
	1 to 2 years	18	9.0%
	2 to 5 years	2	1.0%
	Over 5 years	2	1.0%
	Never	3	1.5%
Family doctor	PCP for sick	65	32.3%
	PCP for check up	28	13.9%
	None	108	53.7%
Place of receiving medical care or advice	Doctor's office	127	63.2%
	Community health center	9	4.5%
	Hospital/ER	15	7.5%
	Charity clinic	48	23.9%
	Other	2	1.0%
Healthy clinics	Wellness center	7	3.5%
	Community care	16	8.0%
	Happy Health Care/Preventive/Health fair	5	2.5%
	None of these clinics	166	82.6%
	Other clinic	7	3.5%
Last visit to dentists	Less than 6 months	14	7.0%
	6 months to 01 year	42	20.9%
	1 to 2 years	25	12.4%
	2 to 5 years	29	14.4%
	Over 5 years	15	7.5%
	Never	76	37.8%
Valid		201	100.0%
Missing		0	
Total		201	
Subpopulation		131(a)	

a The dependent variable has only one value observed in 123 (93.9%) subpopulations

Table 5

The Distribution of Health Status and Health Insurance Types

Current Health Status * Health Insurance Crosstabulation

			Health Insurance			
			Private	Medicaid/ Medicare	None	Total
Current Health Status	Very good	Count	20	2	9	31
		% within Current Health Status	64.5%	6.5%	29.0%	100.0%
	Good	Count	40	8	54	102
		% within Current Health Status	39.2%	7.8%	52.9%	100.0%
	Okay	Count	12	14	16	42
		% within Current Health Status	28.6%	33.3%	38.1%	100.0%
	Poor	Count	1	10	12	23
		% within Current Health Status	4.3%	43.5%	52.2%	100.0%
	Very poor	Count	0	1	0	1
		% within Current Health Status	.0%	100.0%	.0%	100.0%
	Do not know	Count	1	0	1	2
		% within Current Health Status	50.0%	.0%	50.0%	100.0%
Total		Count	74	35	92	201
		% within Current Health Status	36.8%	17.4%	45.8%	100.0%

Table 6

Primary Care Physician and Health Insurance Status

Crosstab

			Family doctor			
			PCP for sick	PCP for check up	None	Total
Health Insurance	Private	Count	39	22	13	74
		% within Health Insurance	52.7%	29.7%	17.6%	100.0%
	Medicaid/Medicare	Count	22	6	7	35
		% within Health Insurance	62.9%	17.1%	20.0%	100.0%
	None	Count	4	0	88	92
		% within Health Insurance	4.3%	.0%	95.7%	100.0%
Total		Count	65	28	108	201
		% within Health Insurance	32.3%	13.9%	53.7%	100.0%

Table 7

Last Visit to Doctor and Health Insurance Status

Crosstab

			Last visist to doctor						
			Less than 6 months	6 months to 01 year	1 to 2 years	2 to 5 years	Over 5 years	Never	Total
Health Insurance	Private	Count	34	33	6	0	0	1	74
		% within Health Insurance	45.9%	44.6%	8.1%	.0%	.0%	1.4%	100.0%
	Medicaid/Medic	Count	30	4	0	0	0	1	35
		% within Health Insurance	85.7%	11.4%	.0%	.0%	.0%	2.9%	100.0%
	None	Count	24	51	12	2	2	1	92
		% within Health Insurance	26.1%	55.4%	13.0%	2.2%	2.2%	1.1%	100.0%
Total		Count	88	88	18	2	2	3	201
		% within Health Insurance	43.8%	43.8%	9.0%	1.0%	1.0%	1.5%	100.0%

Table 8

Place Received Medical Care or Advice by Health Insurance Types

Crosstab

			Place receive medical care or advice					
			Doctor's office	Community health center	Hospital/ER	Charity clinic	Other	Total
Health Insurance	Private	Count	69	2	3	0	0	74
		% within Health Insurance	93.2%	2.7%	4.1%	.0%	.0%	100.0%
	Medicaid/Medic	Count	30	1	4	0	0	35
		% within Health Insurance	85.7%	2.9%	11.4%	.0%	.0%	100.0%
	None	Count	28	6	8	48	2	92
		% within Health Insurance	30.4%	6.5%	8.7%	52.2%	2.2%	100.0%
Total		Count	127	9	15	48	2	201
		% within Health Insurance	63.2%	4.5%	7.5%	23.9%	1.0%	100.0%

Table 9

Distribution of Healthy Clinics by Health Insurance Types

Crosstab

			Healthy clinics					
			Wellness center	Community care	Happy Health Care/ Preventive/ Health fair	None of these clinics	Other clinic	Total
Health Insurance	Private	Count	5	5	4	57	3	74
		% within Health Insurance	6.8%	6.8%	5.4%	77.0%	4.1%	100.0%
	Medicaid/Medicar	Count	1	4	1	27	2	35
		% within Health Insurance	2.9%	11.4%	2.9%	77.1%	5.7%	100.0%
	None	Count	1	7	0	82	2	92
		% within Health Insurance	1.1%	7.6%	.0%	89.1%	2.2%	100.0%
Total		Count	7	16	5	166	7	201
		% within Health Insurance	3.5%	8.0%	2.5%	82.6%	3.5%	100.0%

Table 10

Frequency of Visit to Dentist and Health Insurance Types

Crosstab

			Last visit to dentists						
			Less than 6 months	6 months to 01 year	1 to 2 years	2 to 5 years	Over 5 years	Never	Total
Health Insurance	Private	Count	12	32	11	10	1	8	74
		% within Heal Insurance	16.2%	43.2%	14.9%	13.5%	1.4%	10.8%	100.0%
	Medicaid/Medic	Count	0	1	5	3	1	25	35
		% within Heal Insurance	.0%	2.9%	14.3%	8.6%	2.9%	71.4%	100.0%
	None	Count	2	9	9	16	13	43	92
		% within Heal Insurance	2.2%	9.8%	9.8%	17.4%	14.1%	46.7%	100.0%
Total		Count	14	42	25	29	15	76	201
		% within Heal Insurance	7.0%	20.9%	12.4%	14.4%	7.5%	37.8%	100.0%

Table 11

Distribution of SSI & Medicaid/Medicare by Elderly

Crosstab

			Receive SSI & Medicaid			
			0	Yes	No	Total
Number of elderly in family	None	Count	151	4	0	155
		% within Number of elderly in family	97.4%	2.6%	.0%	100.0%
	One	Count	0	22	4	26
		% within Number of elderly in family	.0%	84.6%	15.4%	100.0%
	Two and more	Count	0	10	10	20
		% within Number of elderly in family	.0%	50.0%	50.0%	100.0%
Total		Count	151	36	14	201
		% within Number of elderly in family	75.1%	17.9%	7.0%	100.0%

Table 12

Distribution of health Insurance Status by Gender

Crosstab

			Health Insurance			
			Private	Medicaid/ Medicare	None	Total
Gender	Male	Count	46	20	29	95
		% within Gender	48.4%	21.1%	30.5%	100.0%
	Female	Count	28	15	63	106
		% within Gender	26.4%	14.2%	59.4%	100.0%
Total		Count	74	35	92	201
		% within Gender	36.8%	17.4%	45.8%	100.0%

Table 13

Multiple Regression Analysis of distribution of receiving SSI & Medicaid/Medicare by multiple predictors

Model Summary[d]

Mode	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.508[a]	.258	.254	.517	.258	69.265	1	199	.000
2	.554[b]	.307	.300	.501	.048	13.827	1	198	.000
3	.569[c]	.324	.314	.496	.017	5.054	1	197	.026

a. Predictors: (Constant), Reason of losing government-aided HI

b. Predictors: (Constant), Reason of losing government-aided HI, Current Health Status

c. Predictors: (Constant), Reason of losing government-aided HI, Current Health Status, PI

d. Dependent Variable: Receive SSI & Medicaid

Table 14

Multiple Regressions between Loss of Government-Aided HI and Other Predictors

Model Summary[c]

Mode	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.251[a]	.063	.059	1.065	.063	13.431	1	199	.000
2	.317[b]	.100	.091	1.046	.037	8.179	1	198	.005

a. Predictors: (Constant), Duration of Residence in US

b. Predictors: (Constant), Duration of Residence in US, Last visist to doctor

c. Dependent Variable: Reason of losing government-aided HI

Table 15

Multiple Regression Analysis between Last Visit to Doctor and Socioeconomic predictors

Model Summary[b]

Mode	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.338[a]	.114	.077	.882	.114	3.099	8	192	.003

a. Predictors: (Constant), Gender, Education in US, Occupation, Marital status, Average an Health Insurance, Age group

b. Dependent Variable: Last visist to doctor

Table 16

Multiple Regression Analysis between Health Insurance and Socioeconomic Predictors

Model Summary[b]

