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ARTICLE

'Swallow medicine, eat rice, pray about health': health, health care and health-seeking experiences of South-East Asian older refugees

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Abstract

South-East Asian refugees have lived in the United States of America for nearly four decades, with early refugee immigrants experiencing ageing and later life within the refugee context. As refugees age, health concerns of this older population grow, highlighting the need for ongoing assessment of refugee health and health-seeking behaviours. This study builds on previous literature that assessed the health and health-seeking patterns of South-East Asian refugees in the early years following resettlement, exploring how health and health-seeking is understood among older refugees 40 years after immigration. This paper includes a subset of 37 older refugees from a larger, community-based participatory, mixed-methods intergenerational study of Cambodian and Laotian refugee families conducted over four years (quantitative N = 433; qualitative N = 183). Thematic analysis of 34 semi-structured interviews with these older refugees in coastal Alabama revealed trends in health and health-seeking practices. Older refugees reported high rates of diabetes and hypertension within their generational cohort, and indicated a shift in health-seeking behaviours, whereby Western biomedicine is sought first for such chronic concerns, followed by traditional medicines for mild ailments such as headaches or colds. Older refugees underscored barriers of language, finances and transportation as limiting access to Western health care. Implications for engaging in community health practices and incorporating services to specifically meet the needs of the ageing refugee population are discussed.

Keywords: refugee ageing; older refugee health; health-seeking; barriers; hierarchy of medicine; traditional medicine

Introduction

South-East Asian refugee families have lived in the United States of America (USA) for nearly four decades following resettlement, resulting in growing communities of multigenerational families, including an increased number of older refugees. As first-generation refugees advance in age, the need to understand trends in older refugee health and health-seeking practices grows, particularly as health risks for

this population exceeds those of US nationals of the same age (Marshall *et al.*, 2016). This study seeks to build on previous literature regarding health and health-seeking behaviours of South-East Asian refugees, attending to the experiences of older refugees as health concerns are exacerbated and following nearly 40 years living within the US context. As the vast majority of research on South-East Asian refugee health was conducted in the early years following resettlement (*e.g.* Sutherland *et al.*, 1983), it is crucial to investigate how, if at all, health and health-seeking behaviours have shifted over time, particularly as refugees who immigrated due to traumatic events such as war and genocide are predisposed to increased health risks (Wagner *et al.*, 2013*a*) and are of advanced age where health concerns are increasingly prevalent.

Literature review

Background

Nearly 150,000 Cambodian refugees fled to the USA during the Pol Pot genocide beginning in 1975, where approximately two million Cambodians were killed, in addition to nearly 50,000 Laotian refugees similarly resettling in the USA shortly following the Vietnam War (Bankston and Hidalgo, 2007; Chan, 2015). In 2000, more than 99 per cent of Cambodians and Laotians over the age of 30 living in the USA were born outside the USA, primarily immigrating from their home countries due to war and violence (Bankston and Hidalgo, 2007). Twenty years later, this generation of refugees is entering later life and ageing out of place, navigating old age within multigenerational refugee and South-East Asian American communities and the broader US context (Lewis, 2009). As ageing refugees endured multiple traumatic events prior to and during resettlement and many have experienced ongoing difficulties in the USA related to acculturation, employment and poverty, all of which can impact health and wellbeing, considering the experience of older refugees, including the effects on the health of these individuals and their health-seeking practices, is crucial (Nicdao *et al.*, 2016; Frost *et al.*, 2019). While the mental health status and risks of South-East Asian refugees have been studied extensively over time, physical health has been less researched, particularly decades after resettlement (Nelson-Peterman *et al.*, 2015; Marshall *et al.*, 2016).

Health disparities among South-East Asian refugee populations

Research on Cambodian refugee health has found significant health disparities, including heightened rates of diabetes, hypertension and hyperlipidaemia among refugee adults when compared to the general US adult population, which in turn heightens the risk for stroke and cardiovascular disease, particularly as individuals age (Marshall *et al.*, 2016). For example, rates of diabetes among the Cambodian refugee population (27.6%) were found to be more than twice that of a probability sample of US adults (12.4%; Marshall *et al.*, 2016). In addition, research has indicated the chances of developing diabetes and hypertension increases with the length of time a refugee has been resettled in the USA, including the odds of being diagnosed with diabetes doubling in refugees 10 or more years post-resettlement

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(Golub *et al.*, 2018). Nelson-Peterman *et al.* (2015) also reported in a study of Cambodian refugee women that a majority of participants were overweight or obese and participated in little or no exercise, indicating a heightened risk for comorbid, chronic disease. Overall, Cambodian refugees have indicated lower ratings of health and health-related quality of life than their Cambodian immigrant counterparts as well as matched Asian American Pacific Islanders (Wong *et al.*, 2011; Sharif *et al.*, 2019). These health concerns may be due to distress associated with acculturation, which has been found to outweigh the positive benefits of diet or exercise (Steffen *et al.*, 2006), as well as the ongoing effects of trauma, starvation or poverty experienced during or following migration (Marshall *et al.*, 2005).

