Determining the Barriers and Beliefs of Salt Lake City Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease

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Executive Summary

The 2003 war in Iraq caused the displacement of over 4.2 million people. Since 2007, over 60,000 Iraqi refugees have resettled in the United States. In Utah, Iraqi refugees are the second largest refugee population. Iraqi refugees have a high prevalence of metabolic and cardiovascular disease prior to resettlement to the United States. Torture exposure, which is high among Iraqi refugees, increases the lifetime risk of metabolic and cardiovascular disease. During integration into western society, barriers prevent refugees from appropriate metabolic and cardiovascular disease prevention, diagnosis, and management.

The primary objective of this DNP project is to determine Iraqi refugee torture survivors' understanding of metabolic and cardiovascular disease, their perceived barriers to accessing health care, and the perceived barriers and factors that cause or perpetuate lifestyle choices associated with metabolic and cardiovascular disease. The secondary objective is to disseminate the research findings to the Salt Lake Iraqi community and a wider audience of refugee health care providers and policy makers.

The project utilized a community-based participatory research model to collaborate with a local organization that provides mental health services to Iraqi refugee torture survivors. The organization hosted three focus groups with 5, 7, and 9 participants (n=21). Questions were designed to determine the shared understandings of the Iraqi refugee community related to metabolic and cardiovascular disease and to identify the social and cognitive factors that affect their health behavior and access to health services. Data was analyzed using thematic categorization and organized into a thematic network model.

Seven major themes were developed during the focus group discussions including: understanding of metabolic and cardiovascular disease, health care access barriers, dietary habits, exercise habits, dietary modification factors, exercise modification factors, and suggestions for health care services. Subthemes were developed from each major theme.

Understanding the perspective of Iraqi patients is important for refugee health care providers and policymakers, as this is the first step in tailoring care to be most effective. There is a need for health care providers to acknowledge the impact of emotional symptoms on metabolic and cardiovascular disease development and progression and assist refugee patients in eliminating barriers to accessing care through community resources and education about the health care system in Utah. Health programs for Iraqi refugees should address emotional and physical causes of illness through education, group exercise, and group discussion. Iraqi women have more significant barriers than men due to cultural beliefs and traditional gender roles and therefore should be the priority of health programs for Iraqi refugees.

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Problem Statement

Metabolic and cardiovascular disease risk is high among many refugee populations, especially refugees originating from non-tropical, middle-income countries, such as Iraq. During resettlement, barriers prevent many refugees from appropriate metabolic and cardiovascular disease prevention, diagnosis, and management.

Clinical Significance and Policy Implications

The prevalence of metabolic and cardiovascular disease among Iraqi refugees resettled in the United States is informed from the overseas medical data. Studies by Yanni et al. (2013) and Mateen et al. (2012) found that the results of the overseas medical exam of Iraqis seeking asylum in Jordan before resettlement in the United States revealed a low prevalence of infectious disease and a high prevalence of metabolic and cardiovascular disease, comparable to other middle-income countries. Among the Iraqis screened in Jordan, 35% had at least one cardiovascular risk factor, including, hypertension, diabetes mellitus, or obesity (Yanni et al., 2013). Integrating into western society after resettlement often catalyzes the progression of metabolic disorders and therefore increases cardiovascular risk (Wagner et al., 2015). Furthermore, evidence suggests that torture exposure, which is high among the Iraqi population, increases the risk of developing cardiovascular and metabolic disease later in life (Willard, Rabin, & Lawless, 2014). Because infectious disease diagnosis and management is the primary focus of the initial health screenings for refugees, metabolic and cardiovascular disease diagnosis may be delayed or missed.

Determining Iraqi refugee torture survivors understanding of metabolic and cardiovascular disease, as well as the barriers they face in accessing health care and making lifestyle changes, would enable refugee health care providers in the United States to provide culturally appropriate care to Iraqi refugee patients. In addition to improving health outcomes,

culturally sensitive medical care has been shown to improve the overall medical experience of refugees (Bhatia & Wallace, 2007). By providing a positive health care experience, culturally sensitive medical care plays an important role in promoting continuity of care. Increasing refugee service provider's awareness of the high risk of metabolic and cardiovascular disease among the Iraqi refugee torture survivor population and increasing their understanding of cultural and access barriers will assist in the promotion of public health policies to reduce the morbidity and mortality of Iraqi refugees (Yanni et al., 2013). The prevalence of metabolic and cardiovascular disease among certain refugee populations is an implication for a policy change to expand the domestic refugee medical exam requirements to include metabolic and cardiovascular disease screening for refugees originating from Iraq and other non-tropical, middle-income countries.

Objectives

1. Determine Salt Lake City Iraqi refugee torture survivors understanding of metabolic and cardiovascular disease, their perceived barriers to accessing health care, and the perceived barriers and factors that cause or perpetuate lifestyle choices associated with metabolic and cardiovascular disease
2. Disseminate research findings to the Salt Lake City Iraqi community and a wider audience of refugee health care providers and policy makers.

Literature Search Strategy

PubMed was the primary database utilized to identify literature pertinent to this project. Search terms included: "Iraqi refugee", "refugee health care", "refugee screening exam", "health care utilization", "health care cost", "torture exposure", "chronic stress", "cardiovascular disease", "metabolic disease", "diabetes", "cultural concepts of health", "health explanatory

model", "social cognitive theory", "health care access barriers", "cultural barriers", "community based participatory research", "focus group methodology", and "qualitative data analysis". Other sources included websites of the Centers for Disease Control and Prevention, United Nations High Commissioner for Refugees, and the Utah Department of Health Refugee Health Program database. Only studies within the last ten years were included in the literature search with the exception of the social cognitive theory article originating in the 1980s, book by renowned physician and anthropologist Arthur Kleinman, and book on focus group planning and analysis. Only studies of Iraqis were included in the sections explaining cultural concepts of health and disease prevalence specific to the Iraqi population. All refugee groups were included in the sections pertaining to refugee health care barriers, health care providers systems' challenges, and research methodology. Personal communication with content experts and faculty chair provided additional references.

Literature Review

Introduction

Individuals fleeing persecution have the fundamental human right to asylum according to the 1951 UN Convention on the Status of Refugees (United Nations High Commissioner for Refugees (UNHCR, n.d.). The UNHCR define asylum-seekers as people who claim to be refugees, but have not had their cases officially evaluated (UNHCR, n.d.). Official refugee status is determined on a case-by-case basis and granted by the national asylum system in the individuals' host country. For purposes of brevity and consistency throughout this paper, "refugee" will be used, acknowledging the sensitivity of labels.

In the last twenty years, the number of refugee applications in the European Union has increased from 15,000 to over 300,000 people per year (Pfortmueller et al., 2013). Currently,

there are 59.5 million people worldwide displaced by war (United Nations High Commissioner for Refugees, 2015). Because of their unique backgrounds and exposure to conflict, refugees arrive with a complex disease profile that varies according to their country of origin (Pfortmueller et al., 2013). Often these problems are exacerbated by lack of health care access and the psychological trauma of seeking asylum and awaiting resettlement (Kumar et al., 2014). This review of literature is focused on identifying problems in the current refugee screening exam process, explaining the unique cultural background and health profile of refugees from Iraq, identifying the challenges of health care providers and health systems as they care for refugee patients, and exploring qualitative research methods to determine the barriers of Iraqi refugees as they navigate the health care system in the United States.

Iraqi Refugees

Background.

Before discussing the health profile of Iraqi refugees it is helpful to briefly discuss the recent political context of Iraq. The 2003 war in Iraq caused the displacement of over 4.2 million people from Iraq and surrounding countries (Mateen et al., 2012). In 2007, in response to this Iraqi refugee crisis, the United States announced an Iraqi refugee-processing program through the United States Refugee Admissions Program and the United States Citizenship and Immigration Services (Willard et al., 2014). Since that time, over 60,000 Iraqi refugees have resettled in 49 states and it is expected that this number will continue to rise over the upcoming years (Willard et al., 2014). In Utah, refugee arrivals from Iraq in 2014 made up 27 percent of the 1,286 incoming refugees, making them one of the largest refugee populations in Utah (Utah Department of Health Bureau of Epidemiology & Utah Department of Health Refugee Health

Program, n.d.). Because Iraqi refugees make up a large part of the refugee population in Utah and the United States, it is important that refugee health care providers in the United States understand the health risks of the Iraqi population.