Mode	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.450[a]	.203	.174	.824	.203	7.012	7	193	.000

a. Predictors: (Constant), Gender, Education in US, Occupation, Marital status, Average anu Age group

b. Dependent Variable: Health Insurance

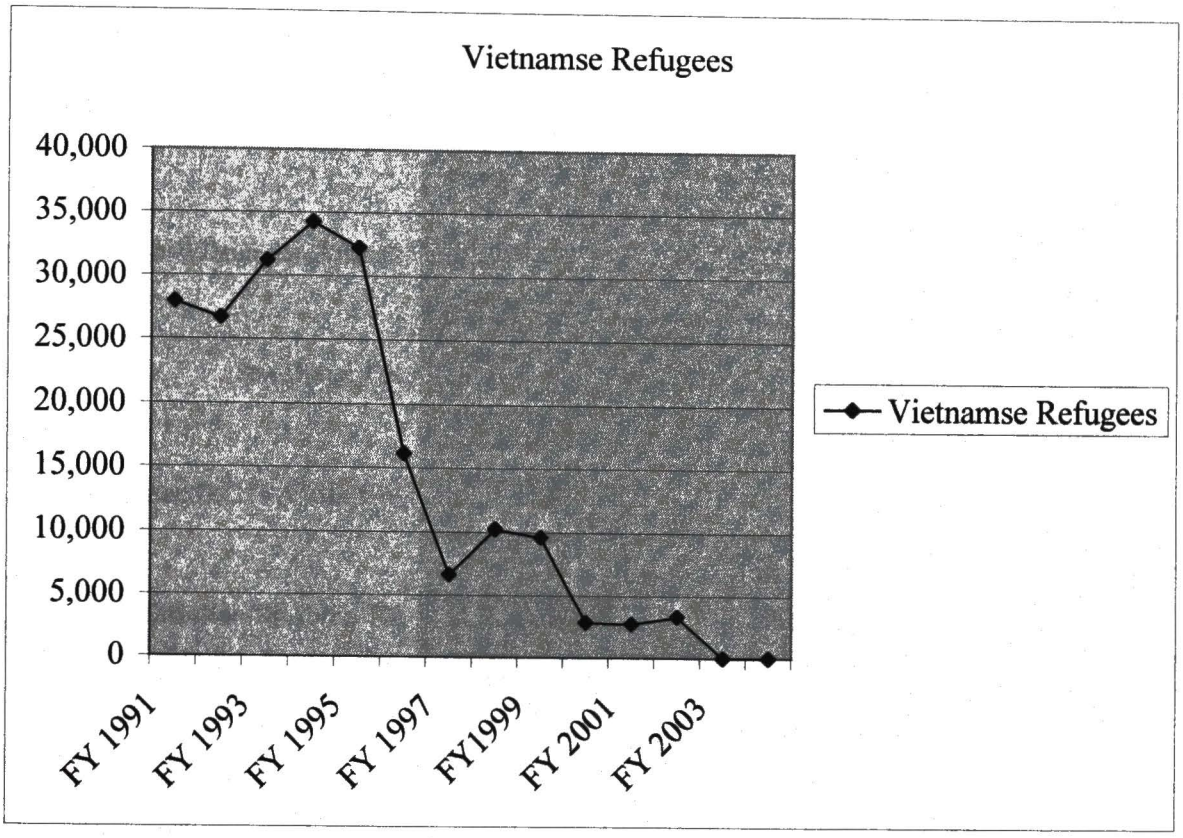
Table 17

Statistical Methods and Purposes

Method	Dependent Variable	Independent Variable(s)	Purpose(s)
Chi-Square Test	Health Status	Health Insurance Types	Relationship b/t HI & Health status (Table 5)
	Health Insurance Types (HI)	Family Doctor	Purpose of visiting (Table 6)
	HI Types	Last Visit to Doctors	Frequency of visiting doctor (Table 7)
	HI Types	Place received medical care or advice	Routine way of accessing health care (Table 8)
	HI Types	Healthy Clinics	Preventive care & HI (Table 9)
	HI Types	Last visit to dentists	HI & Frequency of visiting dentists (Table 10)
	Number of Elderly in family	Receive SSI & Medicaid	Percentage of receiving & losing SSI & Medicaid (Table 11)
	Gender	Health Insurance Types	Difference b/t male and female (Table 16)
Multiple Regression Analysis	Receive SSI & Medicaid	Reasons of losing government-aided HI; Current health status; Place received medical care	Receiving SSI & Medicaid whether relate to health status, place received medical care, and reasons of losing SSI & Medicaid (Table 12)
	Reasons of losing government-aided HI	Duration of residence; Last visit to doctor	Losing government-aided HI whether relative to duration of residence & frequency of visiting to doctor Table 13)
	Last visit to doctors	Gender; Education in U.S.; Education in Vietnam; Occupation; Marital status; Average income, Health insurance types, and age groups	Whether frequency of visiting to doctor relate to socioeconomic status (Table 14)
	Health Insurance Types	Gender; Education in U.S.; Education in Vietnam; Occupation; Marital status; Average income, Age groups	Whether health insurance rate relate to socioeconomic status. (Table 15)

Figure 1

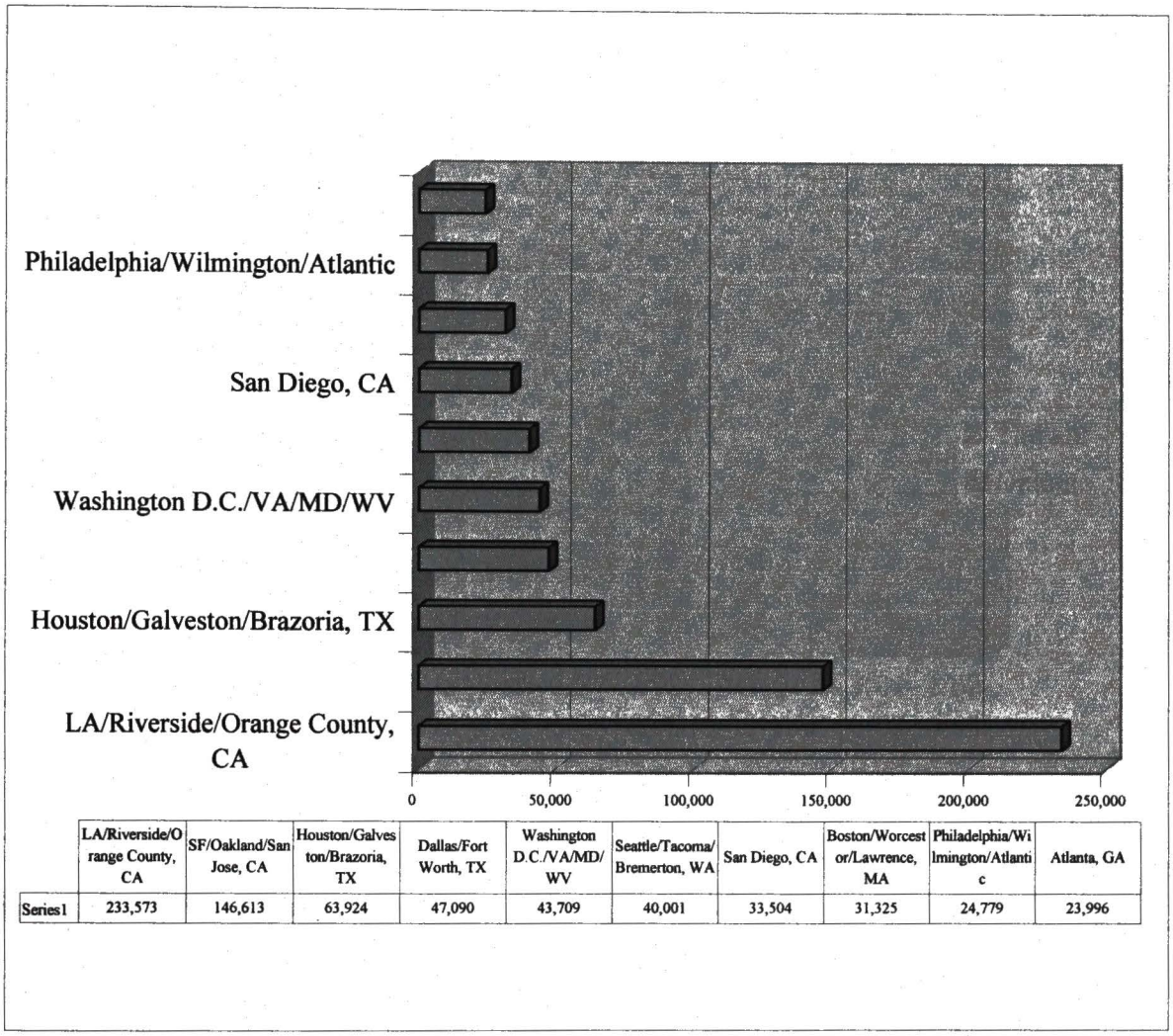
Vietnamese Refugees Arriving in the U.S.



Data source: ORR Annual Report to Congress- 2001 & U.S Department of States Proposal to Congress-2004