Health concerns that manifest because of the stress and strain of resettlement, as well as pre-existing conditions prior to resettlement, when untreated or improperly cared for over time, can progress to worsening and comorbid conditions that are increasingly complex and harder to treat (Frost *et al.*, 2019). These health conditions, including heart disease and diabetes, may additionally be exacerbated due to mental health concerns such as anxiety and depression further increasing health risks and heightening the comorbidity of physical and mental illness (Das *et al.*, 2013). In addition, the effects of traumatic events prior to resettlement, such as starvation, torture and physical injury, may have lasting impacts not only on mental health through the development of post-traumatic stress disorder but also on refugee health status even when no longer amid threat, worsening health outcomes for South-East Asian refugees (Wong *et al.*, 2011). For example, refugees with increased trauma symptoms are more likely to report heart disease, hypertension and overall lower physical health symptoms even decades following resettlement, highlighting the need to explore the health and health promotion behaviours of older refugees who endured multiple traumatic experiences prior to resettlement (Wagner *et al.*, 2013*a*).

Post-resettlement experiences also impact the health of South-East Asian refugees. For example, social disconnection has been linked to poorer health outcomes among Cambodian refugees (Berthold *et al.*, 2019), which may be more prevalent among older refugees as younger generations spend increased time working long hours or may be increasingly acculturated beyond the refugee community (Lewis, 2009). In addition, many older South-East Asian refugees who live in poverty or experience financial hardship have expressed decreased physical functioning, with 70% of refugees in one sample meeting the criteria for probable disability (Wong *et al.*, 2011). Taken together, the physical health of ageing South-East Asian refugees is impacted by multiple factors pre- and post-resettlement, resulting in multiple health disparities among this population that are prone to exacerbation as ageing continues.

Refugee health-seeking behaviours

In the first decade following resettlement, South-East Asian refugees sought home remedies and within-community health care before Western doctors, in part due to lack of understanding regarding the processes of the Western health-care system (Kemp, 1985). Additionally, traditional medicines were employed due to the perceived causation of illness, as symptoms understood through a spiritual context were treated with medicinal practices within the community (Gilman *et al.*, 1992; Lewis, 2007). Kemp (1985) underscored that when South-East Asian refugees

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did seek Western health care, they expected doctors' visits to comprise primarily of dispensing medication, not history taking, education or preventative measures. Although medications were expected, compliance with medication regimens over long periods of time, particularly for chronic conditions, was often not followed (Kemp, 1985).

These health-seeking practices have been impacted by a lack of trust in Western medicine and doctors which, while more prominent in the early years following resettlement, persists among some South-East Asian refugees (Renfrew *et al.*, 2013). Furthermore, in a study of 80 older Cambodian refugees, Das *et al.* (2013) found that older refugees seeking medical care may experience confusion or embarrassment regarding the Western doctor's explanation of their symptoms and health conditions, increasing the stress associated with Western health-seeking practices. Older refugees may also be overwhelmed by diagnoses or by the medicinal regimen prescribed by Western doctors (Becker and Beyene, 1999) and have lower health literacy that hinders health-seeking practices (Crabtree, 2015).

Health-seeking practices are also influenced by the accessibility of available services. For example, a lack of translation or language services for South-East Asian refugees within Western health-care clinics, hospitals and doctors' offices has historically limited Western health seeking (Gilman *et al.*, 1992; Crabtree, 2015), particularly as the reception of health-care services typically includes reading and writing on patient history forms and speaking to multiple staff, nurses and doctors. Refugees may not know what services are available or be able to access them due to lack of familiarity with the US health-care system and insurance systems (Uba, 1992). Overall, more information is needed regarding refugee health-seeking behaviours, particularly related to physical illness and health outcomes, as well as an investigation into how refugees employ traditional and Western medicines (Bellamy *et al.*, 2015).