Metabolic and cardiovascular disease.

Examining the health profile of refugees prior to resettlement provides important information for health organizations in the United States, as they prepare to meet the needs of incoming refugees. Jordan is the country of first asylum for many Iraqi refugees. Data for United States bound refugees who were screened in International Organization for Migration clinics in Jordan from 2007-2009 revealed a high burden of metabolic and cardiovascular disease (Yanni et al., 2013). Of the Iraqi refugees 15 years and older who were screened for chronic diseases, 33% had hypertension, 2.7% had diabetes mellitus, 38% were overweight, 34% were obese, and 19% reported a history of smoking (Yanni et al., 2013). The same study revealed that 11.3% of adults over age 45 had diabetes (Yanni et al., 2013). Another study of the data recorded in the UNHCR refugee database in Jordan in 2010 found that of the Iraqi refugees 18 years and older, 22% had hypertension, 11% had type II diabetes mellitus, 4% had type I diabetes, 10% had vision problems, 10% had hyperlipidemia, and 7% had chronic ischemic heart disease (Mateen et al., 2012).

In addition to metabolic and cardiovascular disease, mental health disorders are a significant health problem among Iraqi refugees. This is largely attributed to the violent background from which most Iraqi refugees fled when seeking asylum. Of the Iraqi refugees screened in Utah from 2008-2009, 56% had experienced torture (Willard et al., 2014). Research from the same study showed that torture survivors of all ages were more likely to report physical as well as mental health symptoms (Willard et al., 2014). The scientific theory behind the

relationship between stress and metabolic disease is that stress-induced changes in the hypothalamic-pituitary-adrenal axis cause glucocorticoid excess. High glucocorticoid levels are associated with insulin resistance, fat-redistribution/central adiposity, low HDL levels, and hypertension (Bergmann et al., 2014). It can therefore be inferred that the chronic and severe stress associated with migration and fleeing persecution and a history of violence and/or torture, puts Iraqi refugees at a high risk of developing diabetes and other metabolic diseases.

Cultural concepts of health.

Understanding cultural concepts of health is crucial for health care providers to provide quality care to refugee patients. There is limited research examining the cultural understanding and/or health explanatory models held by Iraqi refugees. It is reported that Arab Muslims believe illness can be brought on by supernatural, social, and hereditary causes (Kulwicki, 1991). Since Islam is the predominant religion in Iraq, it is expected that Islamic health ideals are evident in Iraqi refugee culture. The belief that the human body is created by Allah and should therefore be respected and taken care of is common among Muslims (Gallager, 2005). It is also common for Muslims to seek a religious opinion about health related issues (Inhorn, 2003). Greater understanding of the cultural concepts of health of Iraqi refugees is needed to create culturally specific health programs. Integrating Iraqi cultural concepts into United States health care could provide positive results for Iraqi patients.

Health Care Provider Systems' Challenges

Health care utilization and cost.

Health care costs and utilization patterns of refugees in their country of first asylum, provides important information for health systems that receive refugees. In 2009, medical aid was suspended to Iraqi refugees due to tertiary health care costs of $6,000 to $20,000 per person

in the refugee camp in Jordan (Mateen et al., 2012). In addition to cost, this illustrates that Iraqi refugees are heavily utilizing tertiary health care. In 2010, Jordan spent approximately 63 million dollars on refugee health care, mostly for Iraqis, providing another example of the cost of Iraqi health care (Mateen et al., 2012).

The high prevalence of metabolic and cardiovascular disease among Iraqi refugees awaiting resettlement suggests that they will have a significant need for health services in the United States once they arrive. Increased health service utilization places a significant financial burden on the United States health care system. In addition to health care costs, metabolic and cardiovascular disease increases daily living expenses for refugees, further contributing to the financial burden on government organizations and NGOs (Mateen et al., 2012). In order to reduce health care costs, health services for Iraqi refugees resettled in the United States must be targeted to control and prevent metabolic and cardiovascular diseases.

Health care barriers.

The most common health care access barriers for the general refugee population identified through this review of literature are language and cultural misunderstandings. In a study evaluating perceived barriers of refugees in San Diego, communication barriers occurred primarily at times when interpreters were not available (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Although medical interpreters are helpful at reducing communication barriers, they are not always capable of providing cultural insight. Downes & Graham (2011) suggest that interpreters with cultural knowledge of the patient's host country (cultural brokers) are utilized when possible.

Integrating into a foreign culture also poses a significant barrier for refugee patients. Lack of knowledge about the United States health care system makes health care utilization difficult.

Morris et al. (2009) states that refugees are often unaware of where to go for health care. Financial and transportation needs pose another significant barrier for refugee patients (Morris et al., 2009). Finances are especially an issue for refugees that are unable to become citizens within the first seven years of arrival to the United States. Refugees who do not receive citizenship in that time lose their Medicaid and Medicare benefits and can no longer afford health care (Downes & Graham, 2011).

One of the greatest barriers for refugees that provides a unique challenge for United States refugee health care providers are traditional views of health. Refugees may believe that illness is spiritual and rely on homeopathic or spiritual treatments (Morris et al., 2009) (Pavlish, Noor, & Brandt, 2010). These beliefs vary according to country of origin and should be addressed in the refugee health care encounter. Downes & Graham (2011) discuss the importance of understanding the health explanatory models of refugees in order to improve health outcomes. The importance of understanding cultural perspectives about health was made scientifically relevant by Harvard physician and anthropologist Arthur Kleinman. Kleinman designed a series of questions to be used clinically that elicit a patient's understanding of their health (Kleinman, 1981). Knowing the health explanatory model of Iraqi refugees would allow refugee health care providers in the United States to approach Iraqi patients about health topics in an informed and sensitive manner.

Qualitative Research Methods

Qualitative research is necessary to identify cultural barriers and beliefs in order to develop culturally appropriate interventions (Teufel-Shone & Williams, 2010). A community based participatory research (CBPR) approach is recommended for qualitative research aimed at gaining insight into the beliefs, perceptions, experiences, and opinions of a homogenous group of

people. CBPR is a collaborative research process that builds on the strengths of community members, organizations, and researchers to better serve the needs of the community (Hartwig, Calleson, & Williams, 2006).

Focus groups are a common qualitative research method used with refugee populations. The group dynamic of focus groups allows discussion that provides useful information not possible to gain through individual data collection (CDC, 2008). Focus group questions are carefully designed to elicit unbiased group discussions from which key themes can be extracted and analyzed (Morgan & Krueger, 1998). Key themes are extracted by identifying perceptions and beliefs that are shared by the group about the research topic (Morgan & Krueger, 1998).

A literature review exploring the role of focus group research with culturally and linguistically diverse groups found that focus groups are a useful tool to gain an understanding of perspectives held by diverse groups and can impact clinical practice to meet the unique needs of diverse populations (Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007). Therefore, focus groups informed by a CBPR framework are supported by the literature to be an appropriate research method to examine culturally and linguistically diverse populations.

Theoretical Framework

The Social Cognitive Theory (SCT) builds upon the framework that human behavior is affected by a combination of individual characteristics and environmental factors (Edberg, 2007). Individual characteristics contribute to self-efficacy or an individual's perceived ability to make a behavior change. Albert Bandura first introduced the concept of self-efficacy in his seminal article in 1977 that found that perceived self-efficacy is a greater predictor of an individual's behavior in a new environment compared to their past behavior (A. Bandura, 1977). Therefore, it is of greater value to assess the self-efficacy of resettled Iraqi refugees rather than

make assumptions based on their health behavior prior to resettlement. In an article in 2002, Bandura explores the cultural context of the Social Cognitive Theory and states that principles of self-efficacy are applicable in diverse groups (Albert Bandura, 2002).