Figure 2

Top Ten Greatest Vietnamese Refugee Populations

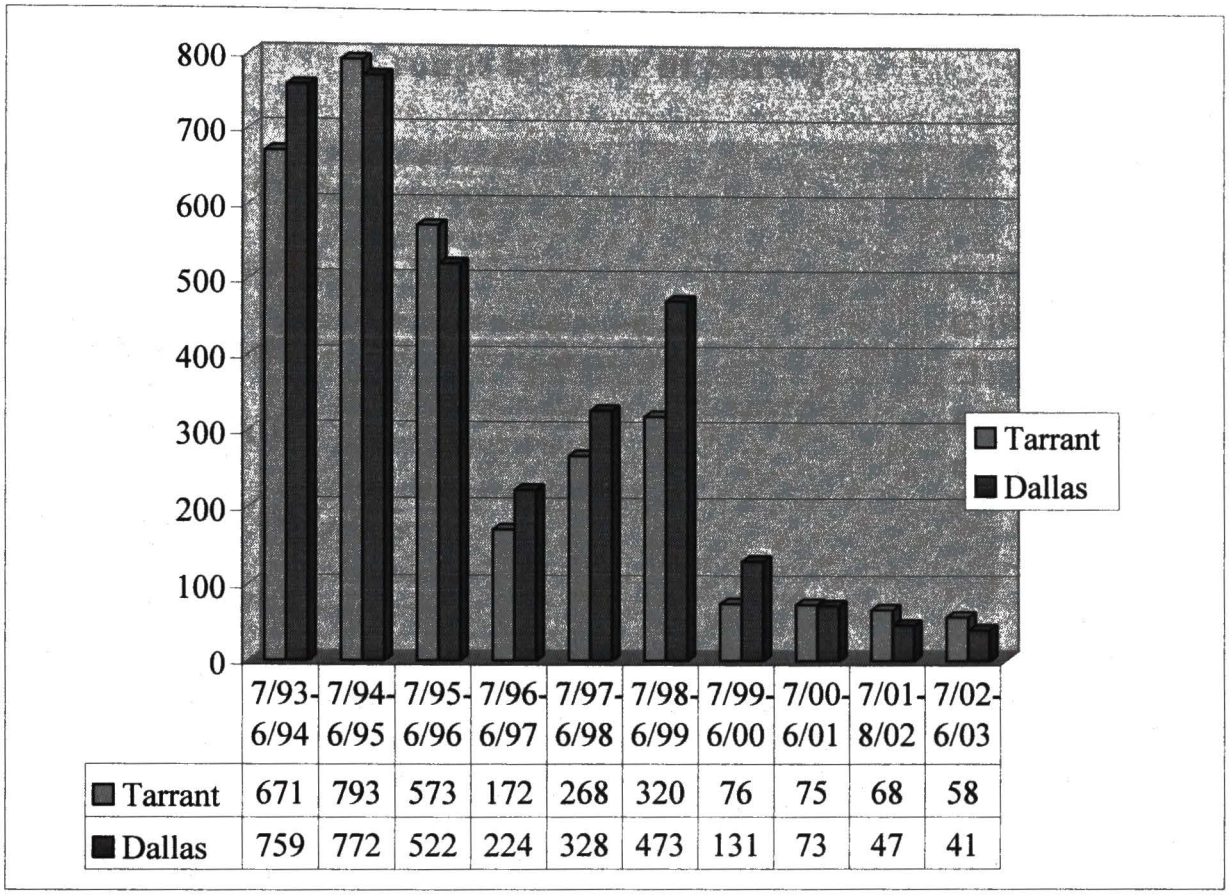


	LA/Riverside/Orange County, CA	SF/Oakland/San Jose, CA	Houston/Galveston/Brazoria, TX	Dallas/Fort Worth, TX	Washington D.C./VA/MD/WV	Seattle/Tacoma/Bremerton, WA	San Diego, CA	Boston/Worcester/Lawrence, MA	Philadelphia/Wilmington/Atlantic	Atlanta, GA
Series1	233,573	146,613	63,924	47,090	43,709	40,001	33,504	31,325	24,779	23,996

Data Source: Census 2000

Figure 3

Vietnamese Refugees Arriving in Dallas & Tarrant County from July 1993 to June 2003

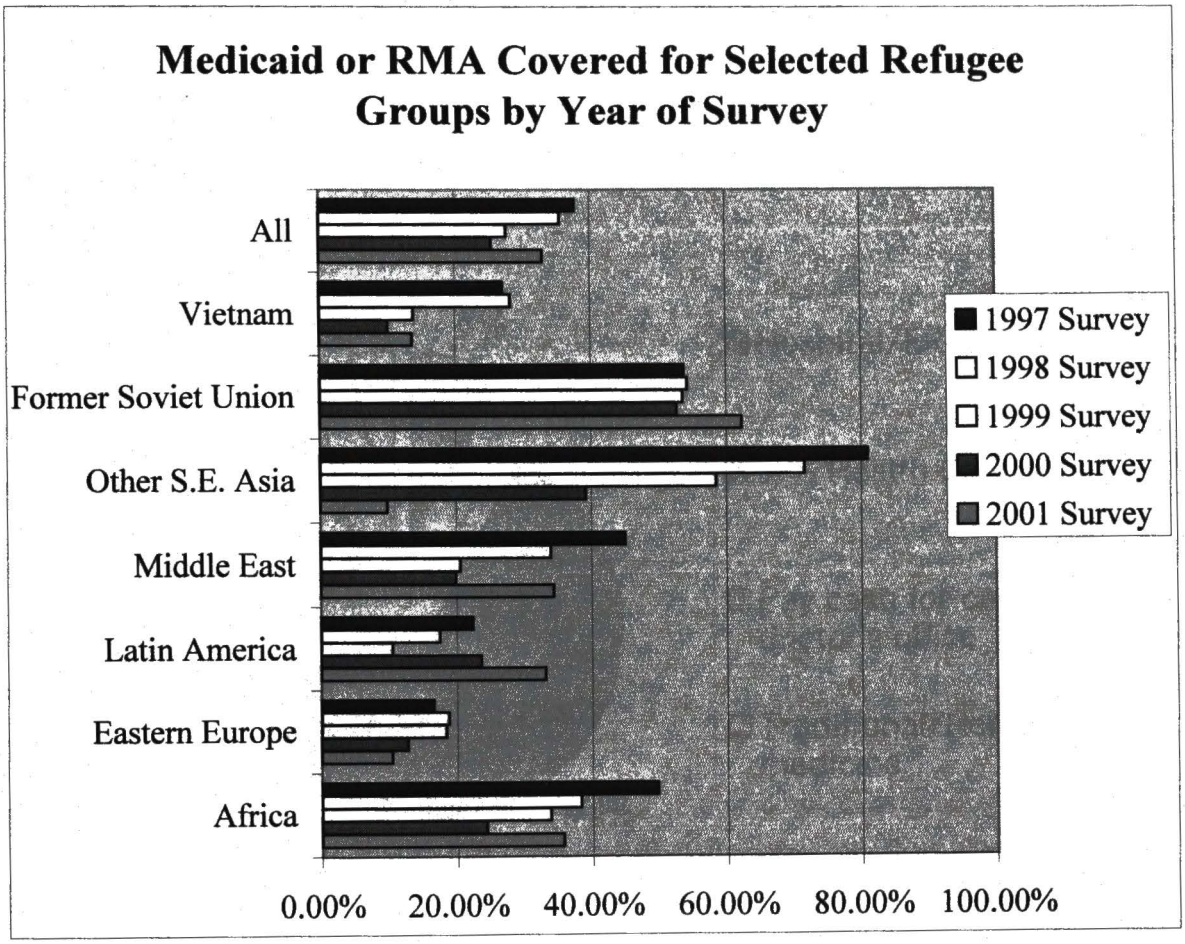


	7/93-6/94	7/94-6/95	7/95-6/96	7/96-6/97	7/97-6/98	7/98-6/99	7/99-6/00	7/00-6/01	7/01-8/02	7/02-6/03
Tarrant	671	793	573	172	268	320	76	75	68	58
Dallas	759	772	522	224	328	473	131	73	47	41