Traditional medicines

Traditional, complementary or alternative medicines (TCAM) have been a part of South-East Asian health-seeking practices prior to immigration, with many TCAM practices continuing post-resettlement. TCAM is often based in spirituality, including practices based on religious understandings of sickness and wellbeing such as seeking prayer from a Buddhist monk, or may be based in the somatisation of spiritual disturbances (Gilman *et al.*, 1992; Lewis, 2007). In addition, beliefs related to disturbances of wind or temperature in the body may lead to traditional practices such as cupping, which serve to re-distribute or rid the body of excess air in the body that is understood to cause varying illnesses or ailments (Muecke, 1983). Herbal medicines are also common and passed down intergenerationally, particularly through older women (Brainard and Zaharlick, 1989; Gilman *et al.*, 1992). In South-East Asian refugee communities, grandparents and other older refugees tend gardens to produce fruits, vegetables and herbs that are then applied as part of these medicinal practices, promoting generativity among this generational subset (Lewis, 2009). Taken together, these traditional medicines among Cambodian and Laotian refugees are whole medicinal systems preserved from the homeland and maintained within the community through older refugees and intergenerational transmission of knowledge and practice (MacDuff *et al.*, 2010).

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Lewis (2007) underscored a hierarchy of medicinal practices among Cambodian older refugees, indicating a propensity to begin to treat illness or disease first with traditional medicines (*e.g.* herbs, roots, teas) and practices (*e.g.* cupping, coining, acupressure), followed by Western biomedicine. This hierarchical approach was noted as reflecting and preserving Khmer identity, as well as preventing negative experiences with the Western health-care systems, which were reported by many (Lewis, 2007). Similarly, Brainard and Zaharlick (1989) indicated a pattern of medicinal hierarchy among the Laotian population, with most Laotian refugees reporting a history of first engaging in traditional health-seeking, followed by Western biomedicine as a form of secondary care. Following resettlement in the USA, Laotian refugees were more likely to employ Western health-seeking strategies than Cambodian refugees, indicating shifting patterns of health-seeking across time and refugee group that may be in part due to the implementation of cultural brokers within Laotian refugee communities who facilitated access to Western care (Brainard and Zaharlick, 1989). This study serves as a follow-up to this inquiry into health and health-seeking practices, attending to potential shifts or continuities in South-East Asian older refugee health engagement. As it has been over 10 years since that study was conducted, and approximately four decades since many South-East Asian refugees first settled in the USA, it is crucial to continually assess the health of ageing refugees and how best the Western health-care system can meet the needs of this population.

Theoretical orientation: lifecourse theory

Lifecourse theory considers individuals and families in their contexts, noting the experiences of cohorts who have endured the same historical events at the same age and period of development (Hutchison, 2014). Elder (1998) indicated four principles of lifecourse theory: the lifecourse is impacted by historical time and place, timing impacts development, lives are interdependently linked and humans have agency to make choices that shape their lifecourse. With these principles, exploring a particular cohort and how the lifecourses of individuals within it are shaped by historical context, time and place throughout the lifespan allows for considerations of shared experiences and patterns that impact development (Elder, 1998). As this study is focused on a particular group of refugees in the period of old age, there is an opportunity to explore how health and health-seeking practices are impacted in the later stages of the lifecourse, which in turn affect the experience of ageing and later-life development.

Previous research on the South-East Asian refugee lifecourse has found that the process of resettlement is ongoing, affecting each stage of the lifecourse including old age (Becker and Beyene, 1999). Traditional understandings of the lifecourse for South-East Asians include more rapid expectations of physical decline and increased signs of ageing from a younger age, as compared to older US individuals of the same age (Becker and Beyene, 1999; Das *et al.*, 2013). Older Cambodian refugees have also been shown to experience increased uncertainty and vulnerability across their lifespan as they aged due to worsening physical health, lack of resources and care, and inability to work due to heightened physical health concerns (Das *et al.*, 2013). These vulnerabilities may in part be due to variance in acculturation,

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which can contribute to chronic disease among refugees, as refugees navigate two cultural systems (*e.g.* South-East Asian and US cultures and medicinal practices; Palinkas and Pickwell, 1995).

Muruthi and Lewis (2017: 135) further noted the ongoing shifts throughout the lifecourse for older Cambodian refugees, indicating adaptations in intergenerational exchanges between older family members and their children, creating a 'fusion' of practices that retain Cambodian tradition while incorporating behaviours common to the US environment. In particular, as refugees age, they develop ways of interacting that seek to heighten wellbeing while remaining culturally relevant and engaged through the end of life (Fung, 2013).