The core function of this DNP project is to conduct focus groups to determine Salt Lake City Iraqi refugee torture survivors understanding of metabolic and cardiovascular disease as well as the barriers that impede metabolic and cardiovascular disease management. The SCT will be utilized to guide the development of focus group questions that will assess the social and environmental factors associated with metabolic and cardiovascular disease of Iraqi refugees. The SCT will also be useful as a framework to determine Salt Lake City Iraqi refugee torture survivors perceived self-efficacy pertaining to health behavior change.

Implementation and Evaluation

An implementation and evaluation plan was created to guide this DNP project and ensure that each project objective was met. Table 1 illustrates the implementation and evaluation process that corresponds with each project objective.

Table 1

Objectives	Implementation	Evaluation
Determine Salt Lake City Iraqi refugees torture survivors understanding of metabolic and cardiovascular disease, their perceived barriers to accessing health care, and the perceived barriers and factors that cause or perpetuate lifestyle choices associated with metabolic and cardiovascular disease	**1. Develop the focus group guide** **2. Select the focus group moderator, interpreter, and note taker** **3. Recruit focus group participants** **4. Schedule 60-90 minute focus group sessions at Utah Health and Human Rights** **5. Identify key themes and analyze data**	**1. Focus group guide developed, as approved by content experts** **2. Moderator, interpreter, and note taker selected** **3. Participants recruited** **4. Focus groups held at Utah Health and Human Rights** **5. Key themes identified and data analyzed, as approved by content experts**

Disseminate research findings to the Salt Lake City Iraqi community and a wider audience of refugee health care providers and policy makers	**1. Identify appropriate conference** **2. Create DNP scholarly project poster and submit to conference** **3. Post newsletter of study findings at UHHR**	**1. Conference selected, as approved by project chair** **2. Poster submitted, as approved by project chair** **3. Findings shared with Iraqi community**

Implementation

Focus group planning.

A community based participatory research model was utilized by collaborating with a community organization, Utah Health and Human Rights (UHHR). UHHR provides mental health services to refugee torture survivors (primary survivors) and their family members (secondary survivors). Iraqi refugees make up almost 50% of the client population at UHHR. UHHR identified the research need that has informed this scholarly project.

Research of focus group methodology was essential to planning the focus groups. The focus group guide (see Appendix A) was created utilizing an evidenced based approach in order to identify key themes related to participants' perceived barriers and beliefs related to metabolic and cardiovascular disease. The questions were influenced by Kleinman (1981) and Bandura (1977) to determine the participants' health explanatory model and self-efficacy toward making lifestyle changes.

Focus group implementation.

Staff members at UHHR recruited Iraqi clients 18 years and older through the UHHR database and scheduled the interested clients to attend the focus groups. The interpreter for the focus groups was a staff member at UHHR who is a native Arabic speaker, Iraqi immigrant, and certified Arabic translator. The focus group moderator for the first focus group was provided by

the Collaboration and Engagement program at the University of Utah. I moderated the second and third focus groups after observation of the first group. The note-taker for the focus groups was a Master of Public Health student from Westminster College who is currently working at UHHR. The moderator, interpreter, and note-taker were CITI trained.

For each focus group the room was set up with the participants sitting in a circle so that each participant was in equal proximity to the moderator and interpreter. The note-taker was seated outside of the circle in the corner of the room and did not participate in the discussion. An audio recorder was set up in the center of the circle. Participants were given a copy of the consent form (see Appendix B) in Arabic, their native language at the time of arrival. Once the group was seated, I explained the consent form to the entire group and participants were given an opportunity to ask questions before giving consent. An excel document was used to record demographic information and indicate that consent was obtained since signatures were not recorded. No names or identifying information were recorded at any time during the groups. Middle-eastern cuisine was provided immediately following the groups.

Focus group data analysis.

Data for this scholarly project was extracted from the notes taken during the focus groups. Handwritten notes were taken during the groups and then expanded notes were typed within 24 hours. Key themes and shared perceptions were identified through analysis of the expanded focus group notes. The themes were separated into major themes and subthemes and organized into a thematic network model (Attride-Stirling, 2001). The audio recordings were turned over to UHHR for thorough qualitative data analysis outside of the scope of this project.

Dissemination of results.

The secondary objective of this DNP project was to disseminate the research findings to the Salt Lake City Iraqi refugee community and wider audience of refugee health care providers and policy makers in order to impact clinical practice and health care policies to improve the health of Iraqi refugees. An abstract for a poster presentation was submitted to the Utah Public Health Association conference (see Appendix C), the American Public Health Association conference (see Appendix D), the University of Utah Student Global Health Initiative conference (see Appendix E), and the North American Society of Refugee Health Care Providers conference (see Appendix F). The scholarly project poster (see Appendix G) was created to illustrate the key findings, purpose, background, methods, and conclusions of this project. The poster will be translated into Arabic and posted as a newsletter at UHHR in April 2016 to share the results with the Salt Lake City Iraqi community.

Evaluation

Focus group planning.

The focus group planning process was evaluated through regular email communication with my content experts and project chair, and monthly meetings at UHHR. My DNP Scholarly Project Proposal (see Appendix H) was presented to the University of Utah College of Nursing faculty in October. Once approved, the project was submitted to the IRB at the University of Utah. My content experts and project chair were involved in approving my IRB application and study instruments prior to submission. The IRB application was then reviewed and approved (see Appendix I) by the University of Utah IRB on February 2, 2016.

Focus group implementation.

About fifty percent of the participants who had confirmed did not attend the focus groups. All participants contributed to the discussion. In each group 1-2 participants had to leave the group early due to schedule conflicts.

Focus group data analysis.

A debriefing form was shared via email between the note-takers, moderator, and interpreter to address any unanswered questions following the group and to discuss important themes. Focus group notes were typed by the note-taker after the group session. Data was then analyzed and key themes were extracted from the notes. The study team reviewed and approved the key themes.

Dissemination of results.

The Utah Public Health association accepted this project for a 30-minute podium presentation to be held at the annual conference on April 12-13, 2016. The Student Global Health Initiative Conference accepted this project for a poster presentation on March 26, 2016. The American Public Health Association, and North American Society of Refugee Health Care Providers will notify abstract applicants in April-June 2016. The scholarly project poster was turned over to the study team for translation into Arabic and dissemination to the Iraqi clients at UHHR through a newsletter.

Results

Demographics

In total, twenty-one people, fourteen women and seven men, participated in three focus groups. The groups were separated by gender due to cultural preferences of participants. Ages of participants ranged from 38 to 65 years old in the women's group and 46 to 82 years old in the

men's group. Five women reported that they did not have a cardiovascular or metabolic disease diagnosis. Of the nine women who reported a cardiovascular or metabolic disease diagnosis, four women reported Type II diabetes mellitus, nine women reported hypertension, two women reported cardiovascular disease, two women reported coronary artery disease, and one woman reported congestive heart failure. Four men reported that they did not have a cardiovascular or metabolic disease diagnosis. Of the three men who reported a cardiovascular or metabolic disease diagnosis, two men reported Type II diabetes mellitus, three men reported hypertension, one man reported cardiovascular disease, and one man reported coronary artery disease.

Themes

A thematic network model (see Appendix J) was used to organize the relevant themes into major themes and subthemes. The following seven major themes were developed from the focus group discussions: understanding of metabolic and cardiovascular disease, health care access barriers, dietary habits, exercise habits, dietary modification barriers, exercise modification barriers, and suggestions for health care services. Subthemes were developed from each major theme. The subthemes are discussed below.

Theme 1: Understanding of metabolic and cardiovascular disease.

Causes.

Participants agreed diabetes and heart disease was caused by factors related to emotions, genetics, diet/obesity, and age. Anxiety/stress, anger, depression, and the trauma of living in a war zone were the emotional factors that participants believed to have caused diabetes and heart disease. Lack of proper treatment was also discussed as a factor that leads to diabetes and heart disease. Lack of exercise, pancreas not making enough insulin, blockage in arteries, and smoking were other identified causes. Fatigue, urinary symptoms, appetite changes, vision problems,

stomach problems, and amputations were reported as symptoms associated with disease progression. Other health beliefs shared by female participants were the belief that the shock of hearing bad news can cause diabetes and heart disease, that asthma can lead to heart disease, and that medications can cause clogged arteries. One woman shared that she believed gestational diabetes led to her child having developmental delays. One man shared that he believed that lifestyle factors can cause diabetes and heart disease but ultimately Allah will take him when it is his time.