Data source: Texas Office of Immigration & Refugee Affair

Figure 4

Medicaid/RMA Coverage for Selected Refugee Groups by Year Survey



Data Source: ORR Annual Report to Congress-2001

Figure 5

Uninsured Vietnamese Refugees Access to Health Care Sources

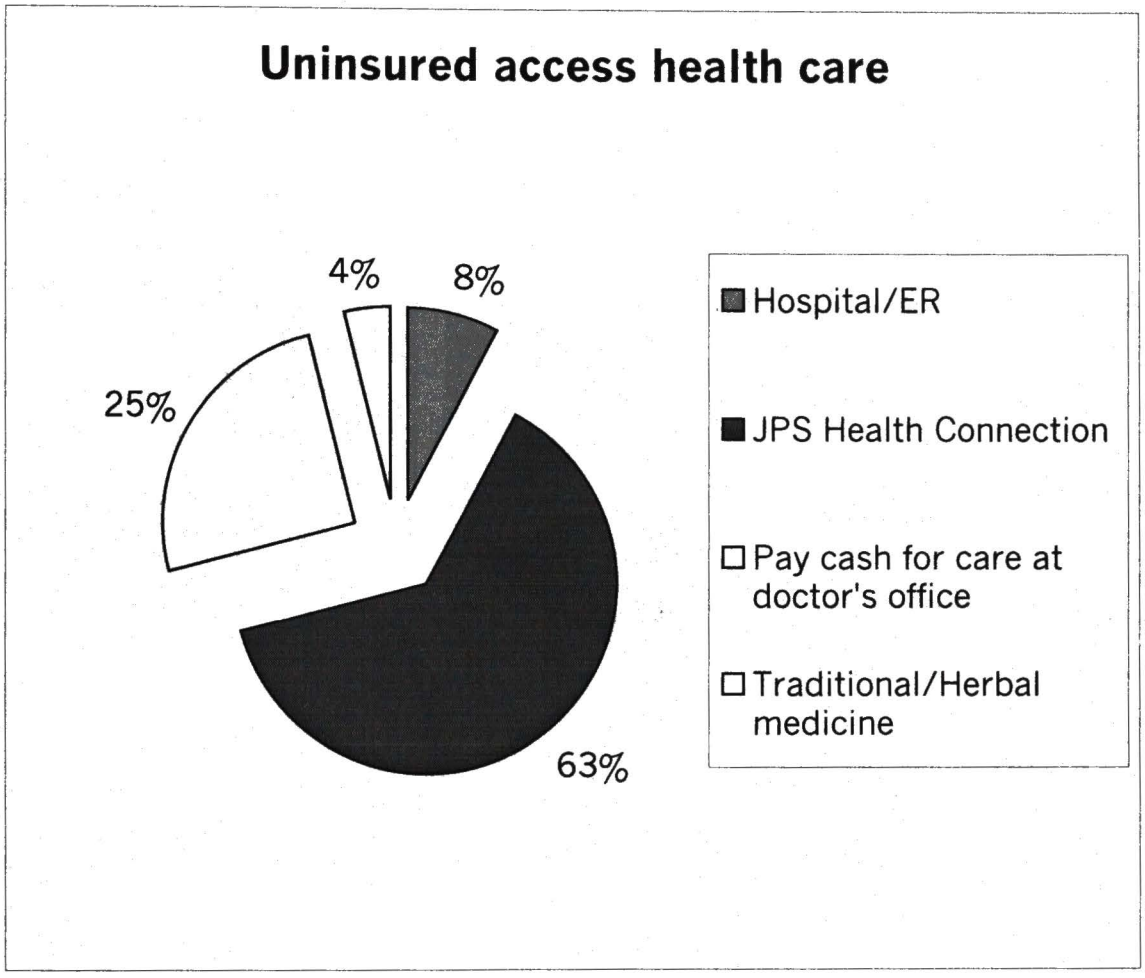


Figure 6

Reasons They Did Not Obtain Medicaid/CHIPS

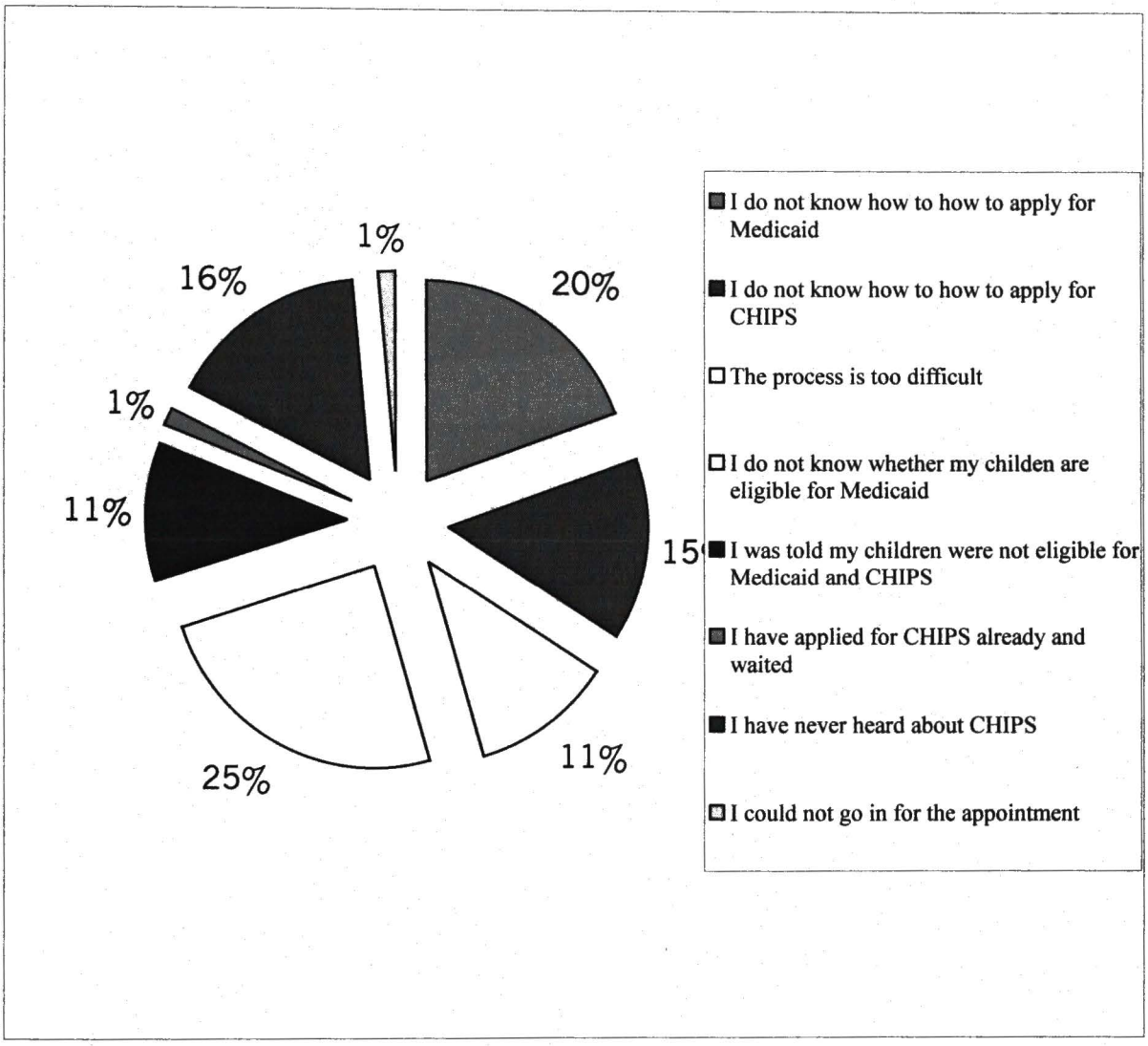


Figure 7

Factors That Keep Refugees from Using Health Care

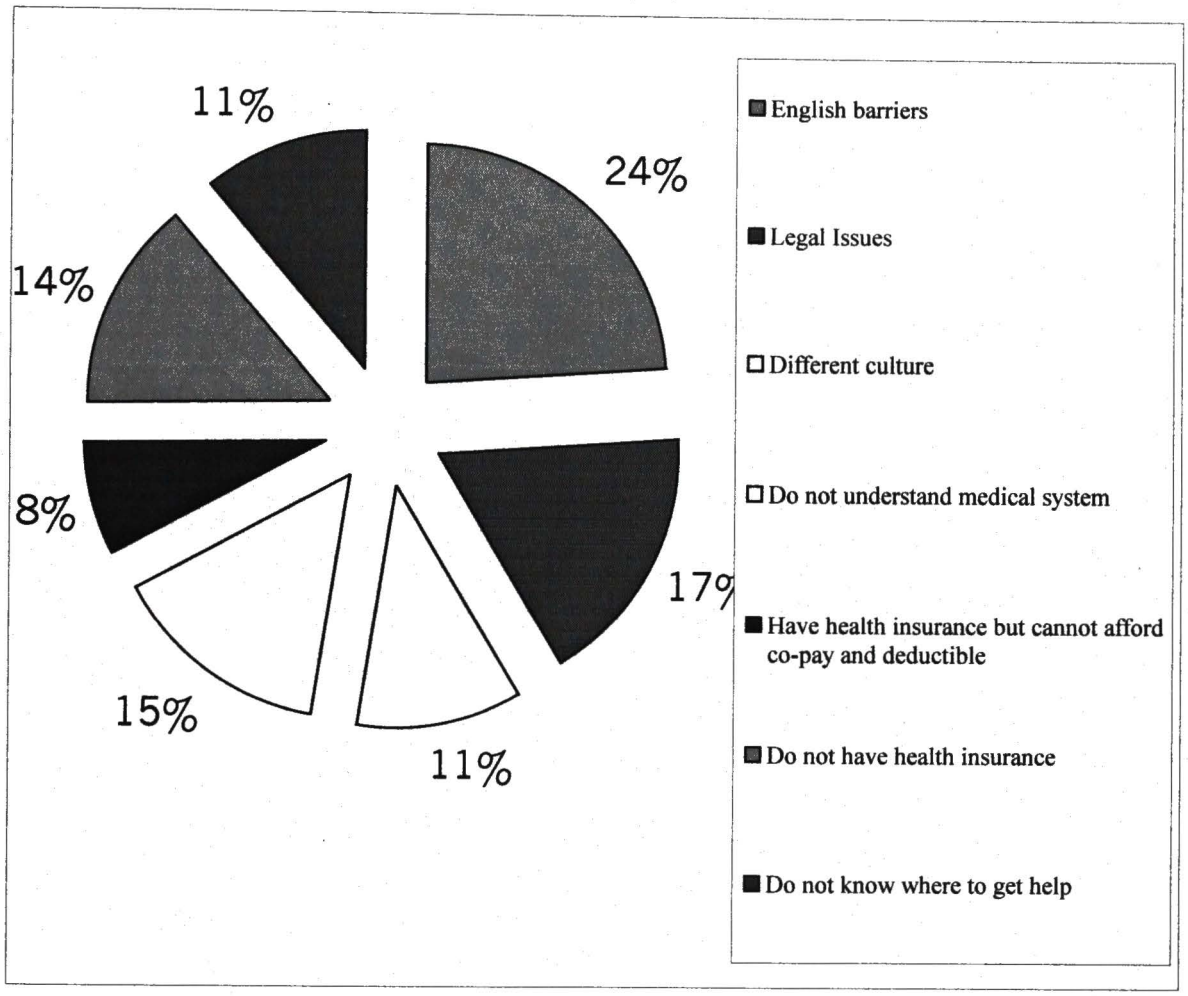


Figure 8

Reasons for Losing Government-Aided Health Insurance

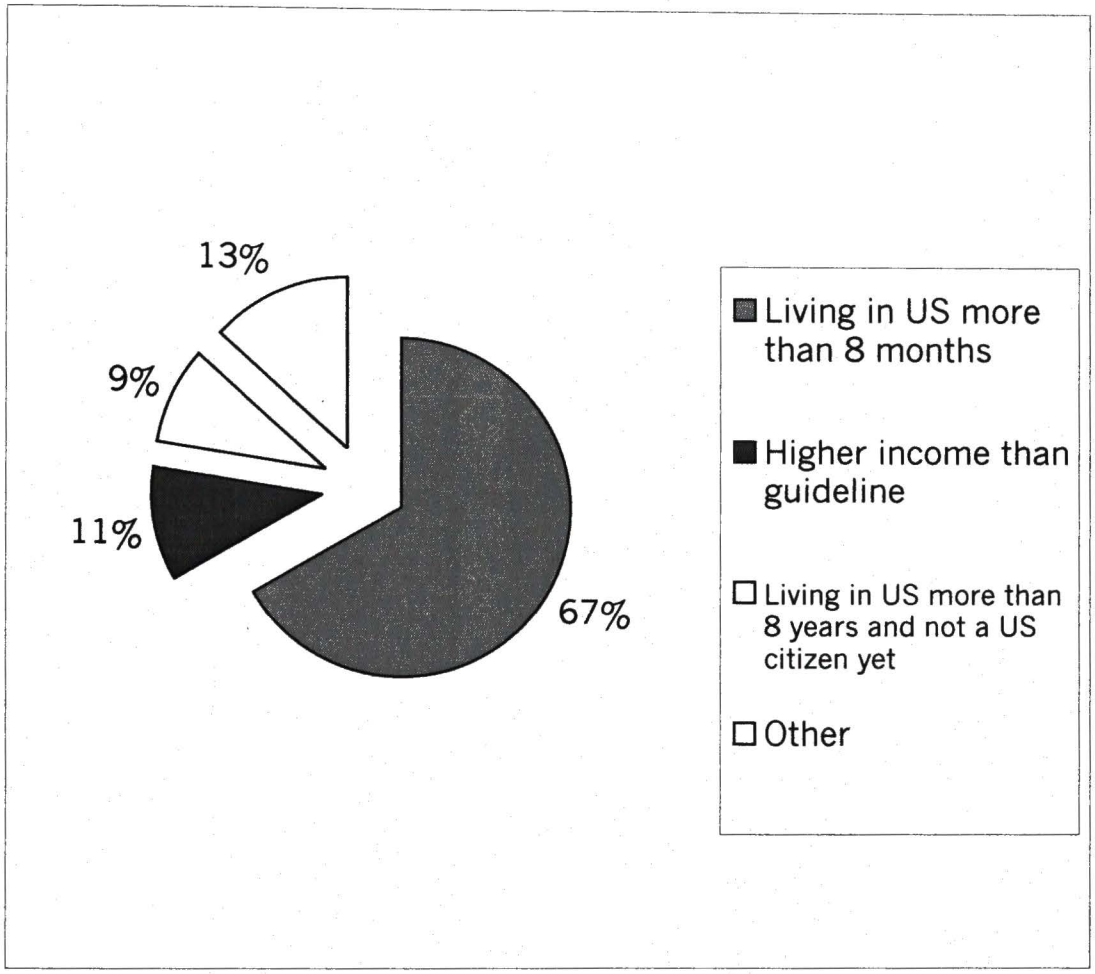


Figure 9

English Barriers in Using Health Care

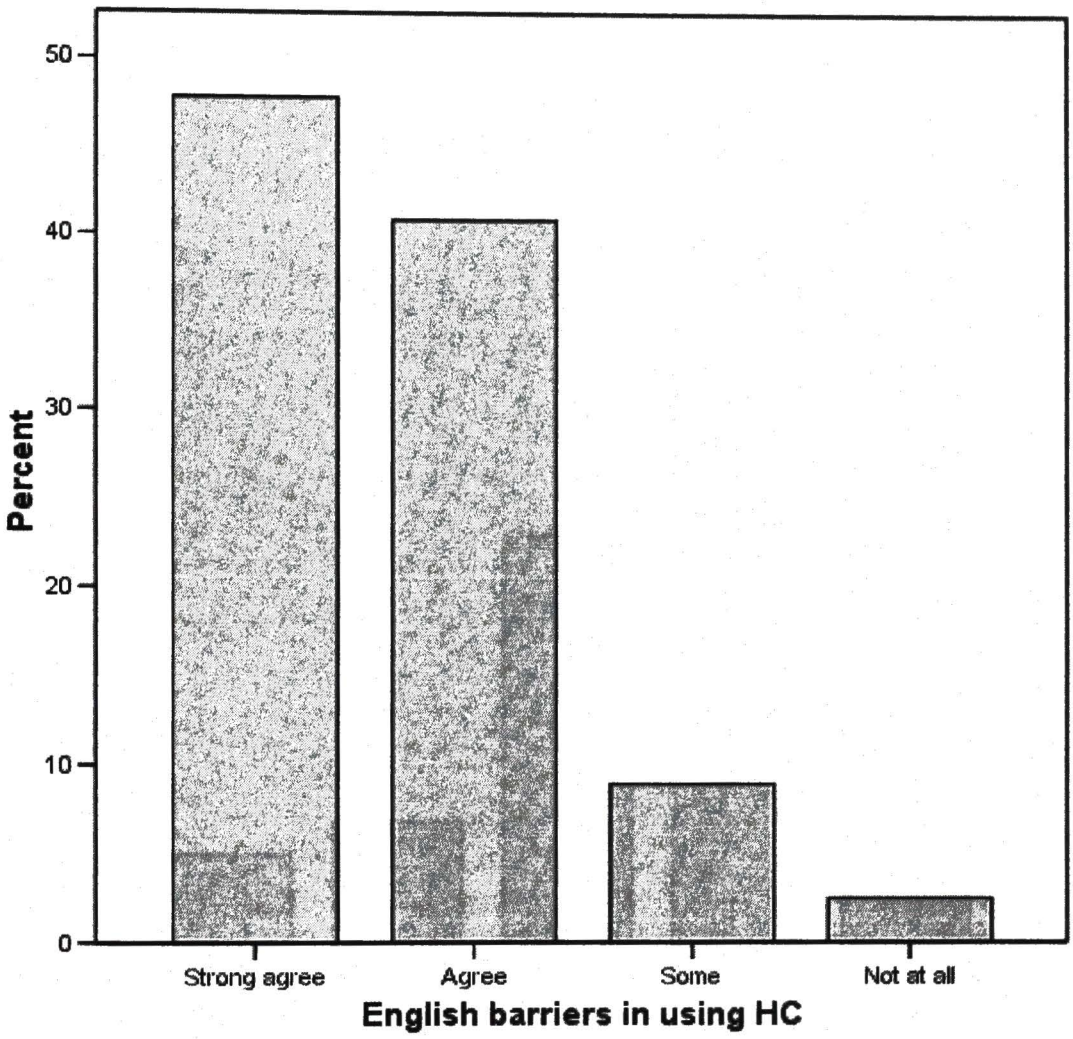


Figure 10

Problems of Spoken English

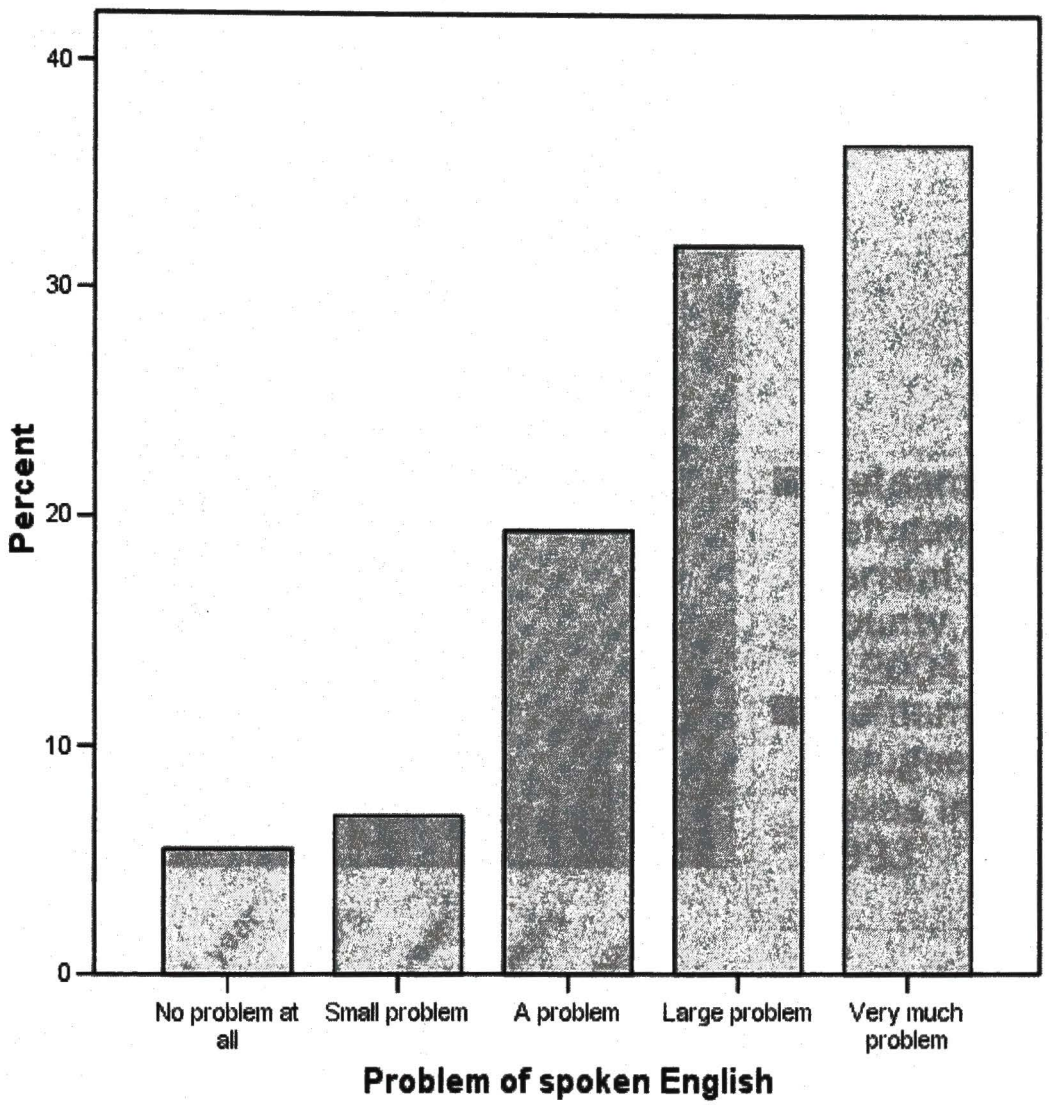
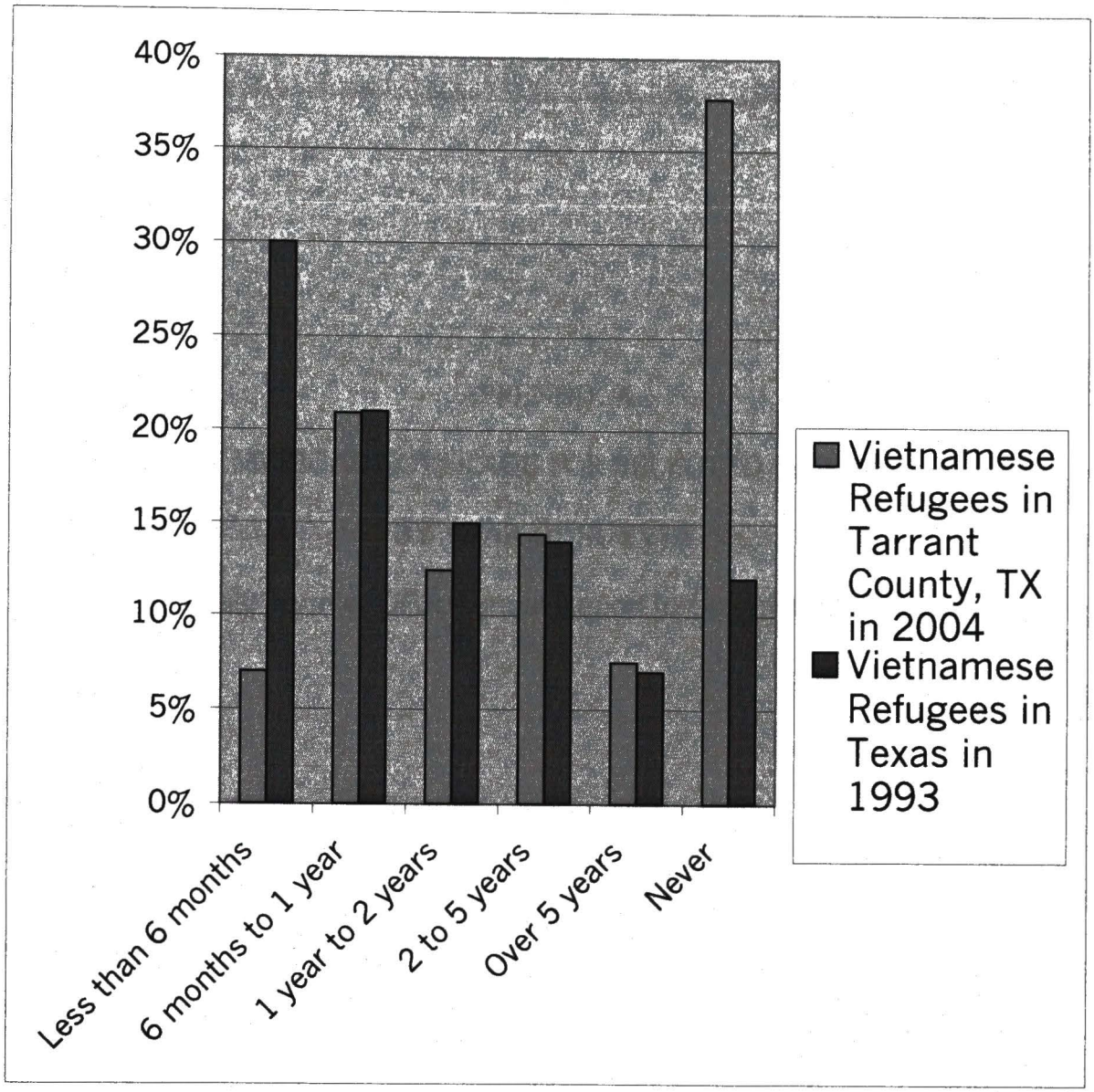


Figure 11

Last visit to dentist



Data source: The study in Tarrant County in 2004 and The Texas Refugee Study from Texas Office of Immigration & Refugee Affairs in 1993.

APPENDIX A

SOURCE OF MEDICAL COVERAGE FOR SELECTED REFUGEE GROUPS

BY YEAR OF SUYVEY

(Data source: ORR Annual Report to Congress-2001)

Source of Medical Coverage for Selected Refugee Groups by Year of Survey

Year of Survey	Africa	Eastern Europe	Latin America	Middle East	Other S.E. Asia	Former Soviet Union	Vietnam	All
No Medical Coverage in any of past 12 months								
2001 Survey	11.9%	9.3%	24.9%	12.0%	15.8%	5.0%	12.7%	11.5%
2000 Survey	15.1	8.8	7.8	7.6	4.7	6.4	5.1	7.9
1999 Survey	12.4	12.2	23.8	12.6	12.4	8.4	10.2	12.6
1998 Survey	24.0	13.0	50.8	27.7	7.5	9.3	26.9	22.3
1997 Survey	7.4	16.0	35.1	29.7	5.7	10.8	20.2	18.4
Medical Coverage Through Employer								
2001 Survey	47.1	78.7	33.5	46.5	73.0	24.5	72.7	50.3
2000 Survey	59.9	73.9	52.7	71.5	56.1	34.3	84.6	61.0
1999 Survey	50.8	64.0	63.4	64.7	29.0	33.0	74.3	56.3
1998 Survey	31.6	58.4	30.9	29.2	15.4	28.9	43.7	37.1