This study considers the health and health-seeking behaviours of older South-East Asian refugees as they move throughout the lifecourse, particularly considering how this refugee sub-population navigates health promotion and maintenance within the Western context, decades following resettlement.

Methods

This study is part of a larger community-based participatory research programme (Minkler and Wallerstein, 2008), the Cambodian-Laotian Community Strength and Resilience Project, assessing family- and community-level strengths, resilience and wellbeing in response to environmental challenges, including health, health-seeking behaviours and household production of health among Cambodian and Laotian refugees in the South-East US region. The research protocol was approved by the authors' university Institutional Review Board. Conceptualised and executed through an integrative team of researchers at the University of Georgia, key community personnel, and a cultural advisory board of insider experts and consultants, in-depth interviews with individuals and families were conducted to elucidate beliefs and behaviours regarding community wellbeing. Semi-structured interviews lasted approximately 30–90 minutes and were conducted in the participants' primary language (*e.g.* Khmer, Lao or English), exploring multiple factors related to wellbeing including personal, familial and community health and health-seeking behaviours. Recorded interviews were translated and transcribed into English by multi-lingual members of the research team at the University of Georgia and from the refugee community.

Participants

Of the 124 in-depth interviews conducted in 2018 and 2019, 33 interviews were completed with 37 participants at or over the age of 60. While previous research has noted for South-East Asian populations that old age can start as early as 40 (Dubus, 2010), 60 years old was determined as the lower bound of the older community due to generational cohorts, as most of those over 60 were adults when they immigrated to the USA during or immediately following the Pol Pot regime and Vietnam War. By the age of 60, most older refugees also had grandchildren, which serves as the primary determination for old age among this population (Dubus, 2010). In addition, as old age is further determined by life expectancy and refugees are living longer lives (Dubus, 2010), the delineation of old age has shifted to reflect increasing lifespans in the community. Participants ranged from

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Table 1. Participant demographics and health concerns

Variable	Total	Cambodian	Laotian
Age:			
Mean	68.42	69.55	67.28
Range	60–86	60–78	60–86
Years in the USA:			
Mean	34.9	34.7	35.3
Range	29–48	30–45	29–48
Sex:			
Male	18	10	8
Female	19	8	11
Health concern:			
Diabetes	10	4	6
Hypertension	16	4	12
Hyperlipidaemia	2	2	0
Cancer	3	3	0
Poor vision	4	2	2
Other	9	4	5
Did not report	5	5	0

Notes: N = 37. USA: United States of America.

60 to 86 years old and had lived in the USA for an average of three to four decades, settling in the US Gulf of Mexico region in a Cambodian and Laotian refugee community. To maintain confidentiality and anonymity of participants within the community, participants are identified via an assigned number that corresponds to the main data. These participants numbers are employed throughout the remainder of this study (for more details on participants, *see* Table 1).

Analytic approach

This study employed Braun and Clarke's (2012) six-phase, comprehensive approach to thematic analysis. To begin the first stage of analysis, familiarisation with the data (Braun and Clarke, 2012), the research team read the transcripts in full prior to coding. Once familiarised with the data, transcripts were coded using initial codes which were produced through a hybrid approach of inductive and deductive coding, with both data-driven and concept-driven codes derived from the research questions comprising the initial codebook (Fereday and Muir-Cochrane, 2006). Once data were coded, preliminary themes were generated and reviewed against collated excerpts of data, and then against the entire set of transcript data by the first author (Braun and Clarke, 2012). During the recursive review process, sub-themes were specified and refined as the preliminary themes

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were examined against collated data and then the entire set of data (Braun and Clarke, 2006). A theme map was created, wherein themes were defined and named (Braun and Clarke, 2012) and then cross-checked by the research team. Finally, an analysis was produced and concurrently written, with data extracts providing 'vivid examples' of the identified themes that were related to the overall research questions guiding this study (Braun and Clarke, 2006: 93). It is important to note that themes and sub-themes were not determined based solely on prevalence within the data, but also through a consideration of 'keyness', or the way in which the theme provides understanding and conceptual meaning to the research questions guiding this study (Braun and Clarke, 2006: 82).

Results

During analysis, three major themes were identified: 'health maintenance', 'health-seeking practices' and 'structural barriers to health care'. These themes are presented below with their related sub-themes.