Severity.

Significant fear was expressed among all participants related to the severity of heart disease and diabetes. Participants believe that diabetes and heart disease are severe diseases and have a long disease course. Heart attack, stroke, poor wound healing, and sudden death were reported as fears of diabetes and heart disease. Participants also reported being afraid of becoming disabled, feeling miserable, and feeling hopeless as a result of being diagnosed with diabetes and heart disease. Another reported fear was passing diabetes and/or heart disease to their children through genetics.

Knowledge sources.

School, personal research, and health care providers were all sources of health education that were shared by participants. Life experience and observations were reported as the most significant source of knowledge. Participants reported that they learned about genetics in school, but noticed from life experience that diabetes and heart disease runs in families. They reported that through their own personal experience with diabetes and/or heart disease and through taking care of family members with diabetes and/or heart disease, they have learned about disease causes and symptoms of progression. Participants with diabetes and/or heart disease also

reported that they received education from their doctors about their diseases.

Treatment preferences.

Participants agree that health care providers with prescribing ability are the preferred professionals to see regarding diabetes and heart disease. The preferred frequency of visits depended on the stage of disease. Medication adjustments were a reason participants believed they should see a medical provider regularly. However, participants shared that walking and running would be a helpful treatment. A significant theme brought up among all participants was a desire for emotional treatments for diabetes and heart disease since they believe emotional and physical health are inextricably related. One participant shared that once he was in Utah and away from the stress in Iraq, he was able to go off of his hypertension and diabetes medications and preferred managing his disease with diet instead of medicine.

Many comparisons were made between the health care prior to resettlement vs. after resettlement. The most common comparison was that health care prior to resettlement was more accessible. They could be seen immediately, if they needed treatment. In Utah, they must wait for weeks to get an appointment. Another reported benefit of health care before resettlement is that they could have their blood sugar checked at the pharmacy and the pharmacist could make medication adjustments. They also reported that blood sugar logs recorded at home could be taken to the pharmacist for medication changes. Participants prefer to see a doctor for severe problems, but liked the option of seeing a pharmacist for minor problems. Although all participants agreed that the quality of health care is better in Utah, many participants stated they preferred receiving treatment before resettlement because they didn't have to wait for an appointment and insurance was not required. The participants shared frustration that health care providers in Utah prescribe many medications and that often the medications cause other

problems or side effects. A reported benefit of treatment in Utah is that annual appointments are made for preventative care and routine follow up appointments are made for chronic disease management. In Iraq, annual/preventative and follow up appointments are not common. Another reported benefit to health care in Utah was quicker more accurate diagnosis, with more effective treatments.

Theme 2: Health care access barriers.

Insurance.

Insurance coverage was reported as the most significant barrier for all participants. Participants stated that most Iraqis lose Medicaid benefits after eight months of being in the United States and are given Primary Care Network (PCN) insurance. All participants describe PCN as "like nothing" and shared frustration with the minimal services that PCN covers. Participants reported that not having insurance prevents them from seeking health services when they need it. Lack of insurance also keeps participants from taking the medication they need because they cannot afford it. When they have Medicaid they see their doctor at least annually for preventative care. Once they lose Medicaid benefits, they no longer see their doctor for preventative care. Men reported that lack of insurance causes them significant stress because they feel like they are not able to provide for their family. This was reported to be especially stressful for men who have full Medicaid benefits due to chronic illness, but whose family lost their Medicaid benefits. One man compared this feeling to being given a plate of food, but not being allowed to share it with his family. He shared that the stress this has caused is so severe that he has considered suicide. He also believes that the stress has made his diabetes and

hypertension worse. Another reported barrier was lack of knowledge about insurance coverage and how to navigate the health care system in the United States.

Time.

As discussed previously, participants reported that having to wait for an appointment was a significant health care access barrier. Participants shared the frustration that in Utah the only way to get immediate treatment is to go to the Emergency Room (ER). Iraqis often go to the ER instead of taking the time to schedule and wait for an appointment. Another frustration shared is that in order to see a specialist they often must get a referral from their primary care provider which further delays treatment. Participants also shared frustration that doctors try many different medications which takes a significant amount of time to find the right treatment and leads to side effects.

Language.

Language was also identified as a challenge for Iraqis when accessing health care in Utah. In order to schedule an appointment they must have an interpreter on the telephone. Sometimes they were not able to communicate the problem adequately over the telephone. They also had to schedule an interpreter to be present at the time of the health care visit. Sometimes the interpreter did not show up for the appointment and often the interpreter was not able to communicate the problem adequately. Participants reported they often do not know what their medical provider is saying because of the language barrier, as well as lack of knowledge of medical terminologies.

Gender.

Women shared that having a male interpreter present for the health care encounter is not culturally appropriate. One woman shared an experience when she was uncomfortable and embarrassed because a male interpreter was the only interpreter available. She stated that she did

not address some of her health problems because he was there. Women reported that having a male health care provider is acceptable, unless they are being seen for an OB/GYN related problem.

Transportation.

Transportation related barriers are also common for Iraqis. Women reported that they do not have cars and do not know how the busses work, which keeps them from going to the doctor. Women also reported that they go to the ER because it is easier to get there. Men reported that having to travel long distances to the doctor is barrier.

Theme 3: Dietary habits.

Food sources.

It is common in Middle Eastern culture to cook food in the home. Eating fast food or going to restaurants is uncommon. Participants report that their food is not processed like it is in the United States and that they use fresh ingredients. Food and produce is bought at grocery stores such as Wal-mart, Rancho Market, and Smith's. Some women reported having small container gardens in ground floor apartments with patio space. However, most families do not have space for a garden. One woman stated that some apartment managers do not allow container gardens.

Common foods.

White rice and flat bread was identified as a staple food item that is served with every meal. Participants reported that their food is not prepared in a healthy way. They reported that almost all food is fried, including vegetables, kebabs, and rice. Stew is a common food, but the vegetables and meat is fried before put into the soup. Participants state that salad with cucumbers

and tomatoes is the only source of raw vegetables that they eat. Fried tomatoes, eggplant, cabbage, and broccoli are the most common vegetables.

Common drinks.

Chai tea was reported to be the most common drink. Coke and milk were also reported. Participants state that in Iraq soda was cheap and easy to access so they developed a habit of drinking it regularly. Women reported that they do not drink enough water. However, men reported that they try to drink lots of water daily.

Theme 4: Exercise habits.

Before resettlement.

Women reported that prior to resettlement they used to exercise regularly, about 3 times per week. Women reported they were in the habit of exercising before they came to Utah. They also reported a more active lifestyle. Their houses were bigger with stairs, long driveways, and big yards. They reported that their muscles were toned from the household upkeep. They also reported that they used to walk everywhere because they did not have cars and there were no school busses. Walking to the grocery store and to take their children to school were the most common reported walking activities.

After resettlement.

Many women reported that they do not exercise at all since arriving in Utah. Some women stated that they try to go walking at least 2-3 times per week. One woman stated that she tries to fit walking into her daily routine by walking her daughter to school. Most women reported that they are not in the habit of exercising in Utah and do not use gyms even though they are accessible in their apartment buildings. Men reported daily exercise. Most reported that they go to the gym, lift weights, run/jog, and/or walk daily.

Theme 5: Dietary modification factors.

Traditional foods.

All participants stated preference for traditional foods are the greatest barrier to making dietary changes. Although they know brown rice is healthier than white rice, it is hard to make this change because that is what they are used to. Traditional Middle Eastern foods are commonly fried. Some participants reported that they have tried to cut down on oil and use recipes that grill or bake instead of fry.

Health status.