1997 Survey	30.8	57.4	36.2	21.2	7.5	27.4	47.5	36.9
Medicaid or RMA								
2001 Survey	35.7	10.4	33.1	34.4	9.9	62.3	13.7	33.0
2000 Survey	24.3	12.7	23.6	19.9	39.2	52.7	10.1	25.5
1999 Survey	33.8	18.4	10.5	20.6	58.5	53.6	13.9	27.7
1998 Survey	38.3	18.8	17.5	34.0	71.6	54.3	28.2	35.6
1997 Survey	49.7	16.6	22.4	45.0	81.0	53.8	27.1	37.8

Note: As of October 2001, October 2000, October 1999, October 1998, and October 1997. Not seasonally adjusted. Data refer to refugees 16 and over in the five-year sample population consisting of Amerasians, Entrants, and Refugees of all nationalities who were interviewed as a part of the 2001, 2000, 1999, 1998, and 1997 surveys. Between the 1997 and the 2001 surveys, the proportion of refugees without medical coverage (throughout the year preceding the survey) has dropped by six percent, medical coverage through Medicaid or RMA has dropped by five percent, and medical coverage through employment has increased from 37 to 50 percent (refer to Table 11).

APPENDIX B

COVER LETTER

(English Version)

Dear Participant,

In order to complete the requirements of my Master of Public Health degree at the University of North Texas Health Science Center at Fort Worth, we are conducting a study entitled "Barriers for health care access among Vietnamese refugees in Tarrant County, Texas". The purpose of this study is to conduct an assessment of barriers that refugees face when attempting to use health care. The information gained from this study may assist social service providers, health care providers, and policy activists to enhance their services and advocacy of legal issues in order to remove barriers and help you and other refugees to access health care better.