Health maintenance

In line with individually reported health concerns among the Cambodian and Laotian older refugee population (for more details, *see* Table 1), participants indicated patterns of disease and health conditions among their generation:

> The greatest health concern is sweet blood [diabetes], high blood pressure and cholesterol that all related to your health, and you go to meet the doctor and help us figure out with our health. (Participant 58)

These common diseases have led to shared health knowledges and communal approaches to addressing health concerns and maintaining or improving health. For example, the colloquial naming of diabetes as 'sweet blood', as seen in the above participant's quote, has implications for how older refugees manage and adapt their lifestyles following a diabetes diagnosis that is based on their overall understanding of disease processes. Participants with diabetes noted avoiding sugary foods, including items associated with a mainstream American diet such as soda and sweet desserts. In addition to avoiding sweet foods, participants indicated further adapting their diets following the diagnosis of a health condition through prioritising lean meats and vegetables:

> Elders may have high blood pressure … We need to watch out for the hygiene of our food. For example, beef has a lot of blood. If you have high blood pressure and you eat beef, you'll die in 8–12 hours. It rises and we fall and die. Avoid eating sweet and sour food. It's not good for the blood. Eat only fish. Rice is sweet, so also avoid that too. Eat vegetable and fruit. It helps our eyes and health. (Participant 40)

For many participants, attention to diet included prioritising foodways that are local to the community, including produce grown in family gardens that are common in the South-East Asian region and allow for the creation of traditional dishes

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and fish, which comprise a primary industry in the South-East US region in which these communities have settled. In addition to gardens serving as a source of healthy foods to maintain health and wellbeing, gardening also serves as a primary mode of exercise and linkages with others in the community for many older refugees, along with walking within the community and local neighbourhoods, and sharing in cultural practices. Overall, attention to diet and exercise serve as primary health maintenance activities, in alignment both with local shared knowledges and with Western medical guidelines (*e.g.* Mayo Clinic, 2019).

Participants also noted that information regarding health and health maintenance was received through specific engagement with Western biomedicine and doctors. For example, Participant 9 noted, 'Every day I take care of myself by doctor's remarks, by myself in order to help in terms of diet, exercise, and other things that can help improve my health problems.' Nearly all participants noted regular and ongoing engagement with Western doctors not only for acute medical concerns (discussed further below), but also for regular check-ups and for advice on maintaining a healthy lifestyle. Many participants also reported their primary health maintenance strategy included following their doctor's recommendations. As the most common instructions noted from doctors included a healthy diet and regular exercise, integration with pre-existing or traditional health understandings within the culture promoted moderate to strong adherence to such health-promotive activities.

Health-seeking practices

Following the trends reported among the theme of 'health maintenance', older refugees with active health concerns engaged in a combination of traditional, culturally bound health-seeking practices and Western practices of seeking care. Health-seeking practices occurred communally, highlighting the collectivist nature of the refugee community and countries of origin. For example, Participant 41 underscored, 'Normally, [neighbours] give you advice because they want us to be well, but if we use it without any results, we need to use other things … like calling the ambulance to take you to the hospital.'

Older refugees reported typically engaging with family members first, followed by neighbours and others in the older cohort, and then, if illness persists, other leaders within the community to 'let the community talk to one another to see what route [they] should take' (Participant 58). After communicating with family and community members, older refugees engaged in multiple forms of health-seeking practices, including traditional medicines as well as engagement with Western physicians, clinics and the US health-care system.

Traditional health-seeking practices

Initially, older refugees engage in health-seeking practices such as coining, cupping or massage as remedies for mild ailments and sicknesses, which were learned within the context of their lives prior to resettlement in the USA. Coining, a form of dermabrasion, includes 'repeated downward pressured strokes in linear fashion over lubricated skin using a hard object' (Tan and Mallika, 2011: 97). For example, Participant 35 described coining as a useful remedy for headaches,

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stomach upset and other general feelings of unwellness. Similarly, cupping includes creating suction on the skin that promotes localised pain relief (National Center for Complementary and Integrative Health, 2020), as does massage, including of the hands and feet to increase blood flow and movement of wind through the body, employed when participants experienced temporary aches and pains.

In addition to cultural health-seeking practices such as those listed above, foodways serve not only to maintain health as previously described, but also as remedies for other ailments. For example, Participant 33 described the use of herbs within traditional medicines, noting 'usually [we] talk about the herbs, most of the herbs [we] boil, eat and help each other, the herbs, the Asian herbs … for stomach-ache, too, it helps relief stomach-ache, allergies'.

Together with traditional herbs, lemongrass and roots foraged from wooded areas or brought to the USA from Cambodia or Laos served as common sources of physical relief among the older population. In addition, rice served both as a staple of the older refugees' diet and as a treatment for sicknesses such as stomach pain. Taken together, these traditional and complementary health-seeking practices not only aided in reducing pain or discomfort from temporary illness, but also maintained meaningful linkages to the Cambodian and Laotian cultures and homelands, including connections to family members in the community and in the older refugees' countries of origin.