One woman, who stated that she has made efforts to cut down on oil and frying and instead grill, boil, and bake food, shared that her motivation for making the change was because she noticed that she didn't feel well after eating greasy food. She stated that her husband was supportive of the change and has noticed he also feels better since reducing oil in their diet. Being diagnosed with metabolic and/or cardiovascular also played a role in motivation to make dietary changes. Women and men also reported prevention of disease development and progression as a reason to make dietary changes. Men reported they are ready to make dietary changes to improve their health.

Theme 6: Exercise modification factors.

Gender.

Men did not report any barriers to exercising regularly. One man reported he has leg pain, which sometimes keeps him from exercising. Women reported many barriers to exercising. The most significant barrier reported was lack of motivation due to depression. Some women reported that in Utah, their husbands have taken over all the roles including grocery shopping so they very rarely leave their homes. All women reported that they spend most of their time at

home, which leaded to feelings of depression and isolation. Other reported barriers included needing permission from their husbands to leave the house and/or exercise, concerns about safety while exercising alone, joint pain, and having young children to take care of. It is also not culturally acceptable for women to exercise in front of men, which makes it difficult for some women to go to a gym. However, some women reported that gender is not a barrier and that they have freedom to make their own choices and can exercise in coed gyms. Several of the women who did not report gender barriers reported that they do not have husbands.

Health status.

Men and women reported that having a health condition motivated them to start exercising. One women stated that she used to exercise regularly because her doctor recommended exercises after she had surgery, but she did not maintain the habit. Several men with metabolic and/or cardiovascular disease reported that their doctors recommended regular exercise.

Theme 7: Suggestions for health services.

Education.

Men and women reported that they would like more education about metabolic and cardiovascular disease causes, symptoms, and consequences, as well as nutrition and steps they can take to prevent disease onset and progression. One women suggested Arabic handouts with information about diabetes and heart disease. Many women reported that they would like education about simple exercises that they can do in their home. Some of the female participants have attended a cooking group at UHHR that modifies traditional foods to be healthier and would like additional nutrition education. Additionally, participants reported that they would like education about how the health care system works in Utah, what services are covered by

insurance, how to qualify for Social Security and Medicaid, and what community resources are available to them. One man suggested an Arabic website with education about Medicaid coverage.

Group exercise.

Women reported that an exercise group of only women would help motivate them to leave the house and be active. Women agree that exercising outdoors would be ideal, but would utilize an indoor gym or exercise group. Men reported that an exercise group is more important for women because they have more societal barriers to overcome and greater difficulty finding ways to exercise. One man stated he has found a gym with a female only section. He is supportive of this as long as she covers her body and wears a hijab. Men responded enthusiastically that they would be supportive of their wives attending an exercise group of women. Men reported that group exercise would motivate them to exercise more and suggested group activities with multiple families such as hiking in the clean mountain air. Women suggested field trips in the community.

Group discussion.

Men and women voiced that they enjoyed having a group discussion about health and would like to have more in the future. After the focus group women reported that they felt more motivated to exercise after the group discussion. Men stated that talking in a group about their health helps to reduce their emotional stress by providing a support group to share and learn from, while also addressing their medical needs. One man suggested a program for Iraqi families and American families to interact with each other to reduce stigmatization about terrorism. He stated this is especially important for women because they are immediately stigmatized because they wear a hijab.

Insurance.

Men and women stated that lack of insurance coverage is the most significant barrier that needs improvement. Women suggested that health care providers provide free mammograms and free preventative health screening exams every six or twelve months. Men voiced understanding that health care providers do not have control over insurance coverage and are also frustrated with the health care system in Utah.

Local resources.

Participants reported that they have noticed that health care providers make an effort to research local resources for generic or discounted medications, as well as free screening exams. However, men had concerns that the generic medications were not as effective. Men stated that it was very helpful when their providers utilize local resources and would like education about how they can find these resources on their own.

Recommendations

The results of this project revealed that Iraqi refugees have a high self-efficacy for health behavior change and a strong desire to improve their health. I recommend that UHHR should implement a lifestyle modification program that addresses both the physical and emotional causes of metabolic and cardiovascular disease through education, group discussion, and group exercise. The program should incorporate the cultural needs and preferences that were discussed during the focus groups. Exercise programs for Iraqi women are especially needed to address the barriers, isolation, and depression Iraqi women experience after resettlement. Implementation and evaluation of the success of the lifestyle modification program is outside of the scope of this project.

Another expansion of this project is to create an education module to help refugee health care providers in Salt Lake City provide culturally appropriate care that addresses the barriers and needs specific to the Iraqi population. Health care providers can make a significant impact by understanding the role that trauma and chronic stress play in causing metabolic and cardiovascular disease; providing greater education about chronic disease causes, prevention, and management; applying principles of health literacy during the health care encounter; ensuring that Iraqi refugees receive gender-appropriate interpreters; and utilizing local resources to improve access to health services. A module providing education to Iraqi refugees about the health care system in Utah would also be helpful in addressing the barriers identified by this project.

DNP Essentials

DNP Essential I Scientific Underpinnings for Practice was met through an extensive literature review examining the health profile of Iraqi refugees prior to resettlement as well as the common barriers of refugees after resettlement. Examining the literature identified cardiovascular and metabolic disease as a significant problem for Iraqis. DNP Essential III Clinical Scholarship and Analytical Methods for Evidence Based Practice was addressed by making a scientific contribution to the refugee health care community in Salt Lake City that will impact clinical practice. The focus group findings have the potential to change the way refugee health care providers address chronic disease in their Iraqi patients. DNP Essential II Organizational and Systems Leadership for Quality Improvement and Systems Thinking, and VII Clinical Prevention and Population Health for Improving the Nation’s Health were met by disseminating the results to a community of refugee health care providers and health care

policymakers in Utah. One of the most important roles of a DNP is to advocate for system level change to improve the health of patients and populations. The findings of this project promote refugee health care policy changes and public health programs to lower metabolic and cardiovascular disease risk in the Iraqi refugee population.

Conclusion

Iraqi refugees make up the largest refugee group in the Unites States and the second largest refugee group in Utah. Although metabolic and cardiovascular disease prevalence is high among the Iraqi refugee torture survivor population, refugee health care providers and policymakers know little about their understanding of metabolic and cardiovascular disease or the perceived barriers that impede metabolic and cardiovascular disease management. Understanding Iraqi refugee torture survivors' perceptions and barriers related to cardiovascular and metabolic disease is necessary to appropriately address lifestyle modification and disease prevention. Culturally appropriate management of metabolic and cardiovascular disease would greatly improve health outcomes in the Iraqi refugee population and reduce the financial burden on the United States health care system. Refugee health care providers and policy makers must advocate for Iraqi refugees by promoting culturally appropriate health programs and promoting policy changes that ensure they receive the quality of care they deserve.

Appendix A

1) Introductory question: Please tell us your first name and a word or image that comes into your mind when you think about diabetes or heart disease?

2) Transition Question: Can you tell us briefly about your experiences with diabetes or heart disease?

Key Questions (theme 1, health explanatory model):

3) What do you think causes heart disease and diabetes?

4) What do you think diabetes and heart disease does to the body? A) How does it work?

5) How severe is diabetes and heart disease? A) Will it have a long or a short course?

6) What kind of treatment do you think you should receive, and whom should you receive it from?

7) How is the treatment in Utah different than in Iraq? A) Which do you prefer?

8) What are the most important results you hope to receive from treatment?

9) What are the chief problems that diabetes and heart disease have caused for you, or for someone you know?

10) What do you fear most about diabetes and heart disease?

Key Questions (theme 2, current dietary and exercise habits)

11) What kinds of food do you eat? A) Where do you get your food?

12) Do you exercise currently? A) What type of exercise do you do? B) How many times do you exercise per week?

Key Questions (theme 3, health care access barriers):

13) Managing and preventing diabetes and heart disease requires assistance from health care providers, such as doctors, nurses, and therapists. Some people find it difficult to obtain this help. Why is this?

14) What makes it difficult to see your doctor regularly?

15) How could health care providers improve their services to better meet people's needs?

Key Questions (theme 4, self-efficacy):

16) Some people find it difficult to change their lifestyle after being diagnosed with diabetes and heart disease. Why is this?