For these reasons, we would like to obtain your input on the perceived barriers that may prevent you from using health care. Participation in this research survey is completely voluntary and there will be no way to identify you as a participant since we are not asking for any identifiable information, and you can return your survey to the investigators at anytime. Furthermore, **the quality of services you receive at the Refugee Services or other agencies will not be affected by your participation (or non-participation) in the survey or any answer that you give.**

Your participation is greatly appreciated. It should only take about fifteen to twenty minutes to complete the survey. If you have any questions about the survey, please feel free to contact the Principal Investigator, Dr. Chiehwen Ed Hsu at (817) 735-5134 or Co-Investigator, Tuan Le at (817) 946-1393 at UNT HSC at Fort Worth. If you have any questions about your rights as a participant in this study, you may contact Dr. Jerry McGill, Chairman of the Institutional Review Board, University of North Texas Health Science Center at Fort Worth at (817) 735-5483.

Thank you for your participation.

Tuan D. Le
MPH Candidate at UNT Health Science Center

APPDENDIX C

COVER LETTER

(Vietnamese Version)

Quí vị kính mến,

Để hoàn thành đề tài tốt nghiệp bằng Thạc Sĩ Y Tế Cộng Đồng tại Trường Đại Học North Texas Health Science Center tại Fort Worth. Chúng tôi đang nghiên cứu đề tài "Những trở ngại trong việc tiếp cận chăm sóc sức khỏe của người tị nạn Việt Nam ở Hạt Tarrant, Texas." Mục đích của đề tài nghiên cứu nầy là tìm hiểu những trở ngại mà người tị nạn gặp phải trong khi tiếp cận với các dịch vụ y tế .Những thông tin có được từ nghiên cứu nầy có thể hổ trợ cho những người cung ứng các dịch vụ xã hội, y tế, và những nhà vận động chính sách cải thiện những dịch vụ của họ và can thiệp vào sự ban hành một số điều luật nhằm xoá bỏ những trở ngại và giúp quí vị cùng những người tị nạn khác có được sự chăm sóc y tế tốt hơn.