Western health-seeking practices

Beyond traditional medicines, older refugees reported relying heavily on Western biomedicine, including for acute illness and injury as well as long-term diagnoses such as the aforementioned diabetes, hypertension and high cholesterol. For example, Participant 58 described how ongoing health problems and concerns led him and his aged wife to seek help from a doctor, noting that, 'We go to the doctor and the doctor tells us what to do to take care of our health and tell us how we need to take care of ourselves, so we just follow their directions.' Many participants repeated this refrain, indicating that when seeking out Western medicine, they are quick to follow doctor's orders and take regular medication as prescribed. Differing from previous findings on the health-seeking behaviours of South-East Asian refugees (*e.g.* Kemp, 1985), older refugees' reliance on Western medicine indicates differing health-seeking practices depending on severity and duration of presenting concerns as well as shifts across multiple decades spent in the USA. As ongoing disease and health conditions such as diabetes, hypertension, high cholesterol and cancer are pervasive within the community, older refugees promote Western health care and medicines among their cohort, encouraging one another to follow doctor's recommendations and supporting health-seeking efforts among the older generation.

Part of Western health-seeking practices include engagement with the US health-care system. For the older refugee population, accessibility to Western health care was increased through the availability of government programmes. For example, Participant 1 described their experience with Medicaid, stating, 'They [help] all the time, I like it, it's good. When it's time they give me my medicine and help me.' Alongside Medicare and Medicaid, many participants indicated gaining health insurance under Obamacare, or the Affordable Care Act. Access to

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insurance through government programmes increased the engagement in Western health-seeking practices among the older refugee population, including receiving and taking medication daily and regularly going to the doctor or local clinic for care. In emergency medical situations, Medicare and Medicaid also benefited the participants' health-seeking practices, as several participants reported calling an ambulance to take them to the hospital to seek rapid care.

Ultimately, Participant 70 represented the integrative way in which the older refugee population engages in health-seeking practices: 'Swallow medicine every day, eat rice, pray about health.' As highlighted by this participant's summation of health-seeking practices, Western biomedicine occurs first, followed by health maintenance practices rooted in traditional beliefs that together form an integrative approach to seeking health and wellness in old age.

Structural barriers to health care

While participants reported ongoing engagement with the Western health-care system as the primary source of medicine and health seeking, barriers to receiving services from a doctor or nurse remained. The barriers noted by participants were overarching and structural in nature, indicating difficulties in accessing health-care services regardless of provider or location (*e.g.* clinic, hospital, emergency room). Participants stated they experienced linguistic, transportation and financial barriers to seeking care within the Western medical system.

Language barrier

The most crucial and commonly faced barrier to engaging with the health-care system and health-seeking practices is the language barrier between older refugees and Western physicians. As older individuals continue to live in refugee communities, the native languages of Khmer or Lao remain the primary form of communication among this population. Even though these refugee communities were established in the South-East US region approximately 50 years ago and language barriers have been a well-documented health-care concern throughout resettlement, limited translation resources are available at clinics, primary care offices or hospitals for older refugees. Participant 2 described the difficulty of the language barrier, stating:

> There wasn't many people that could help the Asians because there weren't any translators. They couldn't help the older Asian people because no one could communicate with them. It was a struggle.

Even for older community members who can speak English proficiently, many cannot read and write the language and are thus unable to complete necessary documents to receive medical services. Due to the lack of official translation services offered by health-care facilities, older refugees rely on local community or family members to translate for them. Participant 41 described the difficulty of depending on family members for language translation:

> The person who don't speak the language face difficulty … When [older people] getting sick, they cannot rely on the children. The children have work, they have

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> very little time. Sickness cannot wait till they are free. They get sick and needs emergency. They look for other people. They don't stay at home. It has problem like that. Thus, people who don't speak the language has a lot of problem.

Transportation barrier

A second crucial barrier to receiving health care is a lack of access to transportation to doctor's offices, clinics or urgent care. Many older refugees reported not having independent means of transportation and, therefore, as the refugee community sits outside the city where clinics and hospitals are located, were limited in their ability to get to a health-care facility for both primary and acute treatment. As Participant 91 describes: 'Just need help to take go to the hospital, but no bus. No nothing over here'.