17) What makes it difficult for you to eat healthy foods? A) What could make it easier?

18) What makes it difficult for you to exercise regularly? A) What could make it easier?

19) Ending Question: We are going to be implementing a program to help those with diabetes and heart disease. What advice do you have for us in this task?

20) Final Question: Is there anything else that anyone feels that we should have talked about but didn't?

Appendix B

Consent and Authorization Cover Letter

Determining the Barriers and Beliefs of Salt Lake City Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease

The purpose of this research study is to find out what Iraqi refugees know about diabetes and heart disease. We want to find out how Iraqi refugees make choices about their health. We want to learn about getting health care in Salt Lake City. The information will help Iraqi refugees. The information will help staff at Utah Health and Human Rights. It will help us understand cultural differences. It will help us find solutions that may improve the health of Iraqi refugees in Salt Lake City. We are doing this study because refugees from Iraq might get heart disease and diabetes more than other people. We would like to find ways to reduce these diseases.

I would like to ask you to talk about what you know about diabetes and heart disease in a group discussion. We will ask you about your health behavior. We will ask about your experiences getting health care in Salt Lake City. This information may help create programs at Utah Health and Human Rights that may help Iraqi refugees have better health. This information may also be used to teach health care providers how to take better care of Iraqi Refugees. Your care at Utah Health and Human Rights will not be impacted in any way. It is possible that you may become upset, if you talk about a poor experience. We ask that everyone keep anything that is talked about confidential. However, it is possible that someone else may not do that. We cannot guarantee that no one will share what you say after they leave. The sound from the group discussions will be recorded. After the discussion a confidential professional will type the contents of the recordings. This will help us carefully examine what is said. Only the people involved in completing this study will have access to this information. Your full name will not be collected or written down. Information from the tapes will be grouped with other people's information. No one will know who said what. Only the people conducting the study will see your specific information. The recordings and typed information will be kept securely locked and then destroyed after one year.

If you have any questions complaints or if you feel you have been harmed by this research please contact Mara Rabin, Utah Health and Human Rights, 801-363-4596. Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by e-mail at irb@hsc.utah.edu.

It should take 90 minutes to be in this study. Participation in this study is voluntary. You can choose not to take part. You can choose not to talk about any topic you choose not to talk about without penalty or loss of benefits. By talking in the group, you are giving your consent and authorization to participate and allow us to use information from your medical record, as described below.

AUTHORIZATION FOR USE OF YOUR PROTECTED HEALTH INFORMATION

Agreeing to this document means you allow us, the researchers in this study, and others working with us to use some information about your health for this research study.

This is the information we will use and include in our research records:

- Demographic information like your age and gender
- Related medical information about you like whether or not you have diabetes or heart disease, and how long you have been diagnosed with those disease
- **How we will protect and share your information:**

- We will do everything we can to keep your information private but we cannot guarantee this. Study information will be kept in a secured manner and electronic records will be password protected. We may also need to disclose information if required by law.
- We will do everything possible to keep information you share while participating in the focus group from those not associated with the project. Thus, we ask you and the other participants to keep the focus group discussion confidential. Still, there is a chance that a group member might mention your comments or name in a later conversation. Consequently, we cannot guarantee that no one will share what you have said after they leave.
- In order to conduct this study and make sure it is conducted as described in this form, the research records may be used and reviewed by others who are working with us on this research:
    - Members of the research team and University of Utah Health Sciences Center
    - The University of Utah Institutional Review Board (IRB), who reviews research involving people to make sure the study protects your rights;
- If we share your information with groups outside of University of Utah Health Sciences Center, we will not share your name or identifying information. We will label your information with a code number, so they will not know your identity.
- If you do not want us to use information about your health, you should not be part of this research. If you choose not to participate, you can still receive health care services at Utah Health and Human Rights and University of Utah Health Sciences Center.

What if I decide to Not Participate after I agree to the Consent and Authorization Form?

You can tell us anytime that you do not want to be in this study and do not want us to use your health information. You can also tell us in writing. If you change your mind, we will not be able to collect new information about you, and you will be withdrawn from the research study. However, we can continue to use information we have already started to use in our research, as needed to maintain the integrity of the research.

This authorization does not have an expiration date.

You have a right to information used to make decisions about your health care. However, your information from this study will not be available during the study; it will be available after the study is finished.

Thank you very much for sharing your experiences to help improve health care for Iraqi refugees in Salt Lake City.

Appendix C

Gmail Brooke Paulsen <brookempaulsen@gmail.com>

Your Abstract for the 2016 Utah Public Health Conference

PH Conference <conference@upha.org> Sat, Feb 20, 2016 at 1:23 PM
To: brookempaulsen@gmail.com

Dear Brooke

Thank you for your submission to the 2016 Public Health Conference for Utah: "Honoring the Past, Celebrating the Future".

We are very happy to let you know that the Conference Planning Committee has APPROVED your Abstract for your presentation titled: **Barriers and Beliefs of Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease**

The conference is being held April 12-13, at the Salt Lake City Sheraton: 150 West 500 South, Salt Lake City.

Action Required:

Complete the submission process by entering information that is required for professional continuing education credentialing.

Go to the Presentation Update Database at: https://www.upha.org/conference/pages/pres-update.htm read the instructions, log in and enter the CEU information

In order to log in and complete this process you will need your last name as it was entered on the system - **Paulsen** - and your Abstract ID - **Ab-142**

Please enter this information as soon as possible. To ensure your presentation slot it must be completed by February 29 at 11:59 pm.

The final acceptance will be sent to you soon after you have updated your Abstract. It will also include date, times, and room assignments for your presentation.

We are excited for your contribution to this conference, marking the centenary of the Utah Public Health Association!

Best Regards,

2016 Conference Agenda & Presenters Committee
Leanne Johnston, Chair ~ 801-585-9971
Linda Bogdanow, Jim Bond, Paul Wightman, Dean Penovich

Appendix D

Gmail Brooke Paulsen <brookempaulsen@gmail.com>

AMERICAN PUBLIC HEALTH ASSOCIATION Abstract #353069 - APHA 2016 Annual Meeting & Expo (Oct. 29 - Nov. 2, 2016)

apha@confex.com <apha@confex.com> Fri, Feb 19, 2016 at 11:00 PM
Reply-To: apha@confex.com
To: brookempaulsen@gmail.com, parkerslc@gmail.com

This message serves as confirmation that your submission was received as noted below:

Title: Barriers and Beliefs of Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease
ID: 353069
Password: 529254

You submitted this for APHA 2016 Annual Meeting & Expo (Oct. 29 - Nov. 2, 2016) (Caucus on Refugee and Immigrant Health).

You may inspect or revise your submission until Friday, February 26, 2016.

We recommend that you look at your submission one more time, just to be sure that it is complete and accurate and free of any embarrassing spelling errors.

To see your submission, simply click on the link below.

https://apha.confex.com/apha/144am/crih/papers/index.cgi?username=353069&password=529254

Thank you for using the American Public Health Association Online Abstract Submission System.

Appendix E

Gmail Brooke Paulsen <brookempaulsen@gmail.com>

Accepted Abstracts - 2016 SGHI Conference

KAJSA ELISABETH VLASIC <kajsa.vlasic@hsc.utah.edu> Wed, Mar 9, 2016 at 9:53 PM

Congratulations on having your poster abstract accepted to the 2016 Student Global Health Initiative Conference at the University of Utah!

Poster requirements:

- Portrait poster format

- Max width 44”

- Max. height 45”

Materials will be provided to hang the posters on the provided easels.

We expect you to be ready to stand and present next to your posters during the poster session from 11:45am – 1:00pm on Saturday, March 26, 2016.

Poster abstracts are currently under committee review for best research awards. If your abstract is chosen, you will receive an email notification next week with more details. Award-winning project presenters will be expected to present orally for 5 minutes during our student research panel from 11:15 – 11:45am with the opportunity for brief Q/A from the audience afterwards.

If you no longer can attend the conference, please let me know as soon as possible.