Vì những lý do nầy, chúng tôi tha thiết có được sự đóng góp của quí vi trong việc tìm hiểu những trở ngại mà có thể cản trở quí vi trong việc chăm sóc sức khỏe. Sự tham gia trong đề tài nghiên cứu nầy là hoàn toàn tự nguyện và chúng tôi sẽ không hỏi bất kỳ thông tin nào mà có thể xác định quí vị là người tham gia trong nghiên cứu nầy, và quí vị có thể gởi lại bản điều tra cho điều tra viên bất cứ lúc nào. Hơn nữa, **chất lượng của các dịch vụ mà quí vị nhận được ở các Refugee Services và các cơ quan khác sẽ không bị ảnh hưởng bởi sự tham gia (hoặc không tham gia) trong nghiên cứu nầy hoặc câu trả lời mà quí vị đã cung cấp.**

Chúng tôi rất cảm kích sự tham gia của quí vi. Để trả lời hết bản nghiên cứu nầy, nó có thể làm mất của quí vị từ 15 đến 20 phút. Nếu quí vị có thắc mắc gì về nghiên cứu nầy, xin vui lòng liên lạc Tiến sĩ Chiehwen Ed Hsu tại (817) 735-5134 (người điều tra chính) hoặc Tuấn Lê (người đồng điều tra) tại (817) 946-1393 tại UNT HSC Fort Worth. Nếu quí vị có câu hỏi gì về quyền lợi của người tham gia trong nghiên cứu nầy, quí vị có thể liên lạc Tiến sĩ Jerry McGill, Chủ Tịch của Institutional Review Board thuộc Trường Đại Học North Texas Health Science Center tại Fort Worth, qua điện thoại số (817) 737-5483.

Chân thành cám ơn sự tham gia của quí vi.

Tuan D. Le
MPH Candidate at UNT Health Science Center

APPENDIX D

SURVEY QUESTIONNAIRE

(English Version)

Please complete each question. If you do not understand any of these questions, please feel free to ask investigators.

1) Are you

( ) Not Vietnamese refugees (*Do not need to participate this survey. Thank you*)

( ) A Vietnamese refugee and not current living in Tarrant County or a current US citizen (*Do not need to participate this survey. Thank you*)

( ) A Vietnamese refugee and current living in Tarrant County (*Please continue the following questions*)

2) Gender/Age groups:

2.a Male _____ Female _____

2b. Age group:

_____ 18-34
_____ 35-49
_____ 50-64
_____ 65 and over

2c. Are you

____Married ____ Single ____ In a partnership ____ Separated
_____Divorced ____ Widowed

2.d) What is your occupation: _____ (*Please specify*)

3) How long have you been in the U.S?

_____ Under 1 year
_____ 1 to 5 years
_____ 5 to 7 years
_____ 7 to 10 years
_____ More than 10 years

4) What is your education level in your country of origin?

_____ 0 to 8th grade _____ 9th to 11th grade _____ High School degree
_____ Some college _____ College degree or higher

5) Have you ever attended school in the U.S

_____ Yes _____ No (*If no skip the following and go to question 6*)

Which level

_____under high school
_____high school diploma
_____some college
_____College degree

_____Vocational training program
_____Graduate school
_____None

6) Ability to speak and understand English
_____ No English
_____ Basic words
_____ Short conversation
_____ 5-10 minute conversation
_____ Speak fluently

7) Ability to read and write English
_____ None
_____ Basic words
_____ Simple phrases
_____ Notes and letters
_____ Anything

8) Ability to use health service in English
_____ Self
_____ Friend or relative
_____ Social worker
_____ Interpreter

9) Average Annual Income
_____ Less than $5,000
_____ $5,000 to $9,999
_____ $10,000 to 19,999
_____ $20,000 to $29,999
_____ $30,000 to $39,999
_____ $40,000 and more

or hourly wage: _____ (dollar/hr)
_____ Full-time _____ Part-time

How many people are there in your family: _____
Number of children under 18 years old: _____
Number of adult (19 to 64 years old): _____
Number of elderly (65 and older): _____

10) What kind of health insurance do you have?

____ Private insurance (*If selected skip the following and go to question 11*)
____ Government Aid Insurance (Medicaid/Medicare)
____ None (*If none, go to question 12*)

11) Payment of private health insurance
____ Employer pays all
____ Spouse's employer pays all
____ Employer pays part
____ Spouse's employer pay part
____ Spouse or I pay all

12) You and/or your family member do not have insurance. Do you have any health care covered in need of care?
_____ Hospital/emergency room
_____ John Peter Smith (JPS) health connection card
_____ Pay cash for care at doctor's office
_____ Traditional medicine/herbal medicine

13) Does your child/children have health insurance?
_____No (*If no, skip the following and go to question 14*)
_____Yes
Covered by _____Your or your spouse employer-based health insurance
_____ Private health insurance
_____ Medicaid
_____ CHIPS program

14) If you did not apply for Medicaid or CHIPS, please tell us why you did not apply for (*Mark all that apply*)
( ) I do not know how to apply for Medicaid
( ) I do not know how to apply for CHIPS
( ) The process is too difficult (asking for too much time and too many receipts, etc.)
( ) I do not know whether my children are eligible for Medicaid or CHIPS
( ) I was told my child(ren) were not eligible so I did not apply
( ) I could not go in for the appointment
Because_____
( ) I have applied for CHIPS already, but I have not received word that whether my child(ren) are eligible or not
( ) I have never heard about CHIPS program

15) Self-rating of health
_____ Very good
_____ Good
_____ Okay
_____ Poor
_____ Very poor
_____ Do not know

16 a) Within the past year, did any one in your family fall ill or get injured?

_____Yes _____No *(If no, skip the following and go to question 17)*

16 b) Did the person receive care for the illness or injury?

_____No _____Yes*(If yes, skip the following and go to question* 17)

16 c) Why did she/he not receive care for the illness or injury?

( ) For this kind of problem, I do not seek care
( ) I could not get an appointment with the doctor or clinic
( ) I do not have an insurance
( ) I did not have the money to pay for the visit
( ) The health provider does not provide anyone that speaks my language
( ) Other *(Please specify)* _____

17) Last visit to doctors

_____ Less than 6 months
_____ 6 months to 1 years
_____ 1 to 2 years
_____ 2 to 5 years
_____ Over 5 years
_____ Never

18) Do you have a regular doctor (primary care physician)?

_____ No *(If no, skip the following and go to question 19)*

_____ Yes. You see doctor when _____Sick
_____Regular check up

19) When needs arise, where do you or family member in need of medical care or advice go?

_____ Doctor's office
_____ Community health center
_____ Hospital/emergency room
_____ Charity clinics

20) Which of following clinics have you used in the past two years?

_____ Wellness center
_____ Community care
_____ Happy health care/Preventive/Health fair
_____ None of these clinics

21) Last visit to dentists (*Most recent dental visit)*

_____ Less than 6 months
_____ 6 months to 1 years
_____ 1 to 2 years
_____ 2 to 5 years
_____ Over 5 years
_____ Never

22) What do the following factors keep you away from using health care
(*Mark all that apply*)
_____ English barrier
_____ Legal issues
_____ Different culture
_____ Do not understand medical systems
_____ Have health insurance, but I cannot afford co-pay and/or deductible
_____ Do not have insurance
_____ Do not know where to get help

23) Is the fact that "your health care provider speaks in English only" prevents you from using health care?
_____ Strongly agree
_____ Agree
_____ Some
_____ Not at all

24) On a scale of 1 to 5, with 1 being no problem at all, and 5 being very much a problem, how much is spoken language a problem for you?

Circle one	**No problem at all**		**Small problem**	**A problem**	**Large problem**	**Very much a problem**
	1	2	3	4	5	
		6 (Did not know)		7 (Refused)		

25) Why was your "government-aided health insurance" (Refugee Medical Assistance/Medicaid/Medicare) cut or will be cut?
_____ Have been living in the U.S for 8 months and more
_____ Have higher income than guideline
_____ Have been living in the U.S more than 7 years and I am not a U.S. Citizen yet
_____ Other *(Please specify)*_____

We are through, thank you. We appreciate your taking time to answer our survey questionnaire. If you have any question or concern please feel free to ask me about this survey.

Thank you for your time

APPENDIX E

SURVEY QUESTIONNAIRE

(Vietnamese Version)

Xin vui lòng trả lời những câu hỏi sau. Nếu qúi vị có thắc mắc về câu hỏi, làm ơn hỏi người điều tra.

1) Qúi vị

( ) Không phải là người Viet Namtị nạn. (*Không cần phải tham gia. Xin cám ơn)*

( ) Là người Việt Nam tị nạn nhưng không cư trú tại hạt Tarrant hoặc đã có quốc tịch Hoa Ky. (*Không cần phải tham gia. Xin cám ơn)*

( ) Là người Việt Nam tị nạn hiện cư trú tại hạt Tarrant. *(Vui lòng trả lời những câu hỏi sau)*

2) Giới/Tuổi:

2.a Nam _____ Nữ _____

2b. Nhóm tuổi:

_____ 18-34
_____ 35-49
_____ 50-64
_____ 65 trở lên

2c. Qúi vị

____Kết hôn (Married) ____ Độc thân (Single) ____ Sống chung (In partnership)
____ Sống riêng (Separated) _____ Li dị (Divorced) ____ Góa (Widowed)

2.d) Nghề nghiệp của qúi vị là gì: _____ *(Vui lòng cho biết rõ)*

3) Qúi vị đã ở Hoa Kỳ bao lâu ?

_____ Dưới 01 năm
_____ 01 đến 5 năm
_____ 5 đến 7 năm
_____ 7 đến 10 năm
_____ Hơn 10 năm

4) Trình độ học vấn ở Việt Nam ?