Many older refugees rely on family members, particularly children or grandchildren, to provide transportation. While family members sought to offer transportation assistance as they were able, appointments often coincided with work hours, costing family members income or barring families from being able to provide necessary transportation:

> It is difficult because [older community members] have no one to rely on taking them to the hospital. Even their own children, they cannot help them regularly or help them in time that they need help. I observed this I find it difficult. (Participant 41)

> Some people don't have the car … They need help to take care them go to see the doctor. Like I have one family. Her husband working. She's a diabetic. She had no car to go, but she had good neighbour. Her neighbour took her go right now. Sometimes she call my in-law to take her go see doctor, but they have like a – in the community once a month to come check-up. (Participant 91)

Financial barrier

As highlighted previously, many participants experience increased accessibility to medical services due to their eligibility and participation with government programmes such as Medicare. While many participants were recipients of Medicare, those who did not qualify or were otherwise unable to participate in this or similar federal programmes reported significant financial strain related to illness and disease, such as Participant 66:

> My health concerns were in this last two or three years, I get sick a lot. I am worried a lot about my living conditions. I am afraid that in the future, I don't have enough money to pay for the bills or other expenses. These are my typical concerns. I get sicker and sicker.

In addition to rising costs of health care presenting a barrier for the older population, sicknesses and disabilities prevented some older refugees from continuing to work, thus causing them to lose both their primary sources of income and insurance. For example, Participant 9 noted, 'I of old age, and I'm old and have a lot of sicknesses; me and my wife has sickness. And now we lack financial means to

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manage this family.' This financial strain limited access to health care, including ambulatory and emergency services, as well as regular care for ongoing medical concerns. Furthermore, some older community members were unable to follow doctor's orders to take sick time from work to recover from an illness or injury or to take regular medication due to financial limitations.

Many of these financial barriers are due to difficulty navigating the health-care and insurance systems. Some older refugees reported being 'scammed' into buying insurance they were unable to use, thus costing them valuable funds that could have purchased medications or paid for an appointment with the doctor. Others like Participant 69 indicated difficulty maintaining insurance due to changes in income, reporting:

> What I don't have is the most needed is when I'm really hurt, I need Medicaid, need insurance, but maybe next year, income might be too little and don't know what to do. I'll see.

Additionally, many participants reported finances limiting access to transportation and translation services at hospitals and clinics discussed above, linking together the structural barriers that prevent older refugees from gaining access to quality health care.

Discussion

The results of this study indicated that diseases more common with increasing age, such as hypertension, were common among the study population, like the findings of other ageing refugee populations (*e.g.* Frost *et al.*, 2019). Diabetes remained a large concern for many older refugees, as has been shown previously in studies of South-East Asian refugees, particularly for those who have endured previous traumatic events (Marshall *et al.*, 2016; Nicdao *et al.*, 2016). As these diseases were commonly experienced and well known within the refugee population, communal understandings of health maintenance related to diet and exercise helped promote individuals' behaviours geared towards promoting health. These communal understandings also aligned with reported orders from Western doctors, further increasing the daily health maintenance behaviours of exercising, taking medication as prescribed, and eating a diet with limited sugars and red meats.

The findings of this study related to health-seeking behaviours add to the current literature on South-East Asian health practices by indicating a crucial shift in health knowledge, maintenance and health-seeking behaviours over time. While traditional medicines are still employed among the older generation of Cambodian and Laotian refugees for acute, temporary sicknesses (*e.g.* headaches, stomach upset), Western medications and doctors are sought for ongoing chronic diseases and health concerns (*e.g.* diabetes, hypertension, cancer), serving as the primary source of health-care intervention. Previous studies of health-seeking practices among South-East Asian older refugees have shown a hierarchy of medicinal and health-seeking practices, wherein traditional medicines served as the primary source of healing and household production of health (*see* Lewis, 2007). The results of this study indicate hierarchy has been inverted over time among Cambodian and Laotian refugees, replicating Brainard and Zaharlick's (1989) findings of earlier health-seeking patterns of Laotian refugees. These shifts may be due to increased

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understanding of Western biomedicine throughout multiple decades in the USA, as well as the heightened globalisation of Western medicinal practices (Mittelman and Hanaway, 2012). In addition, as Cambodian and Laotian cultures are collectivist, health-care decisions are made within family and community settings (Nguyen, 2015). While generational conflicts can arise related to health-care decision making (Nguyen, 2015), younger generations in the family who are more familiar with the Western health-care system may encourage older refugees to engage with US doctors and medicine, bolstered by family members' engagement with older individuals' health-seeking practices to circumvent structural barriers such as by offering transportation and translation services. Furthermore, as part of our practice-research grant, efforts by the research team and local health-care providers to offer health fairs and services and disseminate information regarding transportation services to a particular health-care facility within the refugee community, provide crucial linkages to the US health-care system that promote trust and usage of Western biomedicine.