We **require** all poster presenters to register for the conference. If you have not already registered, please do so at the following link: http://medicine.utah.edu/globalhealth-education/sghi/sghi-conference/index.php

The student fee is $5, all others are $10. Lunch will be included.

Expect a follow-up email from me with further details regarding location and time to set up posters in the coming weeks. If you have any questions before then, please let me know.

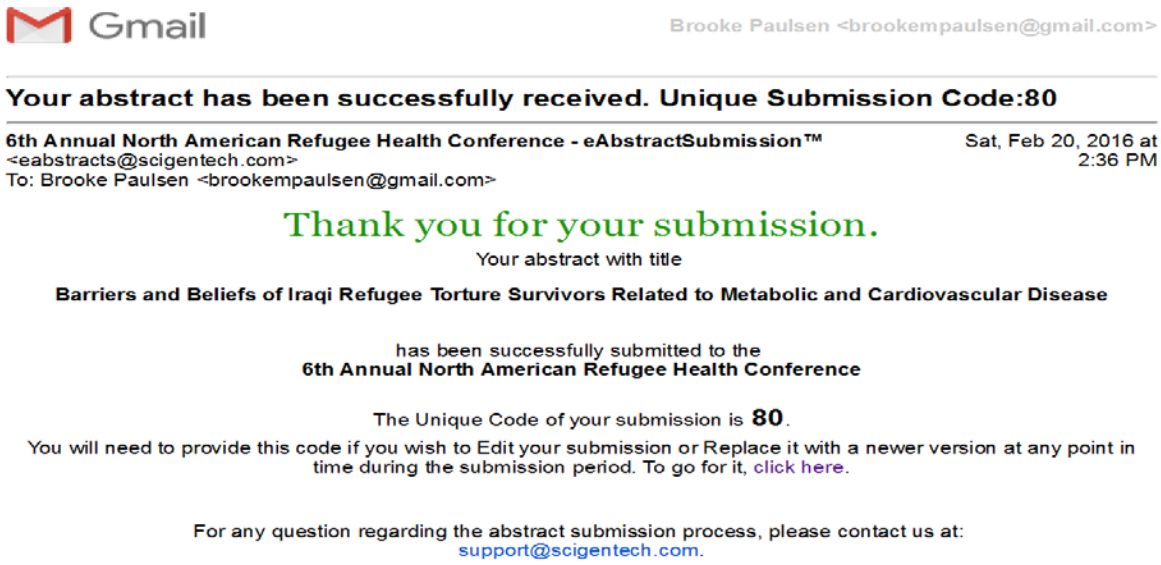
Best,

Kajsa

Kajsa Vlasic, MS1
University of Utah School of Medicine
801.819.6402
kajsa.vlasic@hsc.utah.edu

FINAL Save the Date Flyer.pdf
232K

Appendix F



Gmail Brooke Paulsen <brookempaulsen@gmail.com>

Your abstract has been successfully received. Unique Submission Code:80

6th Annual North American Refugee Health Conference - eAbstractSubmission™ Sat, Feb 20, 2016 at 2:36 PM
<eabstracts@scigentech.com>
To: Brooke Paulsen <brookempaulsen@gmail.com>

Thank you for your submission.

Your abstract with title

Barriers and Beliefs of Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease

has been successfully submitted to the
6th Annual North American Refugee Health Conference

The Unique Code of your submission is **80**.

You will need to provide this code if you wish to Edit your submission or Replace it with a newer version at any point in time during the submission period. To go for it, click here.

For any question regarding the abstract submission process, please contact us at:
support@scigentech.com.

Appendix G

Barriers and Beliefs of Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease

Brooke Paulsen, BSN, MPH Student, DNP Primary Care Student

UNIVERSITY OF UTAH COLLEGE OF NURSING

Key Findings: 1) Believe metabolic and cardiovascular diseases are caused by negative emotions; 2) lack of insurance is the greatest barrier to health care access; 3) men reported anxiety due to lack of insurance; 4) traditional fried foods are the greatest barrier to dietary changes; 5) women reported depression, cultural beliefs, and traditional gender roles to be the greatest barriers to exercising; 6) men are supportive of health programs for women if they meet cultural needs; 7) desire education, group exercise, and group discussion that addresses emotional and physical causes of illness; 8) desire health care providers to treat emotional causes of illness; 9) high self efficacy for improving health behavior

Purpose

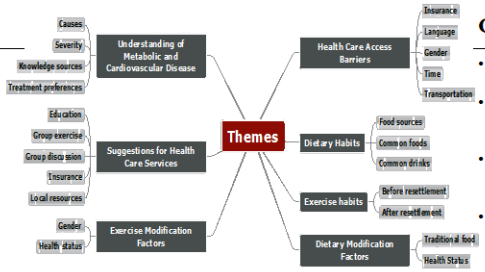
- Determine Salt Lake City Iraqi refugee primary and secondary torture survivors understanding of metabolic and cardiovascular disease, their perceived barriers to accessing health care, and the perceived barriers and factors that cause or perpetuate lifestyle choices associated with metabolic and cardiovascular disease
- Disseminate research findings to the Salt Lake City Iraqi community and refugee health care providers and policy makers

Methods

- Community-based participatory research model
- Collaboration with Utah Health and Human Rights, a local organization that serves refugee torture survivors and their family members
- Three focus groups of 5,7, and 9 participants; separated by gender; interpreter present
- Questions designed to identify the social and cognitive factors that effect health behavior and access to health services
- Themes extracted from focus group notes and organized into a thematic network

Background

- Over 60,000 Iraqi refugees have resettled in the United States since 2007
- Second largest refugee population in Utah
- High prevalence of metabolic and cardiovascular disease
- Torture exposure increases lifetime risk of metabolic and cardiovascular disease
- Barriers prevent appropriate metabolic and cardiovascular disease prevention, diagnosis, and management



Conclusion

- Women face more significant barriers than men due to cultural beliefs and traditional gender roles
- Health programs should address emotional and physical causes of illness through education, group exercise, and group discussion
- Health care providers should acknowledge the impact of emotional symptoms on chronic disease development and progression
- Health care providers should assist refugee patients in eliminating barriers to accessing care

Acknowledgements: Jane Dyer, CNM, FNP, MBA, PhD, FACNM, University of Utah College of Nursing; Mara Rabin, MD, Medical Director, Utah Health and Human Rights; Deepika Reddy, MD, Assistant Professor (Clinical), University of Utah School of Medicine; Lisa Gren, PhD, Assistant Professor, Family and Preventive Medicine, University of Utah; Amal Muftin, interpreter, Utah Health and Human Rights; and Sampson Nde, MPH student, Westminster College

Appendix H

Determining the Barriers and Beliefs of Salt Lake City Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease

Brooke Paulsen, RN, BSN

In partial fulfillment of the requirements for the
Doctor of Nursing Practice degree
October 23, 2015

Background

Overseas medical exam (OME)

- Infectious diseases of public health significance, substance abuse, and severe mental illness

Domestic refugee medical exam (DRME)

- Infectious diseases of public health significance

Background Continued

- 27% of 1,286 incoming refugees in 2014 were from Iraq (UDOH Bureau of Epidemiology & UDOH Refugee Health Program, n.d.)
- Second largest refugee group in Utah
- 35% of US-bound Iraqi refugees have hypertension, diabetes, and obesity (Yanni et al., 2013)
- Metabolic and cardiovascular disease prevalence expected to be high post resettlement

Problem Statement

- Metabolic and cardiovascular disease risk is high among refugees from non-tropical, middle-income countries
- Not screened during DRME
- Barriers prevent metabolic and cardiovascular disease prevention, diagnosis, and management

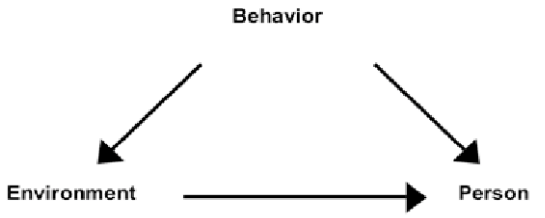
Significance and Policy Implications

- Low prevalence of infectious disease, high prevalence of metabolic and cardiovascular disease (Mateen et al., 2012) (Yanni et al., 2013)
- Perceived barriers and understanding of metabolic and cardiovascular disease is unknown
- Culturally sensitive care improves health outcomes (Bhatia & Wallace, 2007)
- Include metabolic and cardiovascular disease screening in DRME