_____ Dưới lớp 8 _____ Lớp 9 đến 11 _____ Có bằng Tú Tài
_____ Cao đẳng _____ Đại học và sau đại học

5) Qúi vị đã cò học ở Hoa Kỳ

_____ Có _____ Không (*Nếu không xin trả lời tiếp câu số 6*)

Trình độ nào

_____Under high school (Dưới lớp 12)
_____High school diploma (Bằng Tú Tài)
_____Some college (Có học Cao Đẳng)
_____College degree (Bằng Cao Đẳng)

_____Vocational training program(Tham gia chương trình huấn nghệ)
_____Graduate school (Cao học)
_____Other (Khác) _____

6) Khả năng nói và hiểi tiếng Anh
_____ No English (Không biết tiếng Anh)
_____ Basic words (Những từ cơ bản)
_____ Short conversation (Đàm thoại ngắn)
_____ 5-10 minute conversation (Đàm thoại từ 5 đến 10 phút)
_____ Speak fluently (Nói tiếng Anh lưu loát)

7) Khả năng đọc và viết tiếng Anh
_____ None (Không)
_____ Basic words (Những từ cơ bản)
_____ Simple phrases (Những câu đơn giản)
_____ Notes and letters (có thể viết và đọc thư)
_____ Anything (đọc và viết trôi chảy)

8) Khả năng sử dụng các dịch vụ y tế bằng tiếng Anh
_____ Self (Tự giao tiếp)
_____ Friend or relative (Nhờ bạn bè hoặc người thân)
_____ Social worker (Nhờ những người làm công tác xã hội)
_____ Interpreter (Thông dịch viên)

9) Thu nhập trung bình mỗi năm
_____ Dưới $5,000
_____ $5,000 - $9,999
_____ $10,000 - $19,999
_____ $20,000 - $29,999
_____ $30,000 - $39,999
_____ $40,000 và trên

Hoặc lương mỗi giờ : _____ (dollar/hr)
_____ Full-time (toàn thời gian) _____ Part-time (bán thời gian)
Số người trong gia đình qúi vị : _____
Số trẻ em dưới 18 tuổi : _____
Số người lớn (19 đến 64 tuổi) : _____
Số người cao niên (65 trở lên): _____

10) Loại bảo hiểm sức khỏe qúi vị đang có ?
____ Private insurance (Nếu chọn câu này xin tiếp tục đến câu số*11*)
____ Government Aid Insurance (Medicaid/Medicare)
____ Không có bảo hiểm sức khoẻ (Vui lòng tiếp tục từ câu số*12*)

11) Private health insurance (bảo hiểm y tế tư nhân) được trả bởi
____ Employer pays all (Công ty trả tất cả)
____ Spouse's employer pays all (Công ty của vợ hoặc chồng của qúi vị trả tất cả)
____ Employer pays part (Công ty trả một phần)
____ Spouse's employer pay part (Công ty của vợ hoặc chồng của qúi vị trả một phần)
____ Spouse or I pay all (Qúi vị trả tất cả)

12) Qúi vi hoặc/và thành viên gia đình không có bảo hiểm. Trong trường hợp y tế cần thiết qúi vị được chăm sóc bởi
_____ Hospital/emergency room(Phòng cấp cứu bệnh viện)
_____ John Peter Smith (JPS) health connection card (Thẻ Bệnh Viện JPS)
_____ Pay cash for care at doctor's office (Trả tiền mặt cho văn phòng bác sĩ)
_____ Traditional medicine/herbal medicine (Sử dụng y học cổ truyền/thuốc nam/bắc)

13) Con của qúi vị có bảo hiểm y tế không ?
_____ Không (Nếu không xin tiếp tục từ câu số*14*)
_____ Cò
Được bảo hiểm bởi
_____ (Employer-based health insurance) Bảo hiểm từ công ty đang làm việc
_____ Private health insurance (Bảo hiểm tư nhân)
_____ Medicaid
_____ CHIPS program(Chương trình CHIPS)

14) Nếu qúi vị không đăng ký Medicaid hoặc CHIPS, làm ơn cho chúng tôi biết lý do (Đánh chéo vào những lý do của qúi vị)
( ) Không biết làm thế nào để đăng ký chương trình Medicaid
( ) Không biết làm thế nào để đăng ký chương trình CHIPS
( ) Thủ tục qúa rắc rối (đòi hỏi quá nhiều thời gian, chứng từ, và vân vân)
( ) Tôi không biết con tôi có đủ tư cách cho chương trình Medicaid hoặc CHIPS
( ) Tôi đã được cho biết là con tôi không đủ tư cách nên tôi không đăng ký
( ) Tôi không thể giữ các cuộc hẹn
Vì lý do: _____
( ) Tôi đã nộp đơn với chương trình CHIPS, nhưng tôi chưa nhận được trả lời là con tôi có đủ tư cách hay không?
( ) Tôi chưa từng được nghe về chương trình CHIPS.

15) Tự đánh giá sức khoẻ
_____ Very good (Rất tốt)
_____ Good (Tốt)
_____ Okay (Tạm được)
_____ Poor (Kém)
_____ Very poor (Rất kém)
_____ Do not know (Không biết)

16 a) Trong năm ngoái, quí vị hoặc có ai trong gia đình bị bệnh hoặc bị thương không?
_____Có _____ Không *(Nếu không, xin tiếp tục câu số 17)*

16 b) Người bi đau hay bị chương có được chăm sóc y tế không?
_____ Không _____ Có *(Nếu có, xin tiếp tục câu số 17)*

16 C) Tại sao không được chăm sóc y tế khi bị bệnh hoặc bị thương ?
( ) Cho bệnh hay bị thương đó ,tôi không cần sự chăm sóc y tế.
( ) Tôi không thể lấy được cuộc hẹn với bác sĩ hoặc trạm y tế.
( ) Tôi không có bảo hiểm y tế.
( ) Tôi không có tiền để trả cho sự thăm khám nầy.
( ) Dịch vụ y tế không co người nói tiếng Việco.
( ) Nguyên nhân khác *(Xin vui lòng nêu rõ)* _____

17) Lần khám bệnh gấn đây nhất
_____ ít hơn sáu tháng.
_____ 6 tháng đến 1 năm
_____ 1 đến 2 năm
_____ 2 đến 5 năm
_____ Hơn 5 năm
_____ Chưa khám lần nào cả.

18) Quí vị có bác sĩ gia đình không (primary care physician)?
_____ Không *(Nếu không, xin tiếp tục câu số 19)*

_____Có. Quí vị gặp bác sĩ **khi** _____ bị bệnh
_____ Chăm sóc sức khoẻ định kỳ

19) Khi cần sự chăm sóc y tế, quí vi hay thành viên trong gi a đình đi đến đâu?
_____ Văn phòng bác sĩ
_____ Trung tâm y tế cộng đồng
_____ Bệnh viện/Phòng cấp cứu
_____ Phòng khám từ thiện

20) Những văn phòng y tế nào sau đâu mà quí vị đã đến trong vòng hai năm qua ?
_____ Wellness center (Trung tâmsức khoẻ)
_____ Community care (Chăm sóc sức khỏe cộng đồng)
_____ Happy health care/Preventive/Health fair (Chương trình sức khỏa hạnh phúc/dự phòng/hội chợ y tế)
_____ None of these clinics (Không đến bất kỳ cơ quan y tế nào)

21) Quí vị khám răng lần gần nhất là khi nào?
_____ ít hơn sáu tháng.
_____ 6 tháng đến 1 năm
_____ 1 đến 2 năm
_____ 2 đến 5 năm
_____ Hơn 5 năm
_____ Chưa khám lần nào cả.

22) Những yếu tố nào sau đây cản trở quí vi đến với sự chăm sóc y tế.
(*Đánh chéo váo tất cả những yếu tố đúng với quí vị*)
_____ English barrier (Trở ngại về tiếng Anh)
_____ Legal issues (Cản trở bởi một số điều luật)
_____ Different culture (Khác nhau về văn hóa)
_____ Do not understand medical systems (Không hiểu về hệ thống y tế)
_____ Have health insurance, but I cannot afford co-pay and/or deductible (có bảo hiểm y tế, nhưng không đủ tiền để trả co-pay hoặc/và deductible)
_____ Do not have insurance (Không có bảo hiểm y tế)
_____ Do not know where to get help (Không biết đến chổ nào để được giúp đỡ)

23) Sự thật là dịch vụ y tế chỉ nói tiếng Anh, nên cản trở quí vị trong vấn đề chăm sóc sức khỏe?
_____ Strongly agree (Rất đồng ý)
_____ Agree (Đồng ý)
_____ Some (Đồng ý một phần)
_____ Not at all (Hoàn toàn không đồng ý)

24) Với thang điển từ 1 đến 5, với 1 là không có vấn đề gì cả, và 5 là vấn đề rất lớn trong sử dụng tiếng Anh. Khoang tròn một số: **Không có vấn đề gí** **Vấn đề nhỏ** **Là một vấn đề**

1 **2** **3**

Vấn đề lớn **Vấn đề rất lớn**

4 **5** **6** (Không biết) **7** (từ chối)

25) Tại sao chương trình giúp đỡ y tế của chính phủ cho quí vị (Refugee Medical Assistance/Medicaid/Medicare) bị cắt hoặc sẽ bị cắt?
_____ Đã sống ở Hoa Kỳ hơn 8 tháng
_____ Thu nhập gia đình cao hơn sự cho phép
_____ Đã sống ở Hoa Kỳ hơn 7 năm và chưa vào quốc tịch
_____ Lý do khác (Làm ơn nêu rõ)_____

Chúng tôi xin chân thành cám ơn quí vị đã dành thời giờ quí báu của mình giúp chúng tôi hoàn thành bản điều tra nghiên cứu nầy.
Nếu quí vị có những câu hỏi hoặc góp ý gì về bản điều tra nầy, xin vui lòng hỏi chúng tôi.
Xin cám ơn.

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