Another notable finding from this study is that the same barriers that were assessed in the first decade following resettlement (language barrier and lack of translator – Kemp, 1985; geographical and financial barriers – Uba, 1992) remain present for older refugees four decades later. These barriers lie in direct contrast to the growing engagement with the Western health-care system that older refugees reported, highlighting the need for health-care providers, particularly in areas with high concentrations of refugees, to prioritise the implementation of translation services for patients whose first language is not English. Improving local infrastructure, such as through public transportation that reaches refugee communities, also increases the opportunity for older individuals to engage in regular, preventive care, shown to have positive effects for their health as well as for reducing the chronic disease burden of future generations (Woolf, 2010). In addition, policy efforts should continually support the development of affordable health-care options for refugees, as financial barriers including navigating complicated insurance and liability claims may hinder engagement in maintenance doctor's visits and limit the use of emergency services when needed (Uba, 1992).

Implications

As older refugees are engaging with the US health-care system as a primary source of treatment, medicine and health maintenance, providers should consider how to meet the needs of this population, including knowledge of common cultural practices in the community and how to help older refugees successfully integrate biomedicine and traditional medicinal practices. Wagner *et al.* (2013*b*) noted that among ageing Cambodian refugees, those who trusted both Western medicine and traditional medicines reported similar health outcomes to those who employed only Western medicine, indicating opportunities for blended health-care approaches to best meet the health needs of this population, including through health education, maintenance and preventive care strategies, and treatments for long-term diseases common to this refugee cohort.

In regions with high concentrations of South-East Asian refugees, engaging older refugees in health outreach efforts can reduce barriers to health seeking for this

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cohort as well as younger generations (Crabtree, 2015). For example, Grigg-Saito *et al.* (2008) noted that within one South-East Asian refugee community, community outreach and partnerships with community leaders served to increase access to the health-care system and improve overall awareness of local health-care services. Engaging older refugees in organising outreach events was crucial to the success of outreach endeavours, highlighting the crucial role of older refugees within the community and in supporting mutually beneficial health-care practices (Grigg-Saito *et al.*, 2008). In addition, partnering with laypersons from the community, such as prominent community and older refugee leaders, to provide education on common health concerns can increase trust in Western health-care services (Crabtree, 2015), further decreasing barriers to health care. As older refugees are at heightened risk for health concerns, engaging this sub-population in efforts to decrease barriers to health care and promote positive health-seeking practices is crucial for the well-being of this population and the generational health-seeking practices of the community.

Bellamy *et al.* (2015) also highlighted the importance of providing services within US health-care settings to overcome common barriers to health care for refugee communities, including the development of professional translation services to ensure ethical treatment as professional health-care translators can communicate patients' symptoms effectively and promote proper care. Other culturally responsive practices may include asking older refugees how a doctor or healer would treat them in their country of origin to promote trust and integrate traditional health conceptualisations into holistic health-care practices (Ingar *et al.*, 2013; Bellamy *et al.*, 2015). The development and implementation of programmes that deconstruct barriers to health care and meet the needs of the refugee population, including through the incorporation of traditional health beliefs, advocacy and education, and translation services, such as the Refugee Health Nurse Liaison programme, offers the opportunity for multiple barriers to care to be dismantled, increasing accessibility of care for the older refugee population (McBride *et al.*, 2016). This need for health-care services and community resources to be increasingly responsive is crucial as ageing refugees rely more heavily on assistance agencies (Das *et al.*, 2013).

Conclusion

The experiences of ageing among this community include increased disease and illness, as well as active engagement in health-seeking practices to maintain and promote health, despite structural barriers to care. Proactivity among all levels of the US health-care system, including individual providers, community clinics and the federal medical systems should continue to assess and respond to the needs of refugees, particularly as generational cohorts of refugees age. In particular, attending to the ways to integrate culturally responsive practices into Western health-care protocols can reduce barriers to care that have been present since the early days of resettlement. Furthermore, additional investigation into the systemic issues that prevent or limit the delivery of care by Western medical professionals for ageing refugees should be undertaken to understand more completely the challenges to receiving appropriate care that ageing South-East refugees experience. Future

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research should also examine the experiences of cohorts of older refugees in other South-East Asian communities as well as across older refugees of varying national origin to consider how health and health-seeking practices are impacted across the lifecourse.

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