Objectives

1. Determine Salt Lake City Iraqi refugee torture survivors understanding of metabolic and cardiovascular disease, their perceived barriers to accessing health care, and the perceived barriers and factors that cause or perpetuate lifestyle choices associated with metabolic and cardiovascular disease
2. Disseminate research findings to the Salt Lake City Iraqi community, and a wider audience of refugee service providers

Social Cognitive Theory



(Edberg, 2007)

Literature Review

Iraqi Refugees

- Background
  - Iraq war ➔over 4.2 million people displaced(Mateen et al., 2012)
- Metabolic and Cardiovascular Disease
  - Prevalence similar to US (Yanni et al., 2013)
  - 56% torture survivors ➔mental and physical illness (Willard et al., 2014) (Wagner et al., 2015)
- Cultural Concepts of Health
  - Supernatural, social, hereditary, and religious (Gallager, 2005) (Inhorn, 2003) (Kulwicki, 1996)

Literature Review Continued

Health Care Provider Systems' Challenges

- Health Care Utilization and Cost
  - 63 million dollars spent on Iraqi refugee health care in Jordan in 2010 (Mateen et al., 2012)
- Cultural and Access Barriers
  - Language, transportation, finances, traditional views of health (Downes & Graham, 2011) (Morris et al., 2009) (Pavlish et al., 2010)

Implementation and Evaluation

Objectives	Implementation	Evaluation
Determine Salt Lake City Iraqi refugee torture survivors understanding of metabolic and cardiovascular disease, their perceived barriers to accessing health care, and the perceived barriers and factors that cause or perpetuate lifestyle choices associated with chronic disease	1. Submit IRB application 2. Develop the focus group guide 3. Select the focus group moderator, interpreter, and note taker 4. Recruit focus group participants 5. Schedule 60-90 minute focus group sessions at Utah Health and Human Rights 6. Analyze data 7. Identify key themes	1. IRB application submitted 2. Focus group guide developed, as approved by faculty chair and content experts 3. Moderator, interpreter, and note taker selected 4. Participants recruited 5. Focus groups held at Utah Health and Human Rights 6. Data analyzed, as approved by content experts 7. Key themes identified, as approved by content experts
Disseminate research findings to the Salt Lake City Iraqi community, and a wider audience of refugee service providers	1. Identify appropriate conference 2. Create DNP scholarly project poster and submit to conference 3. Share findings with Iraqi community	1. Conference selected, as approved by project chair 2. Poster submitted, as approved by project chair and content experts 3. Findings shared with Iraqi community

Summary

- The barriers and beliefs of Salt Lake City Iraqi refugee torture survivors related to metabolic and cardiovascular disease is unknown
- Findings will improve care for Iraqi patients
- Guided by DNP essentials I, II, III, V, VI, VII

Long term implications:

- Provider education / culturally specific lifestyle modification program

Acknowledgments

Committee

Project Chair: Jane Dyer, CNM, FNP, MBA, PhD, FACNM
Program Director: Julie Balk, DNP, APRN, FNP-BC, CNM
Executive Director, MS & DNP programs: Pam Hardin, PhD, RN

Content Experts

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Deepika Reddy, MD
Assistant Professor (Clinical) at University of Utah School of Medicine
Lisa Gren, PhD,
Assistant Professor, Family And Preventive Medicine, University of Utah

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Appendix I

Gmail Brooke Paulsen <brookempaulsen@gmail.com>

ERICA IRB New Study Approval

irb@hsc.utah.edu <irb@hsc.utah.edu> Tue, Feb 2, 2016 at 3:32 PM
Reply-To: irb@hsc.utah.edu
To: brookempaulsen@gmail.com
Cc: mara.rabin@uhhr.org

INSTITUTIONAL REVIEW BOARD
THE UNIVERSITY OF UTAH
75 South 2000 East Salt Lake City, UT 84112 | 801.581.3655 | IRB@utah.edu

IRB: IRB_00088003

PI: Brooke Paulsen

Title: Determining the Barriers and Beliefs of Salt Lake City Iraqi Refugee Torture Survivors Related to Metabolic and Cardiovascular Disease

Date: 2/2/2016

This New Study Application qualifies for an **expedited review** by a designated University of Utah IRB member as described in 45 CFR 46.110 and 21 CFR 56.110. The research involves one or more activities in **Categories 5, 6, and 7** (published in 63 FR 60364-60367). The designated IRB member has reviewed and approved your study as a Minimal risk study on 1/29/2016. The approval is effective as of 2/2/2016. Federal regulations and University of Utah IRB policy require this research protocol to be re-reviewed and re-approved prior to the expiration date, as determined by the designated IRB member.

Your study will expire on 1/28/2018 11:59 PM.

Any changes to this study must be submitted to the IRB prior to initiation via an amendment form.

DETERMINATIONS

- **Waiver/Alteration Determination:** The IRB has determined that the request for the **alteration of authorization** is approved for this research under 45 CFR 164.512(ii).
- **Waiver/Alteration Determination:** The IRB has determined that the request for **waiver of documentation of informed consent** is approved for this research under 45 CFR 46.117(c).
- **Waiver/Alteration Determination:** The IRB has determined that the request for the **waiver of authorization** is approved for this research under 45 CFR 164.512(i).

APPROVED DOCUMENTS

Informed Consent Document
Consent Form Revision

Surveys, etc.

Focus Group Script-- IRB.docx

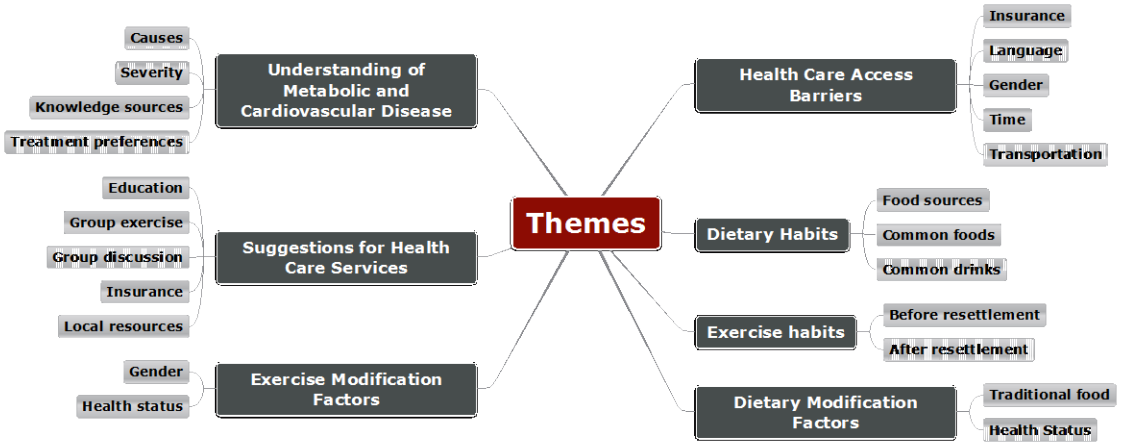
Literature Cited/References
References

Other Documents
Memo--translated documents
Off-site letter of support

Click IRB_00088003 to view the application and access the approved documents.

Please take a moment to complete our customer service survey. We appreciate your opinions and feedback.

Appendix J


Themes
Understanding of Metabolic and Cardiovascular Disease
Causes
Severity
Knowledge sources
Treatment preferences
Suggestions for Health Care Services
Education
Group exercise
Group discussion
Insurance
Local resources
Exercise Modification Factors
Gender
Health status
Health Care Access Barriers
Insurance
Language
Gender
Time
Transportation
Dietary Habits
Food sources
Common foods
Common drinks
Exercise habits
Before resettlement
After resettlement
Dietary Modification Factors
Traditional food
Health Status

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